Chapter 11

Personal Adjustment Counseling

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A Scheme
Chronic or Acute
Absence or Presence
Problem- or Emotion-Focused
Natural or Contrived
Conclusion

The focus of the present chapter is on the personal adjustment needs and counseling services that may be required for individuals who have a hearing impairment. The chapter considers the dynamics of adjustment processes and identifies some meaningful parameters that may be relevant to counseling individuals with a hearing impairment. Specifically, the parameters discussed include: chronic versus acute situations, absence versus presence of stimulation, problem-focused versus emotion-focused coping, and natural versus contrived interventions. Throughout the chapter an attempt was made to relate research on adaptation to other physical impairments and chronic physical conditions to the adjustment processes and counseling needs of individuals with a hearing impairment. Also, some research needs in the area of personal adjustment and counseling of persons with a hearing impairment are identified.

In considering the topic of Personal Adjustment Counseling as related to audiological rehabilitation, one needs to consider how counseling is defined. Personal adjustment counseling focuses on the *adjustment* of persons who have hearing losses. In this chapter, adjustment will be defined as the process of *coping* or adapting to one's hearing loss. Coping and adjustment presume both external behaviors and internal responses. The internal responses can include cognitions (appraisals of one's situation) and emotions (one's reactions to the situation). In the context of audiological rehabilitation, it is important to note that *counseling,* as used in the context of this chapter, extends beyond the narrow definition sometimes applied in audiological settings. In the narrow use, counseling implies the delivery of information, such as informing a client on how to

best use an amplification device. In this chapter, though, counseling is used to cover a broader range, which includes helping a client adapt to a particular problem. This adaptive assistance oftentimes includes focusing on the emotional reactions clients have and the behaviors (coping process) they use to regulate their emotional states. Using the WHO (1980) model of disorder, impairment, and handicap, this type of counseling addresses the *handicap* of the person who has a hearing impairment. Refer to Chapter 17 (Hyde & Riko, 1994) for more information on the WHO definition of impairment, disability, and handicap. In the context of the present chapter, handicap refers to the psychosocial disadvantages in areas such as personal relationships, emotional adjustment, and vocational functioning.

When considering the directions for research in this area, one needs to face an important problem that has crept into many areas of science. As knowledge has expanded, professionals have become specialized to the point of developing great depth of knowledge while sacrificing breadth. It is impossible for most professional individuals to keep up with all the scholarly developments in related areas (e.g., medicine, physiology, psychology). Therefore, scholars tend to focus in one area, often becoming unaware of parallel work in other areas. For example, persons working in the area of audiological rehabilitation became highly specialized in their focus on individuals with hearing losses. This specialization, though, can distract one from the fact that the subject of interest is a *person* who is coping with a physical impairment (in this specific case, the person happens to have a hearing loss).

It is this writer's point of view that there are only a finite number of ways that human beings cope with challenges in their lives. Admittedly, within that finiteness exists the variety and diversity that distinguish humans. Yet, the basic fact remains that persons with hearing losses are persons *first*. In considering adjustment to hearing loss, clinical researchers would be wise to not presume that adjustment to *hearing loss* is something unique and specific. Rather, it might be more parsimonious to assume that there are coping and adjustment processes used by humans dealing with hearing loss that are common to human beings who are struggling with other similar challenges. This broader perspective begins with consideration of the knowledge developed within the field of audiological rehabilitation and expands further across the spectrum of human behavior. Rather than duplicating work already done in other aspects of human coping, researchers interested in issues related to adjustment to hearing loss might look across professional-academic boundaries to what has already been learned about the human adjustment process. Then a researcher interested in hearing loss can investigate what similarities and differences exist between issues related to coping with a disability in general and the particularities of coping with a hearing loss.

