

# Facilitating Ownership of Acquired Hearing Loss: A Narrative Therapy Approach

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Rehabilitative efforts with adults with acquired hearing loss may be hindered by a lack of ownership of the problems associated with hearing impairment and/or their potential solutions. Despite effective technological and behavioral rehabilitative strategies, treatment procedures that lack integrated counseling components may fail to achieve optimal outcomes due to resistance on the part of the client. In this tutorial article, we propose a counseling approach based on narrative therapy to be used with adults with acquired hearing loss. Narrative therapy is described and a counseling approach that may be adapted for use with adults with acquired hearing loss is presented. Finally, a hypothetical example is described in detail in order to further illustrate the potential application of narrative therapy to audiologic rehabilitation.

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Counseling has long been a component of an audiologist's scope of practice, but until recently, little support has been provided to the student or practitioner in developing counseling skills. Fortunately, with the emergence of a doctoral degree, most audiology programs now include counseling education and training (English & Weist, 2005), and distance education programs have also provided practitioners comparable learning opportunities (English & Zoladkiewicz, 2005). Regardless of one's background, however, an audiologist's counseling skills can be considered a "work in progress" that requires ongoing monitoring and reflection. This need for audiologists to continuously upgrade, refine, and expand their counseling skills and approaches is driven by the diverse client needs encountered in clinical practice.

One counseling approach not yet reported in the audiology literature is the "narrative therapy approach." We submit the following tutorial on this approach to support the aforementioned work in progress and to broaden audiology's perspective on "nonprofessional counseling" (Kennedy & Charles, 2001).

### **PURPOSE**

Many adults with acquired hearing loss do not demonstrate benefit from various aspects of audiologic rehabilitation including the use of hearing aids, hearing assistive technologies, and/or communication strategies. These individuals include those who refuse to seek help as well as those who have tried audiologic rehabilitation (usually hearing aids) with little or no success, resulting in non-use or dissatisfaction. Numerous specific factors have been associated with this phenomenon; many of these factors (e.g., lack of recognition, stigma, and denial of the problem) might collectively be referred to as a lack of "ownership" of the hearing loss (i.e., lack of taking responsibility for the problem of and/or the solution for one's hearing loss). The purpose of this tutorial article is to propose a counseling approach based on narrative therapy that might be used with adults with acquired hearing loss who are struggling with issues of ownership. A narrative therapy approach shifts the focus from the clinician to the client encouraging the client to share his/her expertise about his/her problems.

### **OWNERSHIP AND THERAPEUTIC CHANGE**

Any discussion of ownership in audiologic rehabilitation requires that it be differentiated from the psychological construct locus of control. In the context of therapeutic change, ownership may be defined as taking responsibility for, or possession of, a problem or solution (Yalom, 2002). This definition of ownership implies two interrelated processes involved in therapeutic change: ownership of the problem and ownership of the solution. Locus of control, however, refers to whether individuals believe their behavior is under their own control (*American Heritage Stedman's Medical Dictionary*, 1995). As such, locus of control is based on beliefs and expectations whereas the concept of ownership implies ac-

tion in the form of taking responsibility. The interrelationship of these concepts is such that it could be argued that an internal locus of control is prerequisite to one taking ownership of a problem or solution. The purpose of this tutorial, however, is limited to issues related to ownership in a therapeutic context rather than the underlying beliefs and expectations related to locus of control.

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### ***Ownership of the Problem***

The more fundamental issue for therapeutic change involves individuals taking ownership of, or responsibility for, their problems. In fact, Yalom (2002) stated that, "responsibility assumption is an essential first step in the therapeutic process" (p. 141). Yalom further suggested that it is not until patients assume responsibility for their life's situations that they will realize that they are the *only* ones with the ability to change those situations. Clearly, people with hearing loss are not responsible for the fact that they have a hearing loss. However, the assertion here is that clients are encouraged to accept the *reality* of their hearing loss and to take steps that can help them function and communicate better in situations where they have little control. For example, many listening environments are quite difficult for the individual with hearing loss (e.g., noisy restaurants, reverberant rooms, etc.), and clients may feel as though they have no control over these situations. Taking ownership of the problem means that individuals with hearing loss are encouraged to take responsibility over what they *can* control. This would be evidenced by being assertive about their hearing loss and using facilitative strategies in difficult listening situations to enhance communication (e.g., moving away from noise, using visual and contextual cues to perform closure, and using constructive repair strategies to fix communication breakdowns).

For many persons with acquired hearing loss, ownership of the problem may play an important role in their adjustment to their hearing loss and their subsequent success in communicative interactions. Numerous studies have documented the high number of individuals with acquired hearing loss who do not wear hearing aids or who do not use them effectively (e.g., Gatehouse, 1994; Kochkin, 1993; Kricos, 2000; Kricos, Lesner, & Sandridge, 1991; Ross, 2002; Traynor, 1997). The slow, progressive nature of acquired hearing loss makes it easy for individuals to deny their problem and to project blame for their difficulties on the people around them and on their environment (Citron, 2000; Garstecki, 1994). These defensive reactions are reflected in comments heard frequently in the clinical setting such as, "I would hear fine if she wouldn't mumble," or "young people today just don't know how to speak." For some individuals who wear hearing aids, these comments reflect the difficulties many individuals with hearing loss experience when in certain environments or when com-

municating with certain people. For others though, who have not adequately dealt with their hearing loss, such comments relate directly to a lack of ownership of the problem. Interestingly, Citron (2000) echoed Yalom's (2002) previously cited comments, stating that such clients "must realize the importance of accepting their hearing impairment and the aspects of adapting to hearing aid use before the actual fitting process" (p. 459), implying that facilitating ownership of the hearing problem is an important and necessary *first step* toward successful hearing aid use.

