

# **Hearing Impairment, Coping, and Consequences on Family Life**

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A qualitative analysis method gives a license to discover unique categories and problems that exist. In the analysis of in-depth interviews with individuals with hearing loss, 2 coping patterns emerged characterized by controlling or avoiding strategies. Two main types of handicapping situations, relating to environmental factors and to life habits and social roles, were distinguished in accordance with the hearing-impaired individual's own control of what was happening. Consequences of a hearing loss seem to affect the spouse. Spouses differ in their ability to cope with communication difficulties in everyday life. The results are integrated in a family perspective on rehabilitation.

The burden of any disability is shared with one's close relatives. The family, as a social system, is an organization of individuals who stand in a dynamic interchange with one another. Loss of hearing, one of the most prevalent serious disabilities in society, affects the personal safety and the quality of life of the person negatively and, also, for all those who relate to him or her. According to Jones (1987), a hearing disability strikes at the very heart of human life. The very heart of human life is social interactions. This includes all members of the family having to cope with the emotional effects of daily communication difficulties. Due to the interactive nature of such a communication disability, the close relationship might become affected. The social consequences of a hearing disability are enormous and still not fully understood.

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### **Interpersonal Consequences of Hearing Loss**

Studies on the effects of a hearing disability have commonly focused on the person with a hearing impairment and no or very little attention has been focused on the close relatives. Accordingly, studies on consequences of hearing loss on family life are sparsely reported. Beattie (1984) interviewed 96 adult patients at a hearing clinic on social aspects of hearing disability. Two effects of a hearing disability in communication were described: loss of status and dependency on intermediaries or protectors. Clymer (1993) placed special emphasis on the way a hearing loss affects family communication. She argued that a hearing loss can be a major source of dysfunction in the family system and that it is important that professionals help the family to enhance communication within the family unit. Family members often feel helpless about their inability to communicate satisfactorily with the individual with a hearing disability. According to Clymer, this frustration is seldom expressed because it might hurt the feelings of the family member with a hearing loss. Instead, the frustration might be turned inwards. If the family, supported by professionals, works at communication constructively, family life could be satisfying. For example, expressing frustration combined with showing acceptance, could result in a strong, mutually beneficial family relationship.

Miller (1983) studied family factors in audiological rehabilitation of the elderly. According to Miller, the probability for successful rehabilitation or adjustment is greatly enhanced if there is complete support from the other family members. He suggested that relatives should accompany the person with a hearing disability to every examination or rehabilitation session in order to gain insight into the problems of defective hearing. By doing this the relatives can learn how to reduce the difficulties experienced by the family member with hearing disability. According to Miller, the degree of support from family members will determine the success of any hearing rehabilitation program.

Noble (1983) referred to the concept of stigma which is a discreditable attribute of the individual (Goffman, 1963). Being stigmatized means being treated as a deviant and implies a threat of social exclusion. The whole identity of the stigmatized person is reduced to the attribute that is being negatively labeled. Therefore, stigmatized people try to normalize themselves and pass as normal. Noble suggests an expansion of the normal world to accommodate a larger variety of humans, for example individuals with hearing disabilities.

In open-ended interviews with couples, where one of the individuals had a hearing impairment, Jones (1987) found that the hearing loss affected control and interpersonal relations within the family involving a decrease in intimate talk and joking. Husbands and wives often disagreed regarding their perception of the effects of the hearing loss such as ability to answer the doorbell, missing out conversation, and localization of sounds. Héту, Lalande, and Getty (1987) interviewed groups of workers with noise-induced hearing loss (NIHL) and their

spouses. These authors reported several examples of contradictions concerning the couples' experiences of the hearing difficulties. Héту, Jones, and Getty (1993) examined the effects of hearing loss on the intimate relationship. They found that awareness of the hearing impairment and its consequences is impeded by lack of internal reference, blame, misunderstanding, and stigma. These authors argued that because of the progressive nature of an NIHL, mutual adjustment takes place long before the couple becomes aware of the hearing loss and its consequences.