The problems of adjusting to an acquired hearing loss have been discussed in the literature (e.g., Kyle, Jones, & Wood, 1985; Meadow-Orlans, 1985; Thomas, 1984). However, scholars have also investigated the challenges of adjusting to

other acquired physical changes, such as limb loss and mastectomies (Kindon & Pearce, 1982; Taylor, Lichtman, & Wood, 1984; Varni, Rubenfeld, Talbot, & Setoguchi, 1989). There may be patterns of adjustment common to all instances of physical disability. For example, Kindon and Pearce (1982) reported that persons who have limb amputations develop emotional responses such as: anxiety and grief, worry about responses of family members and employers, concerns about future employment, and experiencing stages of adjustment to their physical changes. Taylor et al. (1984) in studying women who had mastectomies, identified issues such as: feelings of control over the physical condition, compliance with a treatment regimen, and attribution of blame for the condition as major components of the coping and adjustment process. The adjustment issues in the two groups noted above are similar to issues discussed in the adjustment of persons who have acquired hearing losses (Erdman, 1993; Meadow-Orlans, 1985; Thomas, 1984). Perhaps aspects of counseling techniques that are successful for persons with limb loss or mastectomies might be applicable to individuals who have an acquired hearing loss.

As another example, rehabilitation and counseling techniques used with persons with tinnitus (e.g., Clark & Yanick, 1984; Hazell, 1987) are strikingly similar to techniques used with persons who have chronic back pain (Hanson & Gerber, 1990). These include the use of relaxation and hypnosis, biofeedback, and even electrical stimulation (transcutaneous electrical nerve stimulation). The electrical stimulation technique may be a treatment analog to tinnitus maskers. It appears that techniques for adjusting to one form of an intrusive, chronic physical problem (low back pain) might be applicable to the problems associated with another form (tinnitus), as was suggested by Sweetow (1984).

A SCHEME

There are different ways one could describe an organization of research into the utility and effectiveness of personal adjustment counseling. A number of issues have been investigated in audiological rehabilitation, and an even greater number of issues have been investigated in the general areas of rehabilitative and psychological counseling. It is important to recognize that an investigator's research plan represents that person's particular interests and values. There are a number of issues that have already been researched in the field, such as the emotional reactions of persons with acquired hearing loss, the impact of hearing loss upon psychological status, as well as other specific features related to the hearing disability and handicap (Erdman, 1993; Thomas, 1984). Erdman (1993) presents an excellent summary of the current state of counseling with adults who have hearing impairments.

In the present chapter the focus is placed on issues of counseling and adjustment that may be common to all persons who experience some form of physical disability and handicap. The purpose is to examine some counseling issues that rehabilitative audiologists could evaluate and apply to their counseling services.

Table 1 lists important parameters discussed in the psychological and medical literature related to coping and adjustment to challenges. One helpful parameter is the distinction of *chronic* versus *acute* situations. For example, some hearing losses (and their associated problems) are chronic, long-standing situations, such as prelingual severe hearing loss. Other hearing losses may be the result of an acute situation, such as a head injury, or a relatively acute situation such as an acquired, progressive hearing loss developed in mid-life. It would be of interest to delineate aspects of coping and personal adjustment issues that differ (or are similar) among adults who have had a chronic hearing loss versus those who experienced a sudden hearing loss. At the present there exists little information on this topic (see Rutman, 1989).

Table 1

Parameters of Personal Adjustment Counseling

1. Chronic versus Acute situations
2. Absence versus Presence of stimulation
3. Problem-focused versus Emotions-focused coping
4. Natural versus Contrived intervention

A second parameter considers the dimension of *absence-presence*. Some aspects of hearing impairment involve the absence of stimuli, which causes stress for a person. The most obvious example is the loss of hearing. The absence of sound stimulation and of an important communication channel has received considerable recognition in the area of audiological rehabilitation. However, perhaps comparisons with persons who have endured other forms of sensory or communication impairments can provide new insights or information regarding adjustment and counseling issues. For example, this might include comparisons with persons with visual impairments and with persons who have neuromuscular diseases that significantly limit expressive communication. Additionally, in contrast to problems of the absence of stimuli, there are also problems of coping associated with the presence of stimuli, for example, tinnitus. Many clients with a hearing impairment report that their tinnitus is more problematic (difficult to cope with) than their hearing loss (Schow & Nerbonne, 1989).