### ***Ownership of the Solution***

Although very much intertwined with ownership of the problem, ownership of the solution appears to be a separate, yet equally important, factor in successfully dealing with difficult life situations such as communicative disorders. Luterman (2001) stressed the importance of empowering clients with communicative disorders and their families to take responsibility for change. He stated that it is not until clients realize that *they* are responsible for altering their situation and experience the power within themselves to accomplish change, that transformations are seen beyond the clinical setting.

The provision of hearing aids is often a major component of audiologic rehabilitation provided for adults with acquired hearing loss. It has been argued that the "marketing hype" on the advances in hearing aid technology has encouraged clients to relinquish any responsibility for the fitting process and place it on the hearing aids and those dispensing them (Sweetow, 1999).

## **COUNSELING IN THE PRACTICE OF AUDIOLOGIC REHABILITATION**

Referring to therapeutic change, Shames (2000) stated, "it is tampering with our basic self-identity. Letting go of who we are or the way we were can be fraught with both fears and pain; pain over the past and fears about the future" (p. 14). For some clients, therapeutic change is less difficult and ownership of the problem and/or the solutions occurs automatically and unconsciously, possibly due to combinations of personality, family, and environmental circumstances. In many cases, however, therapeutic change can be extremely difficult and facilitation of ownership can be accomplished only through appropriate counseling by the audiologist. Although most audiologists would agree that counseling is a critically important tool for helping clients with hearing loss, unfortunately many feel under-prepared or qualified to engage clients in the type of personal counseling required to facilitate ownership (Crandell, 1997; Culpepper, Lucks Mendel, & McCarthy, 1994; McCarthy, Culpepper, & Lucks, 1986).

### ***Narrative Therapy***

One framework that audiologists might use for counseling persons with acquired hearing loss is narrative therapy (Parry & Doan, 1994; White, 1995; White

& Epston, 1990). The basic concept of narrative therapy is that people are “story-tellers” and that the stories they tell about themselves, and that others tell about them, significantly shape their behavior and sense of self (Madigan & Goldner, 1998; Neimeyer, 1995; Winslade & Monk, 1999). Narratives serve to create meaning from experience and, as such, are used for anticipating events, planning actions, and orienting the self in the world (Dimaggio, Salvatore, Azzara, & Catania, 2003). Therefore, a narrative therapy approach to counseling is based on the concept of *constructivism* which emphasizes the active participation of individuals in their own life organization and development. Consequently, audiologists counseling from this perspective relinquish their “expert” status and focus on clients as the experts about their own problems (Neimeyer, 1993c, 1995). This frees the audiologist to play the role of “facilitator,” guiding clients to recognize and experiment with their own unique solutions to their unique problems related to hearing loss. Using aspects of narrative therapy may be more “natural” for audiologists and help them to feel more capable to engage clients in personal counseling.

Winslade and Monk (1999), however, stated that, “We are not the sole authors of our stories.” That is, as our sociocultural and sociopolitical environments, as well as the significant others in our lives, act as “co-authors” of our stories, often imposing sub-plots to our stories that are unwanted and personally limiting (Drewery & Winslade, 1997; McKenzie & Monk, 1997; Neimeyer, 1995). Often, these personally limiting sub-plots can come to dominate the narratives of individuals, creating what are often termed “dominant narratives” that lead individuals to interpret their world only in ways that maintain that dominant story (Neimeyer, 2004). For example, individuals with a hearing loss may only be able to focus on their own narrow views of how their hearing loss affects them personally. However, pressure from significant others, as well as social and political pressures, can have just as much influence and actually modify their stories. Thus, it is important to continue to have significant others complete self-assessment questionnaires in order to determine their influence(s) on individuals with hearing loss.

### ***Evidence for the Effectiveness of Narrative Therapy***

Etchison and Kleist (2000), in their review of evidence for narrative therapy, found an absence of the empirical outcome studies typically associated with “evidence” in the field of audiology. As Etchison and Kleist and others (e.g., Lerner, 2004; Neimeyer, 1993a) have noted, however, this lack of empirical research stems largely from a mismatch between the constructivist epistemological and methodological principles that underlie the practice of narrative therapy and those that are implicit in empirical quantitative research. Constructivist approaches to researching therapy emphasize a qualitative understanding of the meaning given to experience and the interaction between the participant and therapist (Nelson & Poulin, 1997). As such, evidence for the effectiveness of narrative therapy is usu-

ally presented in the form of qualitative research such as case studies (e.g., Besa, 1994; Leahy & Warren, 2006; Nylund, 2002; Weber, Davis, & McPhie, 2006; Wolter, DiLollo, & Apel, 2006), ethnographic studies (e.g., St. James-O'Connor, Meakes, Pickering, & Schuman, 1997), or illustrative cases presented as part of a description for using narrative therapy to treat a particular problem (e.g., Madigan & Goldner, 1998; Winslade & Smith, 1997). Overall, narrative therapy has been demonstrated to be an effective treatment option in the areas of alcoholism (Winslade & Smith), anorexia (Madigan & Goldner; Nylund; Weber et al.), family therapy (e.g., Besa; St. James-O'Connor et al.), adult literacy (Wolter et al.), and stuttering (Leahy & Warren).

