

Teaching Coping Strategies: A Client Education Approach to Aural Rehabilitation

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Traditional audiologic client counseling, with one or two individual sessions as part of hearing aid fitting, is not adequate to promote lasting lifestyle and attitude changes. This article describes a program designed to encourage independent and active management of communication-related problems by hearing impaired people and their communication partners. The *Living With Hearing Loss* program, as taught at Olin E. Teague Veterans' Center, is based primarily on the work of Samuel Trychin, PhD, of Gallaudet University. Components and materials are described that can be used to implement a similar program in a dispensing or educational audiology practice. An adult education class format and extended time frame allow participants to assimilate new information and to generalize skills in new situations. Spouse involvement is also important to the success of the program.

Audiologists and educators of deaf students are recognizing the need to assess and teach coping strategies to hearing-impaired persons. For example, Knutson and Lansing (1990) suggest the need to evaluate communication strategies and target them for intervention when planning rehabilitation for cochlear-implant candidates exhibiting symptoms of depression and impaired social interactions. Tye-Murray, Tyler, Bong, and Nares (1988) and Tye-Murray, Purdy, Woodworth, and Tyler (1990) have discussed the importance of assessment and providing practice in the use of repair strategies via videodisc when communication breakdowns occur. Elfenbein and Davis (1986) describe a videotape test for communication effectiveness which examines various coping strategies in daily living contexts. Kluwin, Blennerhassett, and Sweet (1990) modified the semantic content and syntactic structure of the Adolescent-Coping Orientation for Problem Experiences (ACOPE, Patterson & McCubbin, 1987), and developed a signed version of this 54 item inventory. They found their modified inventory applicable for evaluating coping skills used by hearing-impaired adolescents and suggest that it provides useful

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information for making placement decisions within the schools and determining the need for training in coping strategies. The Communication Profile for the Hearing Impaired (CPHI, Demorest & Erdman, 1986), developed for an adult military population, evaluates communication strategies and personal adjustment in addition to communication environments and performance.

Interest in coping strategies is related to an increasing recognition of the effects of hearing loss on the individual's social and psychological well-being. Knutson and Lansing (1990) found that depression, introversion, loneliness, and social anxiety are associated with inadequate communication strategies, limited communication performance, and poor accommodations to loss of hearing. In an article describing the work of Samuel Trychin, a psychologist with hearing loss, McCarthy (1990) listed twelve recurring issues that Trychin has observed while counseling hearing-impaired people and their families: depression, isolation, anger, exhaustion, anxiety, insecurity, despair, negative self-image, inability to relax, loss of group affiliation, paranoia, and loss of intimacy. McCarthy (1990) also cited Trychin's observation that psychological problems associated with all degrees of hearing loss can become more severe over time if they are not addressed. Rutman (1989) reviewed the empirical research on reactions to acquired deafness and concluded that:

Adventitious hearing impairment is probably the single most devastating sensory loss. Successful adjustment requires the individual to acknowledge this loss and to accept the challenge of restructuring every facet of his or her professional and interpersonal life. (p. 310)

RATIONALE

Although the psychological and social implications of hearing loss may not be actively addressed by audiologists in their aural rehabilitation programs, the ASHA Committee on Rehabilitative Audiology states that it is within the scope of audiologic practice to provide intervention designed to actively encourage acceptance of the loss and to teach skills needed to restore or create effective communication. Their position statement (ASHA, 1984) indicates that audiologists should provide:

(1) guidance and counseling for the client, his/her family, employer, caregiver, teachers and significant others concerning the educational, psychosocial and communicative effects of hearing impairment and (2) individual and/or family counseling regarding acceptance and understanding of the hearing impairment; functioning within difficult listening situations; facilitation of effective strategies and attitudes toward communication; modification of communication behavior in keeping with those strategies and attitudes; and promoting independent management of communication related problems. (p. 37)

COPING STRATEGIES APPROACH TO AURAL REHABILITATION

Intervention focusing on the psychological and social impact of hearing loss

can be provided in a cost-effective manner using an adult education class model rather than an individual treatment model. This approach is not psychotherapy; special training in psychology or counseling is not needed. In fact, many of the topics included are a standard part of counseling new hearing aid users. The difference is that topics are addressed in groups over an extended time frame rather than in one or two individual counseling sessions.