The first two parameters shown in Table 1 consider the nature of the problem. The third parameter considers the nature of the coping effort. Lazarus and Folkman (1984) discuss the components of the coping process, which involve two major coping efforts:

> *Problem-focused* coping is intended to act on the stressor (i.e., to change or ameliorate the problem);
>
> *Emotions-focused* coping is intended to act on one's adjustment to the problem (i.e., to change one's attitudes or feelings).

In this context, one can consider personal adjustment counseling to cover a range from information (problem-focused) counseling on how to modify one's environment, to psychotherapeutic-based (emotions-focused) counseling that entails how to deal with one's feelings about the problem.

The fourth parameter presented in Table 1 addresses the issue of *how* the counseling services are provided to the client. One can distinguish between *natural* and *contrived* forms of counseling assistance (see: Marinelli & Dell Orto, 1977, for a discussion of a self-help model). Natural assistance includes the types of aid and assistance humans offer whenever one person is particularly challenged. This includes methods within a family and methods within a culture to help counsel and support a challenged member. In contrast, one can also consider contrived forms of assistance – those in which a designated clinician attempts to facilitate adjustment (coping, change) in a more formal, prescribed manner.

An examination of the above-mentioned general parameters of personal adjustment counseling reveals a number of critical issues that are directly applicable (and of great interest) to the field of counseling individuals who have a hearing impairment. These parameters describe features involved with the nature of the problem (chronic-acute, absent-present), the type of counseling approach (problem- or emotion-focused), and the therapeutic approach (natural-contrived). These parameters were chosen because they reflect current psychological issues regarding coping and adjustment processes used by people who are confronted with challenges. The following sections provide an expansion of each of these parameters, with a focus on specific research issues related to each parameter as they might apply to audiological rehabilitation.

CHRONIC OR ACUTE

The *chronic* versus *acute* dichotomy lends itself to interesting research possibilities related to coping processes and methods of intervention through counseling. For example, the MMPI – Minnesota Multiphasic Personality Inventory (Hathaway & McKinley, 1943) – has been used extensively to study persons with a variety of health problems. A common pattern of the MMPI profile is known as the *conversion valley*, with elevations on Scales 1 and 3 (Hypochondriasis and Hysteria), and a relatively low score on Scale 2 (Depression). This valley pattern of a low Scale 2 between the peaks of Scales 1 and 3 has been associated with classic symptoms of hysterical conversion and other somatoform disorders. Persons with this profile configuration tend to report some tension, but extreme depression and anxiety appear to be absent (Graham, 1990). Jones, Kinsman, Schum, and Resnikoff (1976) investigated the adjustment of adults with chronic asthma. They found that middle-aged adults who had early-onset asthma (asthma present $\geq$ 40 years) all showed similar MMPI profiles with the conversion valley configuration. In contrast, similarly aged adults with late-onset asthma (asthma present $\leq$ 3 years) showed a variety of profile patterns,

none of which had the conversion configuration. The interpretation of this finding was that the conversion profile is consistent with persons who held their depression in check by focusing on nonsalient physical complaints, and who denied important psychological or physical difficulties. The implication was that over time, persons who experience a common chronic disease process adapted a similar style of coping indexed by the MMPI conversion profile.