### *Narrative Therapy and Acquired Hearing Loss*

Although narrative therapy has yet to be applied to working with persons with acquired hearing loss, the importance of listening to clients' *stories* has been discussed in the literature regarding audiologic rehabilitation. For example, Van Hecke (1994) pointed out the power in narratives and the importance of individuals with hearing impairment being able to "tell their stories." Héту, Riverin, Lalande, Getty, & St-Cyr (1988) emphasized the importance of understanding the "personal meaning" of hearing loss by listening to qualitative accounts of disability rather than using forced-choice assessment scales.

A narrative therapy interpretation of problems with ownership of hearing loss would suggest the need for the individual to revise his/her personal narrative – or story – so that it may include the physiological change that has occurred. For example, a client may demonstrate difficulty with ownership of the problem by denying the existence of any hearing loss; essentially refusing to incorporate that change into his story. On the other hand, a client who demonstrates difficulty with ownership of the solution may present with a history of unsuccessful use of hearing aids and other audiologic rehabilitative strategies. This may be the case because he is dominated by a stereotyped story of impairment in which he sees himself as useless and no longer competent.

## **APPLYING NARRATIVE THERAPY PRINCIPLES TO AUDIOLOGIC REHABILITATION**

A narrative therapy approach to audiologic rehabilitation could easily be incorporated into typical audiology appointments such as the initial evaluation, hearing aid orientation, hearing aid fitting, and follow-up sessions. Group meetings are also an ideal setting for incorporating narrative therapy activities. In addition, the narrative therapy philosophy can provide a framework or focus around which audiologists can begin to better conceptualize their client's problems and organize their rehabilitation interactions. The following discussion focuses on practical ways to incorporate narrative therapy principles into everyday audiologic rehabilitation practice.

### ***Changing the Focus of the Audiology Appointment***

Incorporating a narrative therapy approach into audiologic rehabilitation may actually require few observable changes in the structure of the hearing aid fitting process. Although the structure of appointments may not need to change, the focus of these appointments would need to be adjusted. In a traditional approach to audiologic rehabilitation, the focus is on information giving and the *learning* and *mastery* of new behaviors. In contrast, a narrative therapy approach focuses on the meaningful incorporation of new strategies into current life stories and changes in self-image (i.e., personal narratives) to include the presence of hearing loss and its successful management.

The audiologist may engage in facilitating reconstruction of the client's personal narrative by engaging the client in conversations in which the audiologist's role is a genuinely interested partner, listening and asking questions that clarify and extend the clients' descriptions of themselves. At first, the clients' stories are usually "thin" descriptions of themselves, focused almost entirely on the problem area (Payne, 2000; White & Epston, 1990). White and Epston suggest encouraging clients to move away from stories that describe "the influence of the problem on the life of the person" and toward stories that describe "the influence of the person on the life of the problem." In other words, refocusing the client's story on times when the problem was overcome and when the person was able to somehow avoid or lessen the impact of the dominant story. Winslade and Monk (1999) call these alternative storylines "sparkling moments," and suggest that these are the basis for beginning the reconstruction process.

A narrative therapy approach to audiologic rehabilitation, then, might focus on client directed activities related to recognizing dominant narratives, identifying sparkling moments that contradict the dominant narrative, and reconstructing a personal story that facilitates improved communication and management of the hearing loss.

### ***Moving Past "Learning" to "Integration"***

Typically, in audiologic rehabilitation, clients are asked to try out (new) behaviors that are designed to increase effective communication (e.g., assertiveness in communication situations, communication strategies such as facilitation, anticipatory and attending strategies, and managing the physical environment; Gagné & Jennings, 2000). Usually, however, the focus of therapy is the learning and execution of these behaviors rather than facilitating the development and integration of such experiences into the client's personal story. Often, the behaviors the client is being asked to "try out" feel very "foreign" and "unnatural," even if they are carried out successfully. The meaningful integration of these experiences into the individual's personal narrative, therefore, needs to be facilitated by the processing of experience.

This might be done by setting up an assignment (e.g., being more assertive in

a situation) and having the client identify how the assignment fits with their current personal narrative by talking about how the assignment makes them feel. For example, an individual might say that thinking about being more assertive in a situation feels uncomfortable because “I am not an assertive person.” The audiologist might then ask the individual to talk about times in the past when he/she had been assertive, perhaps suggesting to the client that this might be an unrecognized aspect of his/her story. The client then completes the assignment, being sure to pay attention to both behavioral and emotional results. The audiologist and client then together talk about the event, paying attention to the detail of thoughts, feelings, and outcomes. The audiologist will re-tell the story of the assignment and perhaps share the story (in the presence of the client) with others, also encouraging the client to re-tell the story to friends and family. Of importance is that the audiologist does not have to do any “interpreting” of behaviors or underlying motivations – he/she merely engages the client in a conversation about the event, asking curious questions, and opening the door to a possible alternative self-story for the client.

### ***Group Experience and Reconstructing Personal Narratives***

Group experience may also be a good way to facilitate reconstruction of a personal narrative as it provides a safe, non-threatening forum for experimenting with new behaviors and generates detailed feedback that helps clients process their experience. The group setting allows for multiple telling and re-telling of alternative stories that emerge from sparkling moments encountered in every day life and from group assignments. Yalom (2002) also states that a group situation can be a powerful tool in facilitating individuals’ understanding of personal responsibility or ownership.