Alston, McCowan, and Turner (1994) presented a family strength model designed to delineate factors associated with psychosocial adjustment for African American clients with multiple disabilities. The authors found significant correlations between acceptance of disability, family strength, and successful adjustment. These authors suggested that both the nuclear family and the extended family network should be included in the rehabilitation or adjustment process. Stephens, France, and Lormore (1995) asked persons with hearing loss and their significant others to list the problems they experienced because of their relatives' hearing loss. Significant others reported difficulties with live speech and psychosocial problems whereas the persons with hearing loss reported problems relating to dependency. A gender difference was found: Significant others of female patients emphasized psychosocial problems whereas significant others of male patients emphasized the need to repeat phrases. Stephens and co-workers argued that significant others play a key part throughout the rehabilitation or adjustment process. However, the danger of them dominating the person with hearing loss, who may be less articulate or assertive, must be borne in mind.

### **Coping With Hearing Loss**

The concept of coping is assumed to play a central role in adaptation to illness and disability. Probably, some coping strategies have a moderating effect on the stressful situation (e.g., sitting close to the speaker) and are thereby preventing feelings of handicap. Other coping strategies, for example avoiding social interactions, might result in the opposite: increased feelings of handicap. It is very common for people to use a variety of coping strategies. Probably, the individual's way of coping with life stress in general, as well as his/her basic personality, play significant roles in coping with hearing loss. On the other hand, human behavior is affected by the psychosocial environment, indicating that coping could be situation-specific. Research on coping has mostly focused on *general* coping with stressful events and is seldom focused on coping with *specific* disabilities, for example hearing disability. Existing research on coping with hearing loss is mainly based on questionnaire-data (Demorest & Erdman, 1986; Giolas, Owens, Lamb, & Schubert, 1979; Héту et al., 1987; Lalande, Riverin, & Lambert, 1988), and the focus is on quantifying adaptive and maladaptive communication strategies. Briefly, these quantitative studies have shown that a vari-

ety of strategies were used by individuals with hearing disability, but only a few of them actually supported communication, for example asking for repetition and looking for a quiet area. It was also found that individuals with lowered self-esteem tend to withdraw from communication situations. Qualitative studies on coping with hearing loss give a license to describe coping categories as perceived by the individuals with hearing disability themselves.

### **PURPOSE**

The aim of this paper is to summarize results of our qualitative studies on how individuals and their respective spouses cope with the consequences of an acquired hearing loss. The aim is also to integrate these results in a family perspective on audiological rehabilitation. Coping with demanding auditory and/or potentially handicapping situations (those in which a hearing disability can turn into a handicap) was described from the perspective of individuals with hearing impairment (Hallberg & Carlsson, 1991b, 1993). Experiences of living close to a male with a severe NIHL were described from the perspective of spouses (Hallberg & Barrenäs, 1993).

### **METHOD**

#### **Grounded Theory**

A qualitative method in line with the grounded theory-tradition was used (e.g., Strauss & Corbin, 1990). Such a method gives the investigators a license to discover their own categories and problems that exist in the studied area. In a grounded theory study, collecting and analyzing data are done simultaneously. Data are collected until saturation is reached: This point is met when additional data do not give new information. The aim of a grounded theory study is to generate concepts, a model, or a theory rather than to test any existing theory. The emerging model or theory must be grounded in the empirical data. There are three basic elements of grounded theory: concepts, categories, and propositions. Concepts are the basic units of analysis since they are from the conceptualization of data. These concepts are developed by constantly comparing different pieces of data and seeking a common meaning to it. In a next step, concepts with similar meaning are grouped into categories. Categories are higher in level and more abstract than the concepts they represent. As few categories as possible and their subcategories should be developed, explaining as much as possible of the data. Propositions indicate conceptual relationships between a category and its concepts and also between discrete categories.