The coping strategies approach to hearing loss management used at Olin E. Teague Veterans' Center is designed to teach individuals to deal more effectively with hearing loss. The following is a description of the program and the author's observations and experiences with it.

Program Administration

Seven groups have been taught in four settings by the author using the coping strategies approach. Each presentation has varied, based on individual needs and on experience gained from previous groups.

Candidacy. Most new hearing aid users and their spouses are candidates for this type of educational program. Many experienced users and their spouses with ongoing communication problems could also benefit. Audiologists often assume that experienced hearing aid users have learned to cope effectively, but this assumption should be evaluated. Caregivers of the hearing-impaired elderly and hearing-impaired individuals who cannot or will not use amplification may also benefit from this approach to hearing loss management.

Spouse participation. Family involvement is considered a key element since communication partners learn from the experiences and reactions of their peers in class as well as from the instructor. Families can improve their understanding of the mutual responsibility for good communication, examine effective and ineffective strategies, and work together to improve communication.

Size. Groups of 6 to 12 individuals have been most effective. A group of four (two couples) lacked adequate opportunities for peer interaction. An Elderhostel group of 22 was surprisingly manageable, but some individual members could have benefited from more opportunities for active participation.

Time frame. It is recommended that the program be offered as a weekly series of four to eight two-hour classes. An extended time frame is best since it allows participants time to assimilate information, practice strategies, apply rules, discuss outcomes, generalize new skills, and begin to change behaviors.

Room requirements. Chairs arranged in a circle or around a table allow optimal visibility for speechreading and promote peer interaction. A sound system consisting of two microphones, an amplifier, an audio loop and a speaker is used. A lapel microphone is used by the instructor while a hand-held microphone is passed from speaker to speaker in order to insure a favorable signal-to-noise ratio and encourage only one person to speak at a time. This also serves as a good example of managing a difficult communication situation. Lighting must be adequate for speechreading, and it should be possible to make the room dark enough for viewing videotapes. A blackboard or newsprint flip-chart is needed

to write main points of class discussion. If newsprint is used, a list of multiple solutions to a problem, generated by class discussion, can be given to the person who had experienced that problem. The sound system, seating arrangement, lighting, and written cues combine to help even severely hearing-impaired members follow the conversation.

Agenda. Written agenda are provided for each class. The first meeting is devoted to introductions, goals for the program, explanations of the loop system, discussions of individual problem situations, and rules for communication. The final meeting is devoted to reviewing goals, individual comments about the class, and program evaluations.

Other meetings focus on solving problems experienced by the participants. Information from six content areas is presented. Homework is given for each class: (a) reading material about the content areas, and (b) problem-oriented written assignments focusing on personal application of the materials and use of strategies. All participants complete the same assignments. Representative homework assignments include such items as:

1. Evaluate five common problem situations in terms of the listening environment and your own reactions to them.
2. Complete a check list of possible responses to stress.
3. List two common communication events, specifying the behaviors involved and describing how you reinforce or punish those behaviors.
4. List 15 possible solutions for a frequently occurring problem.
5. Practice rephrasing comments or commands by listing three different ways to say each of these statements.

The majority of class time is reserved for group discussion. Discussions of homework assignments are the most important aspect of the program since members learn from and encourage each other to apply the new information and develop a problem-solving approach to their communication problems.

One or two breaks are needed during the two-hour class. The auditory and visual attention required for the discussions and the personal nature of the topics discussed can be fatiguing. Breaks also create noisy listening situations for practicing strategies and demonstrating assistive listening devices.