## **A HYPOTHETICAL EXAMPLE**

A hypothetical example is presented here to illustrate some of the activities mentioned above. This example by no means is meant to reflect the *only* way that treatment could proceed with the specific client described. In fact, such a prescriptive approach would be counter to the constructivist philosophy that underlies narrative therapy. This example was simply designed to help audiologists get a feel for how the narrative therapy approach might be adapted to audiologic rehabilitation. In this example, a brief case description is followed by a description of a traditional approach to audiologic rehabilitation and further followed by a narrative therapy approach with the same client:

### ***Case Description***

Mr. Smith is a 70-year-old individual who had been experiencing a gradual decline in hearing for over 15 years. He purchased binaural hearing aids approxi-



mately 10 years ago, but did not report much success with them, stating that he “rarely wears them.” However, more recently he has noticed that the quality of communication with his wife has declined and communication with others is almost non-existent as he is in the habit of just deferring to his wife in communicative situations. In addition, he has begun to avoid using the telephone. He scheduled an appointment with Dr. Johnson, an audiologist, at the encouragement of his wife, although he was full of doubts that his communication situation could improve.

### ***Traditional Interaction***

Dr. Johnson went through Mr. Smith’s formal case history, inquiring further about comments such as “I don’t hear most of the time,” “I don’t use the telephone,” and “I’m not happy with my hearing aids.” In probing for more information, Dr. Johnson asked Mr. Smith the specific situations in which he was having the most difficulties, what difficult situations were the most troubling to him, what difficulties he was having on the telephone (e.g., feedback, volume, clarity), and what he does not like about his current hearing aids (e.g., clarity, volume, size, feedback). Mr. Smith answered each of Dr. Johnson’s questions indicating that while church and restaurants presented him with difficult communication situations, what bothered him the most were the difficulties he experienced at frequent family gatherings. With regard to the telephone, Mr. Smith stated that inadequate volume and clarity seemed to be the primary issues. Finally, in discussing his concerns about his current hearing aids, Mr. Smith reported that they have never been satisfactory, citing problems that included background noise, poor clarity, and difficulty with manipulation. Following this interview, Dr. Johnson felt as though she had a good idea of the problems that needed to be addressed. She proceeded with standard audiological testing and then discussed the test results with Mr. and Mrs. Smith.

In presenting the test results to Mr. and Mrs. Smith, Dr. Johnson described the hearing loss and presented reasons why Mr. Smith should consider trying new hearing aids. These included that his current hearing aids were 10 years old and not functioning at their best and that new developments in hearing aids, such as digital signal processing, should result in a more positive hearing aid experience. Mr. Smith, with the encouragement of his wife, agreed to try new hearing aids. He was fitted with appropriate hearing aids and instructed on how to manage them. An appointment was scheduled for 2 weeks at which time Mr. Smith’s progress would be evaluated.

### ***Narrative Therapy Approach***

In using a narrative therapy approach, the audiologist would give the client more of the lead role, simply inviting him to tell his story as opposed to requiring him to answer direct questions. Not only will much of the same information

be gained but a much richer, more complete picture will develop.

Dr. Johnson sat down with Mr. and Mrs. Smith and asked Mr. Smith to tell her about himself. Mr. Smith promptly replied “I tried these hearing aids about 10 years ago and they never were any good for me. I can’t hear anything, with or without them.” At this point he stopped as if that was all there was to his story, or at least all that Dr. Johnson wanted or needed to hear. Dr. Johnson encouraged him to tell her more, taking the role of a conversational partner genuinely interested in his story and eliciting more detail through “curious questioning” (White & Epston, 1990) when necessary.

Dr. Johnson began by prompting Mr. Smith to expand his story, saying: “Tell me more about how this hearing loss affects your life.” Mr. Smith hesitated briefly, but Dr. Johnson gave him time to respond. After a few seconds of thought, Mr. Smith said: “I think I ignored it at first, just figuring it was people mumbling. Then I began to realize I wasn’t hearing the clock chime like I used to or the microwave timer. I noticed that I had to watch people’s faces more in order to understand them, and at church, well, I quit going for a while but now, sometimes I just go to the early service, which is small and they don’t play the organ. I guess I finally thought maybe there was something wrong. It took quite a few years, but eventually I got these hearing aids. They helped some, at first, with television, and quiet places, but I don’t wear them much anymore.”

Dr. Johnson is looking for information in Mr. Smith’s story that demonstrates that there have been times and/or situations where he was able to lessen the negative impact of his hearing loss, either by using his hearing aids and experiencing some benefit with them or by using communication strategies to improve the situation. These are the sparkling moments that can often be found when problem saturated stories are elaborated on to form more detailed, rich stories. It is from these sparkling moments that an alternative story can begin to emerge.

Dr. Johnson continued the conversation by saying to Mr. Smith, “Thank you for sharing that, Mr. Smith. It seems that there have been times when you have been able to challenge the problems associated with your hearing loss by coming up with strategies that have helped you communicate more effectively. I’d like you to tell me some more about those times – how you came up with those strategies and what resources you needed to make them work.” Here, Dr. Johnson is helping Mr. Smith explore some of the aspects of his story that he was taking for granted, facilitating the telling of a richer description of his situation and one not necessarily dominated by failure and the negative impact of the hearing loss.

Mr. Smith thought for a few moments, then replied: “Well, I began to realize the importance of watching people’s faces when I noticed that I missed more of a conversation when someone turned their back on me. My wife used to do that, sometimes still does, and I tell her, ‘You have to look at me when you talk!’ She’s getting better, but I still have to remind her occasionally.” Mr. Smith continued, “Not hearing in church had been a problem for quite a while. I would still go

most Sundays, because I didn't want my wife to miss because of me or go alone, so I still went, but it was so frustrating. Eventually, I began to dread it so much each week that I started to miss more and more. Our preacher asked my wife about me one Sunday and she mentioned to him that I found it so frustrating in church because of my hearing difficulties. He suggested to her that I might want to try the early service, saying that other people had told him that they found it easier to hear him at that service because it is smaller and they play a piano instead of the organ."