The analysis of data consists of three types of coding processes: open coding, axial coding, and selective coding. Open coding deals with labeling and categorizing of phenomena as indicated by the line-by-line analysis of the data. The products of this coding procedure are concepts and categories. Axial coding

deals with making links between a category and its subcategories. Selective coding involves the integration of categories that have been developed to form a theoretical framework. A core category is identified when patterns in the data are related to one and the same category. According to Strauss and Corbin (1990), the core category must be the Sun, standing in orderly systematic relationships to its planets.

### **Subjects**

Twelve individuals, 7 males and 5 females, at the age of 40-60 years participated in two studies by Hallberg and Carlsson in 1991 (b) and in 1993. These individuals had acquired hearing losses of different onsets, degrees, and types. Hearing loss ranged from mild to severe. Ten of the subjects had hearing aids and all of them were employed. The sample was strategically selected in order to give variability in the data by including individuals with different background conditions such as teacher, industrial worker, office clerk, farmer, nurse, and engineer. Ten females, spouses of men with severe NIHL, formed the sample in a third study (Hallberg & Barrenäs, 1993). The females were requested to participate in the study by their husbands, who were patients at the hearing clinic. These men were participants in a group rehabilitation program designed for males with NIHL and their spouses.

### **In-Depth Interviews**

Each subject was interviewed on five occasions, once a month, at the hearing clinic. Each taped in-depth interview lasted for 60-90 min. The interview questions were open and the subjects were encouraged "to tell it as it is" in their own words. The individuals with hearing loss were asked to describe stressful situations related to their hearing disabilities and what they did, thought, and felt in these situations. The interview questions to wives of men with NIHL were focused on their experiences of living close to a man with impaired hearing: for example, What are the problems? What are the strategies to cope with listening and communication strategies in everyday life? Has the couple's way of living changed due to the husband's hearing loss? All audio-taped interviews were transcribed verbatim by the investigator.

## **RESULTS**

### **Coping With Hearing Loss**

Two coping patterns, each including several qualitatively different strategies, emerged in the analysis of the in-depth interviews. The individuals used strategies included in both of these coping patterns in an attempt to manage demanding auditory situations in everyday life. The two coping patterns were labeled *to control the social scene* and *to avoid the social scene*. The coping patterns, each pattern consisting of several coping strategies, formed a model of coping with

hearing loss (see Hallberg & Carlsson, 1991b).

*Controlling strategies* are characterized by actively and constructively managing the situation, planning one's activities, and preventing disturbed interactions with the environment. The subjects in the sample took the command over the situation by, for example, acting as a spokesman or as a secretary at a meeting at work. To a great extent they put the responsibility of communication difficulties on the other participants: "If you want me to hear, you have to speak up." The data also reflect the subject's own responsibility for the outcome such as: instructing others how to behave in demanding auditory situations to enhance the hearing, informing others about the hearing impairment, and asking others for repetition. One way to control the environment is to seek extra input by comparing received information or decisions with a colleague or with available minutes of meetings to reconstruct the contents of the information. This strategy might imply that the person with hearing loss puts great demands on himself/herself to be as competent as his colleagues, but the strategy also demands adaptation and responsibility from the environment.

The other coping pattern, *avoiding strategies*, is characterized by an attempt to avoid or escape from situations that can be demanding or threatening. The person with hearing loss prefers to be alone and might take his coffee break in his room or in another quiet place instead of being exposed to potentially hearing-demanding and threatening situations. By these avoiding strategies, the person with hearing loss has controlled indirectly situations he experiences. This escape from communication may be self-protective in a short perspective but could also lead to self-centeredness. Also, the individual with hearing loss tries, in different ways, to joke about the hearing difficulties and to minimize the disability by positive comparisons to others having worse hearing, to better endure it or to accept it. Wishful thinking is one way of minimizing the disability and maintaining the hope that the hearing status might be better.