It would be interesting to apply this research paradigm to the audiological rehabilitation research. There is some evidence in the literature that experienced depression is variable among persons with acquired hearing impairments. Knutson and Lansing (1990), in their study of candidates for a cochlear implant, used the MMPI, as well as other measures of depression and anxiety. They reported a large range of scores on Scale 2 (Depression) of the MMPI (Scales 1 and 3 were not reported), as well as a large range of scores on the other measures of depression and anxiety. Although their subjects had a great range in the number of years of hearing loss (1-44 years) no report was made of correlations between psychological measures and duration of hearing loss. In his research on acquired hearing loss Thomas (1984) stated that it was difficult to retrospectively determine the onset of hearing loss, nevertheless the author found it "difficult to believe that the time elapsed since the onset of hearing loss is unimportant for psychological well-being" (Thomas, 1984, p. 85). One may infer that Thomas believed that an extended experience with hearing loss would be correlated with worse psychological functioning, however his data (given his best estimates of duration of hearing loss) did not corroborate this. Moreover, data obtained from persons with asthma suggests that over an extended period of time there may be a positive adaptation to chronic disabilities that results in lessening a person's perceived handicap (Jones et al., 1976).

These different patterns of adjustment related to duration of the disability suggest that different rehabilitation counseling services might be needed, depending upon the duration of the condition. As an example of differential counseling needs for chronic and acute situations, consider Roth and Cohen's (1986) argument that there are two basic modes of coping with stress – approach and avoidance. Each style has costs and benefits associated with it. The approach style, involving consideration of a problem and a search for more information and more help, offers the benefits of releasing emotional tension, resolution of trauma, assimilating the problem into one's life, and taking the necessary steps to ameliorate the problem. However, the costs associated with an approach style include increased distress and nonproductive worry.

The avoidance style offers the benefits of reduction of stress, increased hope, and accommodation to the problem in slow "dosages." The costs include avoidance behaviors that are disruptive to effective coping, and the minimizing of constructive, effective action regarding the problem. Roth and Cohen (1986) believe that the avoidance style is more effective during the acute stage of a trauma, because it can help protect a person from being overwhelmed by the challenges and the enormity of the changes. Eventually, it is less effective for

a chronic situation, because it prevents a person from effectively adapting to a change in condition. In contrast, an approach style is more helpful in a chronic situation, because it facilitates constructive adaptations to the problem. However, an approach style is less helpful in an acute situation, because it tends to exacerbate the distress.

This model of coping is an interesting reminder to clinicians that an avoidance technique like *denial* is not necessarily a negative coping method for a client. There may be times, such as in the acute stage of a problem, that denial may prove useful in protecting a person from being overwhelmed by the enormity of a problem. However, denial can delay or prevent adjustment as the problem moves into a chronic phase, in which recognition of the changes is necessary in order to make appropriate adjustments for effective living.

Research is needed into the efficacy of differential counseling techniques during acute and chronic phases of hearing impairment. If the Roth and Cohen (1986) model is valid, then one can determine if there are differentially effective counseling techniques for each of the phases. During the acute phase, perhaps a clinician should *not* try to counteract denial, but rather be more nondirective and supportive of a client, emphasizing the need for hope and for a reduction of intense emotions associated with an acute trauma. When a person with a hearing impairment is in a chronic phase, perhaps the clinician should focus counseling techniques to something more directive, in order to facilitate an approach style, in which the client is encouraged to become more specific and more focused in dealing with the problem. The Roth and Cohen model seems consistent with the Jones et al. (1976) results showing that persons in an acute stage may be more vulnerable and need a modulated approach to their problem. This is in contrast to persons in a chronic stage who have developed more psychological protection for themselves. A research issue to be addressed here is whether different forms of rehabilitative counseling are more effective at different phases of adaptation to a hearing loss. A question to ask is whether supportive, non-directive counseling is more helpful during the acute phase of the diagnosed hearing impairment, and whether directive counseling is more efficacious when presented during the chronic phase of the disability.