Dr. Johnson wanted to help Mr. Smith see that there was an alternative story to the one he so briefly told her initially. Instead of a story dominated by the description of Mr. Smith as an unsuccessful communicator, she wanted him to see that he already experiences some successes, and that he does so through effective problem solving and resourcefulness. By doing this she may be able to break his resistance to further audiologic rehabilitation and enter into a new rehabilitation program with a more positive outlook. In this way he becomes a large factor in that success (i.e., has *ownership* of the solutions) and the confidence and belief that success is possible.

After listening to Mr. Smith's detailed description, Dr. Johnson again highlighted Mr. Smith's alternative story before proceeding. "Mr. Smith, I've noticed that you've been extremely resourceful in the way you've been able to challenge the impact that the hearing loss has been having on your life. I'm hopeful that we can work together to find more resources with which you can continue to overcome some of the challenges presented by the hearing loss." Mr. Smith commented, "I've never really thought of it that way, but you could be right. I usually do seem to find a way to get around problems, even if sometimes it doesn't seem like a very good solution."

Dr. Johnson then proceeded with standard audiological testing and discussed the findings with Mr. and Mrs. Smith. Rather than presenting the idea of amplification as a "solution" to Mr. Smith's problem, Dr. Johnson suggested that new hearing aids might be another *resource* that Mr. Smith could recruit to help him challenge the effects of the hearing loss. Mr. Smith agreed to give new hearing aids a try and would return in 2 weeks.

Once this alternative story began emerging, Dr. Johnson wanted to help reinforce it with Mr. Smith. Before Mr. Smith left the appointment, Dr. Johnson again briefly summarized for him the new storyline that she had heard him tell, looking for him to confirm her observations and also wanting Mr. Smith to hear this new story being told. The alternative story was also told to Mrs. Smith who was encouraged to elaborate on it. This involved her recognizing and talking about the successes that Mr. Smith experiences and the resourceful ways in which he finds to cope with the hearing loss. Mrs. Smith, admitting that she does sometimes talk to Mr. Smith when he is not looking at her, confirmed his account that he is assertive with her in reminding her to look at him or to get his attention be-

fore she speaks. In addition, she also stated that she has noticed at their frequent extended family meals and gatherings that Mr. Smith often manages to get a family member or a small group outside in order to visit. She stated that she now recognizes that this may be a positive strategy that he was using to get away from the noise inside the house. After the first appointment with Mr. Smith, Dr. Johnson wrote a letter to him for the purpose of emphasizing the alternative story that Mr. Smith had begun to tell her (see Appendix A). As described previously, we are not the sole authors of our stories but co-authors with often greater influence on the construction of our stories coming from cultural stereotypes and the stories told about us by significant others rather than the stories we tell about ourselves. Consequently, it is important for clients to hear the clinician and significant others telling and re-telling their emerging story.

Mr. and Mrs. Smith returned in 2 weeks for the fitting of his new hearing aids. The discussions at this appointment focused on further construction of the new story for Mr. Smith. The story, which began to emerge at his last appointment, is centered on resourcefulness and problem solving leading to successful management of the hearing loss. Dr. Johnson asks Mr. Smith to write down, in detail, the successes that he experiences during the next 2 weeks and what resources he used to accomplish them. She compares her request to that of writing in a diary, or journal. In addition, she encourages Mrs. Smith to write down her accounts of successful moments Mr. Smith experiences with the hearing aids and in communication situations in general.

At the follow-up appointment, Dr. Johnson wants to facilitate continued development of the new story and so she encourages Mr. Smith to recount, in detail, his successful experiences. In addition, she encourages Mrs. Smith to discuss the positive experiences that she noticed. Mr. Smith began to read his entries: "I went to the regular church service on Sunday and Kathy and I decided to sit closer to the front thinking this may help what I'm able to hear with the new hearing aids. I think the combination of being closer and wearing the new hearing aids made a difference. I didn't catch everything that was said, but I felt a part of the service. On Tuesday, I went to the grocery store with Kathy. The store was noisier than I remember. I don't recall the intercom being so loud or the carts squeaking so much! However, I was able to hear the cashier in spite of her being female so I am writing this as a successful experience overall. Friday night, the kids and grandkids came over for dinner; had a house full. I found that if I concentrated on one person at a time and tried not to get frustrated if I missed something, I could follow some of the conversations at the table – except, of course, when everyone talked at once. I also often had trouble hearing the grandkids, but I was able to get some time one-on-one with each of them after dinner, and I had very little difficulty in those conversations." Dr. Johnson responded to Mr. Smith's comments, saying, "It sounds like you did find the hearing aids to be a resource that was useful in combination with some of the other problem-solving

strategies that you have been using.” Mr. Smith agreed that they did seem to help at times and that this encouraged him to try to come up with new ways to approach some of the problems posed by the hearing loss.

Mrs. Smith shared parts of her observations during the past couple of weeks stating, “Bill and I went to the 11:00 service at church on Sunday. He suggested we move from our regular pew to a pew closer to the front. He only asked me to repeat what the preacher said two times, and once he even filled in something for me that I had missed! He seemed more relaxed and ‘in control.’”