Using *technical aids*, *adaptation of work*, and *recovering* were three coping strategies adopted more or less by all subjects. It was obvious in the data that after a day at work the person with hearing loss feels tired and needs peace and quiet before he is able to live a normal family life. In our studies, the same individual used a variety of strategies, but each individual seemed to have a preference for one of the coping patterns: controlling or avoiding strategies. The emerging core variable, which explained the findings, was socio-psychological: Individuals with hearing loss strive to preserve their normal identity and to prevent their definition as a deviant in social interactions. Both coping patterns, that is controlling or avoiding strategies, attempt to maintain the normal social identity and, also, to avoid being labeled as a deviant in interactions with normally-hearing individuals. Goffman's (1963) theory of labeling and spoiled identity expanded the understanding of the interaction between the hearing-impaired and the so-called normal people.

### Handicapping Situations

The interviews showed that the interaction with others was described as very restricted and that life had become less satisfying. The individuals with hearing disabilities described a perceived barrier between themselves and people with normal hearing in social interactions. Those with NIHL failed to respond appropriately to the socially created and desirable communicative rules. Their experiences were: (a) they perceived that people in general showed neither understanding nor sympathy, (b) they perceived imposed limitations of self and/or environment, and (c) they had feelings of frustration and aggression and also a frustrated need of self-assertion. To sum up, they described *a restriction in social interactions* or expressed in other words: it was impossible for them to participate in society on equal conditions as normally-hearing people. Their descriptions gave a picture of the structure of handicap in individuals with impaired hearing, which might be summarized in two main dimensions: threat to the self-image and interpersonal distress.

A hearing loss is a mutual communication impediment, with need for adjustment from the receiver as well as from the sender of a message. Despite this, the responsibility for using adjustment strategies is generally attributed to the individual with a hearing impairment. It was obvious in the interviews that a hearing disability can turn into a handicap in a variety of situations representing many facets of life. Two main categories of potential handicapping situations emerged in the data: (a) *situations relating to environmental factors*, which describe the general obstacles when receiving information attributed to sender-problems or environmental circumstances, and (b) *situations relating to the individual's life habits and social roles* (see Hallberg & Carlsson, 1993). These main categories of situations were distinguished in accordance with the individual's own *control* of what was happening. Situations relating to environmental factors were partly outside the control of the person with a hearing disability, whereas situations relating to life habits were to a greater extent controlled by the individual himself/herself. This means that a hearing disability can turn into a handicap due to environmental conditions.

One common way to adjust, or cope with a hearing disability is to avoid potentially handicapping situations, such as group meetings, parties, and restaurant visits. In a short-term perspective this escape from communication may be self-protective. However, self-protection could also lead to self-centeredness, resulting in, for example, a lack of concern for family members' feelings. In a long-term perspective, the cost could be loneliness, isolation, and decreased quality of life for the individual as well as for the family. In-depth interviews with men with NIHL (Hallberg & Barrenäs, 1995) showed that their dominating coping pattern included to avoid, or escape from, interactional situations (i.e., avoiding strategies). However, in some conditions the men used more controlling strategies, for example in communication on important topics with one or few known

individuals at work. It was also obvious that they showed more irritation and aggressiveness at home than at work. Probably, a hearing loss is a source of annoyance and dysfunction within the family.

### **The Perspective of Spouses**

In-depth interviews with spouses showed that living with a man with NIHL often is a demanding and exhausting task. The interviews also showed that most men were unwilling to spontaneously admit the hearing loss and its consequences on family life and close relationships. However, the data showed convincing evidence that the consequences of an NIHL to a great extent affected the spouse, and that the ability to cope with these consequences differed among the wives. Two main categories emerged as core variables in the data: (a) the husband's unwillingness or reluctance to acknowledge hearing difficulties and (b) the impact of hearing loss on the intimate relationship. The interpretation of the data is that there is an on-going game on the part of the male, who is aware of his hearing loss but rejects or denies hearing-related problems. The driving force of this game is to protect a positive self-image and to avoid being defined as deviant. There was a clear difference in the data whether the spouse participated in the game or not. The driving force for participating in the husband's game was her striving to protect the image of a socially-normal couple. Combinations of variations in the two core variables were related to four qualitatively different management patterns used by the spouses to deal with the situation: *co-acting strategies*, *minimizing strategies*, *mediating strategies*, and *distancing strategies* (see Hallberg & Barrenäs, 1993). These strategies and their relationships to the core variables are briefly described below.