Program evaluation. As with many aural rehabilitation programs, attempts to document benefits of this program with performance measures have proven to be somewhat frustrating. However, subjective course evaluations by clients have been uniformly positive, with most participants rating components "helpful" or "very helpful." Eighty-nine percent of those who began the program completed it, and the attendance rate has been 85%. Some have traveled 40 to 120 miles to attend.

Pre and post-testing with the Hearing Performance Inventory (Giolas, Owens, & Schubert, 1979), the Hearing Handicap Inventory for the Elderly (HHIE, Ventry & Weinstein, 1982), and the Beck Depression Inventory (Beck, Rush, Shaw, & Emery, 1979) have not shown significant changes. A one year follow

up was done with one VA group; no differences were noted on the HHIE, but consistent positive comments were made concerning the usefulness of the information and the desire for a "refresher class."

HHIE data from one client is representative. His pre-test total score was 90, post-test total was 74, and one year later his total score was 88. Clearly no significant score change was observed. However, this client drove 65 miles and stayed overnight in a motel before each class, reporting that he never knew when he'd be too dizzy to drive and didn't want to miss a class. A year later he reported spending more time with his family. He had avoided them for many years because of his hearing. Clearly, this man received benefits that are not being reflected by traditional objective measures.

COMPONENTS OF THE *LIVING WITH HEARING LOSS* PROGRAM

Using Trychin's materials as a framework, and supplementing them with other materials, such as Kaplan, Bally, and Carretson (1985), Erber (1988), and self-developed materials, the *Living with Hearing Loss* program taught at Olin E. Teague Veterans' Center has six components:

1. Environmental Management

When clients and their families recognize that specific factors in a listening situation affect speech recognition ability, they can apply strategies for improvement or set realistic expectations for performance. Trychin's materials, a workbook (Trychin & Boone, 1987b) and accompanying videotape (Trychin & Boone, 1987a), with "right way" and "wrong way" versions of communication interactions, provide separate lists of rules for hearing-impaired listeners and those who communicate with them. Kaplan et al. (1985) also provide complete and practical material. Many times simple, obvious solutions to communication problems are available. For example, one couple argued frequently about when to leave pool parties given by friends until the wife realized that she liked to leave early because she could not speechread after dark. Now they go in separate cars and both enjoy themselves.

2. Principles of Behavior

Clients are encouraged to focus on specific, observable behaviors rather than guessing the intentions of another person. Hard-of-hearing people and those who live with them may need to develop the ability to carefully examine communication behaviors in order to decide what changes are needed. A workbook (Trychin, 1987b) and videotape (Trychin, 1987a) provide examples of effective and ineffective communication behaviors and contain questions and answers that can be used for class discussion or individual study. Clients frequently rate this as a very enlightening component of the program. One man counted the number of times his wife turned and walked away while talking to him. By ignoring

her when she did this and reinforcing her (by paying attention to her and occasionally thanking her) when she completed the message before leaving, he saw a decrease in this irritating behavior.

3. Assistive Devices

The extended time frame of the class provides ample opportunity to demonstrate assistive listening and alerting devices. When the advantages of the improved signal-to-noise ratio have been experienced, acceptance of devices has been high. Hearing-impaired participants have been more assertive in requesting use of the devices, and spouses have been more willing to use direct audio input or FM transmitter microphones after enjoying relaxed conversations in a noisy crowd. Clients appear to enjoy "show and tell" with their own devices and are eager to try as many options as possible.

4. Stress Management

The negative effects of stress, fatigue, muscle tension, and anxiety can significantly interfere with the hearing-impaired person's ability to communicate. Trychin (1987c, 1988) provides discussions of how hearing loss can contribute to stress. Clients learn that their reactions to stress, that is, tight shoulders, cold hands, and so forth, can be used as signals so that conscious efforts can be made to relax. They can also recognize that their communication ability will not be at its best when they are stressed. There are three components to stress management training.