ABSENCE OR PRESENCE

A concept of *absence* versus *presence* does not seem to be considered in the audiological rehabilitation literature, but does suggest an important clinical dimension in the coping attempts, and counseling needs, of a client with a hearing impairment. The most common coping challenge is hearing *loss* – the absence of something. Clients report the problems of being cut off from social intercourse – lack of communication, loneliness, and isolation (Knutson & Lansing, 1990; Thomas, 1984). The loss of hearing sometimes generates suspiciousness and misunderstanding, which can cause a person who has a hearing impairment to appear paranoid to others even though they are not (Thomas, 1984; Vernon

& Andrews, 1990). The counseling challenge in these cases is to help a client deal with the fact that there is something missing in their lives – the absence of normal hearing in a hearing culture. There is a need for continued research into the psychosocial effects of long-term deprivation of a sensory modality and its effects on coping status. For example, Fitzgerald, Ebert, and Chambers (1987), found that adults with recently acquired blindness were depressed, suspicious, and seemed to demonstrate paranoid ideation. The authors' data regarding family status and counseling needs caused them to recommend counseling regarding the acceptance of the disability, helping the clients to acquire specific skills to adapt to the disability, and counseling for the family members. These recommendations are similar to traditional counseling endeavors in rehabilitative audiology (Erdman, 1993). The above suggests that there are similarities in the adjustment process and counseling needs among persons with hearing impairments and those with visual impairments. Further research into the possible common coping mechanisms between the two populations could yield information on efficient (and general) counseling approaches that address the needs of persons with sensory deficits.

In contrast, there are some problems associated with hearing loss that create coping problems because of the *presence* of stimuli. The problem of tinnitus is the most common example. Although there has been some work done on treatment techniques (see: Tyler, Stouffer, & Schum, 1989 for a brief summary), more work is needed in the area. Are cognitive behavior modification and relaxation therapy the best counseling techniques for helping a tinnitus client manage the irritating, intrusive problem of tinnitus? An interesting analog for research in this area may be chronic low back pain. There is an extensive literature in back pain, including psychological research into methods of coping and management (e.g., Brockway & Steger, 1981; Hanson & Gerber, 1990).

Turner and Clancy (1988) compared an operant behavioral technique, a cognitive-behavioral technique, and no treatment among persons who have back pain. They found that the two treatment techniques showed positive improvements in patient functioning. Moreover, subjects in the operant behavioral group displayed better immediate gains and those who underwent a cognitive-behavioral treatment program displayed better long-term gains. In a subsequent efficacy study, Turner, Clancy, McQuade, and Cardenas (1990) found that a *combination* of physical exercise and behavior modification techniques (e.g., not reinforcing pain behaviors) was more effective than either method used by itself. Pinkerton, Hughes, and Wenrich (1982) have pointed out that the majority of patients with chronic low back pain failed to respond to traditional medical regimen. They described a model of a reciprocal relationship between pain and tension in which the physiological problems interact with psychological responses to create more intense physical problems. As a result, the investigators recognized the importance of behavioral treatments to help intervene in the cycle of chronic pain.

An efficient approach may be to use methodologies of back pain research to

systematically investigate whether similar treatment procedures are also applicable to individuals who suffer from tinnitus. As mentioned above, there are some specific intervention techniques that have been designed and tested for their efficacy with back pain patients. If one accepts the logical connection between the general problems associated with tinnitus and with back pain, then one can see the possibilities of using similar treatment techniques. This area seems to be an excellent place for research into counseling interventions. These intervention strategies may expand the scope of counseling techniques that rehabilitative audiologists would consider appropriate for their clients, such as reframing the person's perception of the problem or changing the environment in terms of what health behaviors are reinforced or extinguished. This consideration of treatment variations leads to the next parameter described below.

PROBLEM- OR EMOTION-FOCUSED

Lazarus and Folkman (1984) have described two coping processes: *problem-focused* and *emotion-focused.* The first style involves externally directed methods of adapting to problems. The second refers to internally directed methods. This model is helpful when considering methods of counseling for individuals with a hearing loss. Problem-focused counseling can include counseling about amplification, social support, and methods for improving the quality of one's life. Amplification counseling includes helping a client learn how to best use amplification, as well as learning to appreciate the limits of amplification (i.e., what it *can* and *cannot* provide for an individual; Sanders, 1993). The efficacy of such counseling is summarized by Erdman (1993). However, Erdman indicates a continuing need for information on variables that have an effect on treatment compliance. Such compliance may be related to problem-focused counseling, but it might also be related to the emotional adjustment of the client (also see: Noh, Gagné, & Kaspar, Chapter 18).