Some of the spouses using co-acting strategies did not perceive the husband's hearing disability as a problem or as an impediment in daily life. Accordingly, they did not admit any impact of hearing loss on the close relationship. These spouses shared their husbands' unwillingness to acknowledge problems related to the hearing loss. One spouse said,

As I have told you, I don't think of the situation as stressful. Everything at home functions well. There is nothing special to focus on . . . you just have to adjust to each other. As a spouse you have to be patient.

Together they tried to protect, for themselves and for others, the social image of a fully-normal couple. Generally, interaction between people is facilitated if the persons involved share the perception of reality. At least in a short-term perspective, these co-acting strategies seem to be a functional way of adjusting to a hearing disability.

Most spouses using mediating strategies said that the hearing loss frequently caused misunderstandings and irritation within the family, which possibly could have a negative impact on the close relationship in the future. It was obvious that the children in the family more often turned to their normally-hearing mother



than to their father with a hearing disability, leading to an imbalance within the family such that the parent with hearing disability became less involved in family matters. Several spouses took the main responsibility for the husband's ability to hear, and to respond adequately, in interactions with other people. One of these spouses said,

It is very stressful to me . . . I must work extremely hard all the time and I must be very attentive . . . I must listen to what others say and at the same time make sure whether he is involved in the discussion or not.

This responsibility, or control, over the couple's social image, takes a great deal of energy on the part of the spouse. This control, or mediating strategies, also created feelings of stress and vigilance in the spouse. In a long-term perspective, this double work possibly affects the close relationship.

When using minimizing strategies the spouse shares the husband's unwillingness or reluctance to acknowledge hearing difficulties. However, at the same time, the spouse admits some influence of the hearing loss on the couple's close relationship. One of these spouses said,

During the last years I have become more and more silent . . . there is no use in discussing the problem with him . . . it does not work, it always ends up in a conflict and you want to avoid that . . . especially me.

An example of a minimizing strategy is to "clench your teeth" and avoid marital conflicts in order to maintain domestic peace and to present an image of a socially-normal couple to people around. Some spouses regarded the husband as mentally altered and, also, that he has grown so much older. This indicates that a man with NIHL might be stigmatized at home.

Distancing strategies, also identified in the data, mean that both parties had adjusted to the situation, but in different ways. The spouse did not play the game of denial or rejection of the hearing problems and she strongly admits that their intimate relationship has become affected negatively by the hearing disability. One of these spouses said,

It is hard to get in touch with one another . . . we are on different levels, so to speak . . . sometimes it is almost impossible to reach each other. You may say that there is a mutual irritability between us. The hearing loss has really affected our intimate relationship.

The couple lived side by side in a marital relationship but the communication between them was minimized or almost non-existent. The husband preferred to stay at home, watching the TV or reading a book, whereas the wife went alone to the theatre, to parties, or to see her friends. Accordingly, the couple cannot preserve for themselves or for others the social image of a normal couple. Of course, it is impossible to know if the hearing disability is the main cause of the disturbed marital relationship or just a facilitating factor in a process of a relationship breaking down.

## DISCUSSION

### Stigmatization

The connection between sensory decline and general decline in cognitive function in people of old age is often extended inappropriately to people who are only hearing impaired (Miller, 1983). This means that hearing problems often are attributed to a person's cognitive ability rather than being viewed as perceptual problems. Overgeneralization is at play when signs of hearing impairment are taken as signs of rudeness and stupidity. Social interactions are crucial for maintaining the self-image and the social roles. It was obvious in our in-depth interviews that a hearing loss often results in disturbed interactions with others. Frustration, irritation, and inferiority in social interactions were mentioned frequently by the subjects. Individuals with hearing disabilities are often defined by others as deviant persons, not only persons with disabilities but totally deviant persons. The self-image of the individual is threatened by this stigmatization. According to the data, the coping strategy chosen in a specific context intends to prevent or minimize stigmatization and thereby maintain a positive self-image of normality. This is similar to what Goffman calls to pass as normal. Héту (1996) has also described the stigma attached to hearing impairment and the need for normalization of the identity.