It was important for Mr. Smith to hear his wife telling this “new” story about him. The more an individual tells a story and the more he hears a story being told about him, the more that story assumes a dominant role in the person’s narrative. After the follow-up appointment, Dr. Johnson drafts a second letter to Mr. Smith (see Appendix B). In this letter, Dr. Johnson summarizes what Mr. and Mrs. Smith reported, focusing on the successful problem-solving that they both recognized separately.

### *Using Therapeutic Documents*

In this hypothetical case, therapeutic documents (Appendixes A and B) were used to reinforce to clients particular aspects of their appointments, such as their emerging alternative story or milestones that they have reached (Payne, 2000). Payne suggests that these documents can serve as reminders or affirmations of discoveries that may otherwise be easily forgotten after the client leaves the appointment. He warns, however, that documents used inappropriately can be counter-productive and he emphasizes two primary guidelines regarding their use: (a) timing is important, and (b) documents must be client-created or co-created. On the topic of timing, Payne suggests using documents after the client has assisted in the discovery of the more detailed description of himself, or, the emerging, alternative story. In addition, Payne warns against presenting documents too early in the client’s progress that are overly focused on the positive which can present a disparity between the audiologist’s recount of the current situation and the client’s perception of it. This also can relate to the second suggestion made by Payne regarding the clients’ participation in the development of their documents. When a document is at least co-created by the client, it is more likely to be a document that provides meaning to that client. As stated in previous discussions, the constructivist approach does not place the audiologist in the expert role for the purpose of interpreting client behaviors or comments. A document written solely by the audiologist may tend to do just this. However, a co-created document would avoid any attempt to “read between the lines” or assume to understand feelings behind statements or actions. For example, a letter written by the audiologist to his or her client may be considered “co-created” if the audiologist recounts statements made by the client or describes actions that the client took that were in line with his or her goals. However, if the audiologist were to

also include his or her own interpretation of the meaningfulness of the statements or actions, or statements congratulating the client on his or her accomplishments, the letter may be construed as emanating from a position of power on the part of the audiologist and have an entirely different effect.

### CONCLUSIONS

Although the narrative therapy approach to audiologic rehabilitation described above can (and should) be individualized to suit the needs of each client, there will be many clients seeking the services of an audiologist who have already taken ownership of their problem and solution, for whom such intervention may not be necessary. The integration of narrative therapy into general audiologic practice, however, may improve the long-term effectiveness of, and satisfaction with, audiologic rehabilitation for almost all clients. For example, encouraging clients to become more of a “self advocate” as a person with a hearing loss will help them incorporate this new aspect into their existing story. By being open and “up-front” about their hearing loss, they begin to weave that aspect into their existing story about themselves while also encouraging others to update their stories about them. Such repeated telling and re-telling of this new, emerging story, the “selling” of the story to significant others in the client’s social community, and the subsequent co-authoring of this emerging story by those significant others, may effectively help the client build ownership of the problem and the solution. Furthermore, by taking active steps (with the encouragement of the audiologist) to deal with the loss in creative ways such as becoming involved in self-help groups and educating themselves about hearing, hearing loss, and potential remediation, clients may incorporate this change into their personal stories without becoming dominated by personally limiting, stereotypical narratives. The use of therapeutic documents may also help clients effectively integrate emerging stories, or changes to stories, and would invariably have a positive effect on the satisfaction of clients with respect to audiological services.

### INCORPORATING NARRATIVE THERAPY IN AUDIOLOGIC REHABILITATION

This discussion would be incomplete without approaching the topic of how this approach fits into the real clinical world where time is money. For the majority of clients, adopting a narrative therapy approach would represent only a small investment of additional time. The reason for this is that audiologists using this approach would not necessarily do more, but, rather, they would organize their thinking about their clients differently. As emphasized throughout this paper, a narrative therapy approach is not focused on techniques; there are no new “things” that need to be done. Instead, this approach can simply change the way

the audiologist thinks about the client and the problems they may present by focusing on the clients' own knowledge of their problems and the potential solutions.

Depending on audiologists' current approach to audiologic rehabilitation, a slight increase in time spent listening to the client may occur. Although the same type of information (e.g., description of a problem) would be gathered whether using a narrative therapy approach or traditional approach, the way that information is obtained is typically different. For example, the audiologist may encourage clients to talk about their life with a hearing loss instead of presenting a standardized form or asking direct questions to gain specific information. This does not imply that standardized forms are not useful or important. The use of narrative therapy may provide an avenue that is just as or even more useful than such forms or questionnaires. Allowing clients to tell their stories may involve a small increase in time for the audiologist but is likely to improve client satisfaction and may decrease future time demands on the audiologist because the audiologist has a deeper understanding of the client's unique situations.

For some more difficult clients (those who are traditionally not fit with hearing aids or those who are fit and return their hearing aids for credit or to try different hearing aids) there would likely be an increase in time spent working with the client at the front end of the process. It may be likely, however, that the investment of such time and effort on the part of the audiologist might be recovered later in the process by increasing client satisfaction, promoting more successful hearing aid use, and eliminating multiple return visits for hearing aid returns and, possibly, reordering.