Relaxation training. The use of relaxation techniques to bring physical responses to stress under control can result in more effective communication in distressing situations. Separate trainee and practitioner manuals for relaxation training are available (Trychin, 1986c, 1986d). Exercises include deep breathing, deep muscle relaxation, visualization, and autogenic relaxation procedures. Audio and video tapes (Trychin, 1986a, 1986b) also contain relaxation techniques. One participant, a tax accountant, learned to use deep breathing in the privacy of the rest room several times a day. She reported that her concentration and productivity increased, her fatigue and irritability decreased, and her teen-aged daughter commented on her improved mood.

Assertiveness training. Assertiveness is required in order to follow the rules for good communication and to use coping strategies effectively. According to Kaplan et al. (1985) passive communication behavior results in frustration, isolation, feelings of inadequacy, and reduced self-esteem. An assertive hearing-impaired person is one who willingly admits to a hearing problem, explains the problem to other people when appropriate, and suggests ways to improve communication. Rocky Stone, Executive Director of Self Help for Hard of Hearing People, states that "Many problems, worries and anguish stemming from hearing impairment can be avoided by the cultivation of an honest and open method of communication, with insistence on the right to understand and be understood" (DiMichael, 1985, p. 3). One woman had great difficulty understanding heated

discussions between herself, her husband, and her teen-aged daughter. She realized that much of the trouble was that two of them often spoke at once. Having seen the benefit of passing a microphone in class, she asked them to agree to sit at the table and talk only when they were holding the salt shaker. They agreed, their rate of speech decreased, they spoke one at a time, and her understanding improved greatly. She reports that she still doesn't win many arguments, but she appreciates knowing what they were about and taking part in the decision making of the family.

Advocacy. Hearing-impaired people can increase their sense of control by taking a pro-active role in the political issues related to the civil rights of those with hearing loss. They can also play an important role in educating the general population about the effects of hearing loss and can influence the implementation of the Americans with Disabilities Act of 1990. One man wrote to the chairman of the board of a luxury hotel chain to complain that a visual smoke alarm was not available for him during his stay and that employees had no idea what he was asking for. He received a free week-end stay in the city of his choice and an assurance that devices would be bought and employees trained.

5. Cognitive Therapy

Negative thoughts about difficult listening situations can contribute to social withdrawal and isolation in hearing-impaired people. Cognitive therapy is based on the view that thoughts, feelings, and behaviors are related, and that the ways people feel and act are greatly influenced by their thoughts and their perceptions of the world around them. The goal of cognitive therapy is to help people recognize, reality-test, and change thoughts that interfere with their ability to cope with difficult situations. This concept may be unfamiliar to many audiologists. A popular discussion of cognitive therapy for depression can be found in Burns (1980). Trychin and Wright (1989) provide guidelines for the hearing-impaired individual to use in recognizing self-defeating thoughts and replacing them with more productive ones. For example, an unemployed accountant reported that he lost his job and could not find another because he was hearing impaired. Further questioning revealed that he thought that all normal-hearing people think he is dumb when they see his hearing aid, that past co-workers have kept important information from him, that his bosses had intentionally assigned him to the noisiest desk, and that he had gone to many interviews without expecting to get a job. The reality of each thought was checked, with other class members directing most of the discussion. More positive thoughts about work were suggested, such as planning to use assertiveness during an interview, educating boss and co-workers about his communication needs, finding and requesting the quietest work station, confirming understanding of information presented at meetings, and focusing on excellent job performance.

6. Coping

Coping involves expending effort to manage events or situations that are stress-

ful, maintaining a positive, problem-solving attitude, and learning from difficult situations. Two types of coping strategies are described in our program. First, emotion-focused coping involves feeling better at the moment. Trychin's behavior workbook (Trychin, 1987b) provides a discussion of emotion-focused coping behaviors, with examples of how escape-avoidance behaviors can result in social isolation. Second, problem-focused coping involves solving the problem. Problem-focused coping with specific anticipatory and repair strategies are described by Kaplan et al. (1985). Participants are urged to replace emotion-based strategies with problem-focused strategies.