### Gender-Difference in Coping With Hearing Loss?

In our studies we found that males often prefer invisible nonverbal strategies, for example watching the speaker's face and concentrating intensely. The aim is then to catch the main points of the information, which indicates a transactional communication goal. Also, men often pretend to hear or try to guess what was said in communication. Women, on the other hand, used a variety of strategies: asking for repetition, informing others about the hearing loss, and asking others to catch their attention before speaking to them. Interviews with women with NIHL indicated that they measured the emotional temperature in any communication situation (Hallberg & Jansson, 1996). In a warm and friendly atmosphere, controlling strategies were used; for example, asking people to speak up or repeating what they have said. In an unfriendly atmosphere, avoiding strategies dominated; for example, pretending to hear or guessing what was said. Accordingly, the perceived emotional climate in a specific communication situation directed how much of attention and space the woman was allowed to take. This indicates that there might be a gender difference in coping. This assumed gender difference in coping could be explained by the fact that women and men are exposed to different communication and listening situations. Folkman and Lazarus (1980) argued that the situation, as such, rather than the gender seems to influence coping.

### **Gender Differences in Communication Goals?**

According to our interviews, the environment contributes considerably to a listener's difficulty in understanding speech, for example, by the acoustical conditions and the speaker's articulation. Pichora-Fuller, Johnson, and Roodenburg (in press) discussed the interactional and the transactional dimensions of communication. Although both dimensions are included in most communication, the interactional dimension of communication dominates in small talk and conversations whereas the transactional dimension dominates in information giving. Pichora-Fuller and co-workers discussed a model, in which miscommunication was seen as depending on two factors: the communication goal (transactional or interactional) and the mode of processing (surface or deep processing modes). In addition to differences in coping, there might be a gender difference in the main goal of communication. Research has indicated that males often prefer transactional communication and that they try to catch the main points of information (McKellin, 1994). Women, on the other hand, often adopt more relational listening behaviors. It has been shown that maladaptive coping strategies, such as preferring invisible nonverbal strategies, guessing what was said, pretending to hear, and avoiding communication, significantly contribute to feelings of handicap (e.g., Hallberg & Carlsson, 1991a).

### **Reluctance to Acknowledge Hearing Difficulties**

Living with NIHL is described differently from the perspective of the husband and from the perspective of the spouse. In-depth interviews with men with NIHL (Hallberg & Barrenäs, 1995) showed that their spontaneous description of the effects of the hearing loss on family life was, "There are no problems with my hearing. We live as we have always lived . . . nothing have changed. But my wife speaks with a very weak voice and the children speak very fast . . . they are always in a hurry" (Hallberg & Barrenäs, 1995, p. 229). However, after some reflection most men admit that they were unwilling to go with their spouses to a cinema, a theatre, or a party due to "lack of interest" and maybe, due to expected hearing difficulties. Often, the spouses also stayed at home instead of interacting with others. In some cases the husband stayed at home alone and his wife went to the party with friends. Probably, these consequences of the husband's hearing disability might have negative effects on the couple's relationship.

In-depth interviews with spouses of men with NIHL showed that there was an ongoing game-playing from the part of the male, who was aware of his hearing impairment but verbally rejected or denied any problem related to the hearing loss. Some spouses played this game too, whereas others did not. All women in the study were living together with men who had received economical compensation for their occupational hearing losses. The data showed convincing evidence that the consequences of a hearing loss to a great extent affected the spouse, and that the ability to manage these consequences differed among

spouses. Erdman (1993) stated that spouses tend to underestimate the amount of difficulty experienced by the person with hearing loss. If this is the case, the spouses might not give their family member with impaired hearing the natural social support which would help them to cope with the hearing loss (Schum, 1994). Another question raised by the results of our study is whether the coping strategies used by the spouses are permanent or represent different steps in a process. For example, what will happen when the couple no longer are employed and actively engaged in working-life and, accordingly, have more time to spend together?