Finally, research based on this narrative therapy approach to audiologic rehabilitation should be conducted to investigate the effectiveness of this approach compared to more traditional approaches. In addition, research into the reconstruction of personal narratives might focus on the assessment of self image through the use of traditional constructivist research tools such as repertory grids and implications grids as described by Fransella, Bell, and Bannister (2004) and Neimeyer (1993b). Alternatively, DiLollo, Manning, and Neimeyer (2003, 2005) described two different approaches for investigating the problem of stuttering from a self image perspective that might also be adapted to address the problem of acquired hearing loss. These approaches included the use of a specific content analysis scale, the Cognitive Anxiety Scale (Viney & Westbrook, 1976), and a measure of "cognitive complexity" (Crockett, 1965) to evaluate the meaningfulness of constructs (beliefs about the self) related to speaker roles. In addition, qualitative research methods could also be used to track changes in clients' personal narratives over the course of an audiologic rehabilitation program. These measures could be combined with more traditional measures of progress in audiologic rehabilitation (such as self-assessment scales) to assess the impact of changes in narratives as they relate to changes in behavior.

## ACKNOWLEDGEMENTS

This work is based in part on a capstone project completed by the first author as part of the requirements for the Doctor of Audiology degree at Central Michigan University. We wish to thank Bob Neimeyer for his reading of the manuscript and his insightful and helpful comments and suggestions.

## REFERENCES

- American Heritage Stedman's Medical Dictionary.* (1995) Boston: Houghton Mifflin Co.
- Besa, D. (1994). Evaluating narrative family therapy using singles system research designs. *Research on Social Work Practice, 4*, 309-326.
- Citron III, D. (2000). Counseling and orientation toward amplification. In M. Valente, H. Hosford-Dunn, & R.J. Roeser (Eds.), *Audiology treatment*. New York: Thieme Medical Publishers, Inc.
- Crandell, C.C. (1997). An update on counseling instruction within audiology training programs. *Journal of the Academy of Rehabilitative Audiology, 30*, 77-87.
- Crockett, W.H. (1965). Cognitive complexity and impression formation. In B.A. Maher (Ed.), *Progress in experimental personality research* (Vol. 2, pp. 47-90). New York: Academic Press.
- Culpepper, B., Lucks Mendel, L., & McCarthy, P.A. (1994). Counseling experience and training offered by ESB-accredited programs. *ASHA, 36*, 55-58.
- DiLollo, A., Manning, W.H., & Neimeyer, R.A. (2003). Cognitive anxiety as a function of speaker role for fluent speakers and persons who stutter. *Journal of Fluency Disorders, 28*(3), 167-186.
- DiLollo, A., Manning, W.H., & Neimeyer, R.A. (2005). Cognitive complexity as a function of speaker role for adult persons who stutter. *Journal of Constructivist Psychology, 18*, 215-236.
- Dimaggio, G., Salvatore, G., Azzara, C., & Catania, D. (2003). Rewriting self-narratives: The therapeutic process. *Journal of Constructivist Psychology, 16*, 155-181.
- Drewery, W., & Winslade, J. (1997). The theoretical story of narrative therapy. In G. Monk, J. Winslade, K. Crockett, & D. Epston (Eds.), *Narrative therapy in practice: The archaeology of hope*. San Francisco: Jossey-Bass Publishers.
- English, K., & Weist, D. (2005). Proliferation of AuD degrees found to increase training in counseling. *Hearing Journal, 58*(4), 54-58.
- English, K., & Zoladkiewicz, L. (2005). AuD students' concerns about interacting with patients and families. *Audiology Today, 17*(5), 22-25.
- Etchison, M., & Kleist, D.M. (2000). Review of narrative therapy: Research and utility. *The Family Journal: Counseling and Therapy for Couples and Families, 8*, 61-66.
- Fransella, F., Bell, R., & Bannister, D. (2004). *A manual for repertory grid technique*. Chichester, England: John Wiley & Sons.
- Gagné, J., & Jennings, M.B. (2000). Audiological rehabilitation intervention services for adults with acquired hearing impairment. In M. Valente, H. Hosford-Dunn, & R.J. Roeser (Eds.), *Audiology treatment*. New York: Thieme Medical Publishers, Inc.
- Garstecki, D.C. (1994). Hearing aid acceptance in adults. In J.G. Clark & F.N. Martin (Eds.), *Effective counseling in audiology*. Englewood Cliffs, NJ: Prentice Hall.
- Gatehouse, S. (1994). Components and determinants of hearing aid benefit. *Ear & Hearing, 15*(1), 30-49.
- Hétu, R., Riverin, L., Lalande, N., Getty, L., & St-Cyr, C. (1988). Qualitative analysis of the handicap associated with occupational hearing loss. *British Journal of Audiology, 22*, 251-264.
- Kennedy, E., & Charles, S. (2001). *On becoming a counselor: A basic guide for nonprofessional counselors and other helpers* (3rd ed.). New York: Crossword Publishing Co.
- Kochkin, S. (1993). MarkeTrak III: Why 20 million in US don't use hearing aids for their hearing loss. *The Hearing Journal, 26*(2) 26-31.
- Kricos, P. (2000). The influence of nonaudiological variables on audiological rehabilitation out-