Emotion-focused counseling places its primary emphasis on helping people adjust their emotional responses and reactions to problems. This is particularly helpful when a client is struggling with a problem that cannot be easily resolved. For example, a person may be facing a dramatic and precipitous loss of hearing due to a tumor. There may be little that can be done to change the fact that the person will have a significant hearing loss. In this case, problem-focused counseling has limited utility. Instead, an emotion-focused counseling approach that helps a client to determine an effective method of managing the emotional reaction to the problem may be more appropriate. Given the constraints of service time and training faced by rehabilitative audiologists, it is important to determine what types of emotion-focused counseling strategies could be appropriately and effectively used by audiologists. There is some evidence that in some forms of time-limited therapy, persons who can form understanding relationships with a client may be as effective as highly trained psychotherapists (Frank, 1985). However, there is a need for more research in this area of audiological rehabili-

tation.

Research has shown that cognitive restructuring techniques can promote positive emotional adjustment to chronic diseases (Taylor & Aspinwall, 1990). Cognitive restructuring involves helping the client restructure attitudes about the disease process in order to develop a more positive outlook on the situation, and to reduce the effects of two types of highly probable emotional reactions – anxiety and depression. When it is difficult for a person to avoid the negative implications of a chronic illness, one may try to identify the benefits of experiencing such a situation (e.g., finding meaning in the experience, or deciding that one has become a better person by learning to cope with the event). By emphasizing some positive aspects of the experience, one attempts to mitigate dwelling on negative thoughts that exacerbate the anxiety and depression associated with the disability.

Cognitive behavior modification and cognitive restructuring techniques are currently enjoying widespread use in psychotherapy (Mahoney & Freeman, 1985). An important direction in audiological rehabilitation research is to determine the efficacy of cognitive restructuring methods of counseling, particularly in mitigating the common problems of anxiety and depression. It would be useful to determine specific positive attitudes clients have identified on their own, or have developed in conjunction with professionals. Experimental studies could be designed to investigate the effectiveness of those specific attitudes when they are incorporated into a cognitive restructuring counseling approach.

NATURAL OR CONTRIVED

The *natural* method that people use to help them cope with life changes and life stress is social support from family, friends, and cultural networks. Taylor and Aspinwall (1990) stated that the presence of social support is associated with recovery from illness, reduced risk of mortality, reduced distress in chronic illness, and positive adjustment to chronic disease. However, they point out that social support can be confounded by the disease process. The type of disease might influence whether or not people receive social support – cancer can create fear and aversion among family members and friends, while also signalling the need for those individuals to provide support to the person. Varni et al. (1989) investigated a variety of factors that are possibly related to self-esteem observed among children with limb deficiencies. They found that classmate social support was most highly related to positive self-esteem, followed by the absence of family conflict and the presence of family organization. In contrast, Lane and Hobfoll (1992) have shown that individuals with chronic illness symptoms may express anger, which causes potential supporters to be angry, in turn reducing the amount of social support available to the patient. Social support, then, can promote coping processes with chronic disabilities, but such coping can be jeopardized by the nature of the illness or the person's response to the illness.

In the area of hearing impairment, Thomas (1984) discussed the importance

of family support, as well as the challenges to families of persons with hearing loss. He reported a mix of positive and negative responses from individuals to family members with hearing losses. Erdman (1993) stated that spouses tend to underestimate the amount of difficulty experienced by the person who has a hearing impairment. If that is the case, they may not recognize the need to rally their resources to assist the spouse who needs support. There is a need for research to determine how to best facilitate the natural forms of social support that family members and friends can provide to individuals with a hearing impairment. Moreover there is a need to identify the effects that social support have on individuals with a hearing impairment, as well as on that person's significant others (e.g., improved physical functioning, reduced distress, positive adjustment, improved self-esteem).