Héту, Riverin, Getty, Lalande, and St-Cyr (1990) described difficulties in acknowledging hearing problems in males with NIHL. Based on the statements in their interviews, these researchers differentiated between denial, minimization of the problem, reluctance to talk about the hearing problem and its consequences, and attempts at normalizing. According to Héту and co-workers, the threat to the person's social identity was expressed not only in reluctance to endorse an image of being a person with a hearing loss but also through attempts to assert that he is normal despite a hearing problem. This also implies concealing any sign of hearing loss. A similar picture was found in our interview-study.

#### **Acceptance of Hearing Loss**

Acceptance seems to be a significant factor in the process of psychological adjustment to acquired hearing loss (Hallberg, 1994). High degree of acceptance means that the hearing loss has been integrated into the individual's self-concept and, also, indicates non-discriminatory attitude towards people with disability. Wright (1983) argues that acceptance means to feel valuable and worthy despite the disability, which includes to maintain a positive self-image. The hearing disability can still be seen as limiting, and the individual strives to improve hearing rather than hide the disability and acts as if the disability does not exist. Acting as if the disability does not exist demands awareness of the disability in every situation (Wright, 1983). By idolizing normality the individual might expect others to ignore the disability and treat him or her like anyone else. There is a similarity between behaving as if the disability does not exist and trying to pass as normal (Goffman, 1963). In line with the suggestion by Noble (1983), the normal world should be expanded and accommodate individuals with hearing loss. If the individual is able to accept his/her hearing impairment and can avoid feeling of inferiority, he/she is in a strong position to achieve maximum audiological rehabilitation (Miller, 1983).

#### **Clinical Implication**

The psychosocial environment, including the family and significant others, often contribute to the creation of handicapping situations and feelings of handicap in the individual with hearing impairment (Hallberg & Carlsson, 1993). If

the aim of rehabilitation is to eliminate handicapping situations and thereby prevent feelings of handicap, then it is necessary to include the spouses and/or other close relatives in any audiological rehabilitation program. Another goal of the rehabilitation should be to increase the likelihood that mutually satisfactory everyday communication occurs (e.g., Carson & Pichora-Fuller, 1997; Montgomery, 1994). Therefore, it is important that professionals strive to reach beyond the medical model and, also, as a routine focus on the whole family in the rehabilitation or adjustment process (e.g., Gagné, Héту, Getty, & McDuff, 1995; Getty & Héту, 1991; Hallberg & Barrenäs, 1994). Medical models mainly transform information to individuals at risk and should be complemented by psychological models aimed at changing attitudes and beliefs and enhancing self-esteem (Carson & Pichora-Fuller, 1997). Such an interdisciplinary health model, designed for groups of individuals with hearing disabilities and their close relatives, could include:

1. Offering the couple/family adequate knowledge about the hearing impairment and its consequences and how to prevent the progression of hearing loss (transactional goal). This increased knowledge is a necessary condition for changing beliefs and attitudes. Informational counseling should also focus upon available technical aids such as hearing aids, hearing protectors, and other auxiliary devices.
2. Offering the couple/family psychosocial support in the process of mutual acceptance of hearing loss within the couple/family (interactional goal). This includes group-discussions, support from group members, and self-esteem enhancement efforts.
3. Teaching and training the couple/family in effective coping with the situation, for example less *over-protection* from the part of the spouse/family and less *self-protection* or escape from communication from the part of the person with hearing disability (relational goal). Coping and adjustment include both external behaviors and internal responses. If professionals help the family to work constructively at communication and coping, the quality of life in the family unit can be satisfying, despite the fact that one family member has a hearing disability.

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