An example of successful coping involves a family reunion. A client mentioned this as an upcoming problem situation, stating that he always had a terrible time, he never understood a thing, nobody liked him because he was so hard to talk to, and that he expected to get indigestion and a headache from the noise. Group discussion focused on the accuracy of his thoughts about his popularity in the family, his negative expectations of the events, and possible ways to improve this situation. The next week he reported surprise at enjoying the event. He avoided the noise of the crowd by asking individual family members to go for walks and had enjoyable conversations with each one, enjoyed the meal by watching people and not trying to listen, chose the quietest corner in the room, asked the host to turn down the stereo, and borrowed a personal FM system. This man, hearing impaired for 40 years, found success when he applied the coping strategies learned in class to develop more realistic expectations and a plan of action for this difficult listening situation. He is representative of many of the experienced hearing aid users who have participated in this program. They have not learned to cope effectively on their own. Many of their methods of coping are passive ones. By learning more assertive techniques, they report that more successful communication is achieved.

FUTURE APPLICATIONS

In Clinical Research

Studies employing single subject design are more appropriate than analysis of group data for investigating coping behaviors. For evaluation purposes, the use of the CPHI (Demorest & Erdman, 1986) is now used in our program, and it is hoped that this instrument will be more sensitive to the behavior changes we have observed. A need exists for other measures that examine specific communication behaviors. Also, the coping skills used by experienced hearing aid users and hearing-impaired persons who are not aided should be investigated. Sociology, psychology, nursing, gerontology, and other professional disciplines may have perspectives that will prove productive. The works of Demorest and Trychin have shown that psychologists can make significant contributions on behalf of hearing-impaired people. Additional interdisciplinary collaboration is needed.

In Dispensing Practices

A four to eight week program could be bundled with the cost of hearing aids and offered on a regular basis. Clients could be billed separately for the program. Possible benefits include fewer hearing aid returns, more realistic expectations and improved acceptance and satisfaction with amplification. Montgomery (1991) has stated that class participation after purchase is the single best way to insure hearing aid use. Increased hearing aid sales to current non-users and increased assistive device sales may be expected. Customer satisfaction with the quality of services from the audiologist is also likely to rise, and that satisfaction can lead to more referrals. Word-of-mouth referrals from experienced hearing aid users have been the main source of new clients in our program. The need exists. When the program is offered, clients and families have taken advantage of it. Fees have been charged in two of the four settings employed by the author. Audiologists typically charge for tangible products (evaluations or hearing aids), but they appear reluctant to charge for their time and expertise. The careers of speech-language pathologists and psychologists attest to the fact that the public will pay for services that they deem important and useful.

In Educational Settings

Kluwin et al. (1990) stated that "it is clear that non-copers will have difficulties in any situation and further work is needed with them to strengthen the resources needed to function in school" (p. 290). A coping strategies program for mainstreamed middle and high school students within a school district could be very helpful for developing repair strategies and interpersonal skills and for increasing self-esteem. Leavitt (1990) provided material appropriate for high school students.

CONCLUSIONS

The strength of a coping strategies approach is that it treats the whole person (and family unit) and not just the hearing loss. It provides focus on the dynamics of interpersonal communication and opportunities for peer interaction. It takes a problem-solving approach to the challenges that hearing loss can introduce into the daily lives of our clients. It gives clients and family members the time to assimilate new information and begin to make changes; an outcome that cannot be expected from single counseling sessions with individual clients.

Audiologists are encouraged to add this or a similar approach to their practices in order to provide services that focus on their client's psychological and social well-being. Their clients will function more effectively on a daily basis and be better prepared to manage communication problems. Audiologists may also find the long-term relationship with clients a rewarding change from their clinical routine.

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