Research can be extended to determine whether *contrived* forms of assistance enhance the coping process. Professional intervention can be considered a modest form of contrived assistance used to stimulate a natural form of assistance available to a person. For example, an audiologist might offer several group rehabilitation sessions for clients and family members, in which the family members can receive encouragement to provide appropriate support to the client and can receive more specific information to help them better understand their role in the rehabilitation/coping process. The audiologist, serving as a group leader, might facilitate discussion between the client and the family members to help clarify the particular needs of the client. This type of group therapy is commonly used in the clinical practice of audiological rehabilitation (Davis & Hardick, 1981; Sanders, 1993). It would be helpful to determine if this form of contrived support is more efficacious to the client's coping and adjustment than an individually based counseling program or no professional involvement.

Another area of research could focus on more direct support provided by the audiologist. Clients who are isolated and do not have a social network of family and friends are often considered a high risk group by mental health practitioners. They are more prone to problems of anxiety and depression. It would be helpful to verify if similar findings are observed among individuals with a hearing loss. First, it must be determined if socially isolated clients experience more problems of adjustment associated with their hearing loss than do clients who have a supportive social network. If so, it may be of interest to examine the effects of intervention by an audiologist with the intent of providing social support for isolated clients. Such intervention might include introducing the individual to self-help groups or providing information about senior citizen groups. If the audiologist provides support that is not naturally occurring in the client's life, is this effort successful in improving the coping process of the client? Measures of the coping process could include hearing handicap inventories, as well as measures of depression, isolation, and anxiety (Knutson & Lansing, 1990; Thomas, 1984).

If audiologists' social support is efficacious with isolated clients, an additional area of research would involve identifying the scope of the professional interven-

tion. One could investigate whether the social support of an audiologist, focused on assistance with hearing-related issues, is sufficient to help the coping process of an isolated client, in contrast to support provided by a mental health professional, who might presumably expand the scope of issues related to adjustment. A variant on this would be to examine the efficacy of group versus individual intervention among clients with a hearing loss who do not have a broad social network, to determine if one form of intervention is more helpful than another. The purpose of this is to investigate whether or not a group experience better assists an isolated client to make a transition from a contrived support relationship to a more naturally occurring social relationship.

The research focus on this area of natural and contrived intervention is to determine how much natural support can promote adjustment, when a contrived form of support from a professional is necessary, and what should be the nature of the professional intervention.

CONCLUSION

The purpose of this chapter was twofold. First, in considering the issue of personal adjustment counseling, an attempt was made to be inclusive in the consideration of the dynamics of adjustment. In this inclusiveness, it was emphasized that a primary characteristic of persons who have a hearing impairment is that they are first and foremost *human beings*. As human beings, they operate under the same principles and conditions of adjustment as do other humans. The proposition is that there are a finite number of ways that people cope, and what is known about coping processes in other health and stress related conditions may be applicable to the coping process of persons who have a hearing impairment.

The second purpose of this chapter was to identify some meaningful parameters in personal adjustment that merit further investigation in the area of hearing impairment. In choosing these parameters, specific issues that are observed in clinical situations were considered. Further, an attempt was made to identify parameters that are meaningful in the broader area of psychological research into coping processes. Throughout this chapter an attempt was made to organize some important themes and suggest meaningful lines of research in the area of personal adjustment counseling for individuals with a hearing impairment.

It is important to recognize that there are other important parameters and many more meaningful questions that need to be addressed in the area of personal adjustment. Individual clinicians have their own perspectives and predilections concerning audiological rehabilitation and coping processes relevant for help to a person with a hearing impairment. However, it is hoped that the present chapter served as a catalyst for thought and reaction regarding this important component of audiological rehabilitation.

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