- comes. *Ear & Hearing*, 21(4), 9S-14S.
- Kricos, P.B., Lesner, S.A., & Sandridge, S.A. (1991). Expectations of older adults regarding the use of hearing aids. *Journal of the American Academy of Audiology*, 2, 129-133.
- Larner, G. (2004). Family therapy and the politics of evidence. *Journal of Family Therapy*, 26, 17-39.
- Leahy, M.M., & Warren, A. (2006). Making stuttering manageable: The use of narrative therapy. In *Research, treatment, and self-help in fluency disorders: New horizons. Proceedings of the Fifth World Congress on Fluency Disorders, Dublin, Ireland, July 25-28*, 320-324.
- Luterman, D.M. (2001). *Counseling persons with communication disorders and their families* (4th ed.). Austin, TX: PRO-ED, Inc.
- Madigan, S.P., & Goldner, E.M. (1998). A narrative approach to anorexia. In M.F. Hoyt (Ed.), *The handbook of constructive therapies: Innovative approaches from leading practitioners*. San Francisco: Jossey-Bass Publishers.
- McCarthy, P.A., Culpepper, B., & Lucks, L. (1986). Variability in counseling experiences and training among ESB accredited programs. *ASHA*, 28, 49-52.
- McKenzie, W., & Monk, G. (1997). Learning and teaching narrative ideas. In G. Monk, J. Winslade, K. Crockett, & D. Epston (Eds.), *Narrative therapy in practice: The archaeology of hope*. San Francisco: Jossey-Bass Publishers.
- Neimeyer, R.A. (1993a). An appraisal of constructivist psychotherapies. *Journal of Consulting & Clinical Psychology*, 61, 221-234.
- Neimeyer, R.A. (1993b). Constructivist approaches to the measurement of meaning. In G.J. Neimeyer (Ed.), *Constructivist assessment: A casebook* (pp. 58-103). Newbury Park, CA: Sage.
- Neimeyer, R.A. (1993c). Constructivist psychotherapy. In K.T. Kuehlwein & H. Rosen (Eds.), *Cognitive therapies in action*. San Francisco: Jossey Bass.
- Neimeyer, R.A. (1995). Constructivist psychotherapies: Features, foundations, and future directions. In R.A. Neimeyer & R.J. Mahoney (Eds.), *Constructivism in psychotherapy* (pp. 1-10). Washington, DC: American Psychological Association.
- Neimeyer, R.A. (2004). Fostering posttraumatic growth: A narrative contribution. *Psychological Inquiry*, 15, 53-59.
- Nelson, M.L., & Poulain, K. (1997). Methods of constructivist inquiry. In T.L. Sexton & B.L. Griffin (Eds.), *Constructivist thinking in counseling practice, research, and training* (pp. 157-173). New York: Teachers College Press.
- Nylund, D. (2002). Poetic means to anti-anorexic ends. *Journal of Systemic Therapies*, 21, 18-34.
- Parry, A., & Doan, R.E. (1994). *Story re-visions: Narrative therapy in the postmodern world*. New York: Guilford Press.
- Payne, M. (2000). *Narrative therapy: An introduction for counselors*. Thousand Oaks, CA: SAGE Publications.
- Ross, M. (2002). *Why people won't wear hearing aids*. Available at: [www.therubins.com](http://www.therubins.com)
- Shames, G.H. (2000). *Counseling the communicatively disabled and their families*. Needham Heights, MA: Allyn & Bacon.
- St. James-O'Connor, T., Meakes, E., Pickering, M.R., & Schuman, M. (1997). On the right track: Client experience of narrative therapy. *Contemporary Family Therapy*, 19, 479-495.
- Sweetow, R.W. (1999). Counseling: The secret to successful hearing aid fittings. In R.W. Sweetow (Ed.), *Counseling for hearing aid fittings*. San Diego, CA: Singular Publishing Group.
- Traynor, R.M. (1997). The missing link for success in hearing aid fittings. *The Hearing Journal*, 50(9), 10-15.
- Van Hecke, M.L. (1994). Emotional response to hearing loss. In J.G. Clark & F.N. Martin (Eds.), *Effective counseling in audiology*. Englewood Cliffs, NJ: Prentice Hall.
- Viney, L.L., & Westbrook, M.T. (1976). Cognitive anxiety: A method of content analysis for verbal samples. *Journal of Personality Assessment*, 40, 140-150.
- Weber, M., Davis, K., & McPhie, L. (2006). Narrative therapy, eating disorders and groups: En-

- hancing outcomes in rural NSW. *Australian Social Work*, 59, 391-405.
- White, M. (1995). *Re-authoring lives: Interviews and essays*. Adelaide, Australia: Dulwich Centers Publications.
- White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*. New York: W.W. Norton & Company.
- Winslade, J., & Monk, G. (1999). *Narrative counseling in schools: Powerful and brief*. Thousand Oaks, CA: Corwin Press, Inc.
- Winslade, J., & Smith, L. (1997). Countering alcoholic narratives. In G. Monk, J. Winslade, K. Crockett, & D. Epston (Eds.), *Narrative therapy in practice: The archaeology of hope*. San Francisco: Jossey-Bass Publishers.
- Wolter, J.A., DiLollo, A., & Apel, K. (2006). A narrative therapy approach to counseling: A model for working with adolescents and adults with language-literacy deficits. *Language, Speech, and Hearing Services in Schools*, 37(3), 168-177.
- Yalom, I.D. (2002). *The gift of therapy: An open letter to a new generation of therapists and their patients*. New York: Harper Collins.

## APPENDIX A

### EXAMPLE OF A THERAPEUTIC DOCUMENT TO EMPHASIZE AN ALTERNATIVE STORY

PROFESSIONAL HEARING SERVICES  
255 Kelly Lane  
Wichita, KS 67260

Mr. William Smith  
25 White Court,  
Wichita, KS 67220

May 14th, 2006

Dear Mr. Smith,

It was such a pleasure to meet you today and talk with you about some of the things that are going on in your life. In thinking about our conversations, I recalled all the different ways that you were resourceful in facing the challenges posed by the hearing loss. Without the benefit of useful hearing aids, you have successfully attended church and family gatherings and worked hard at maintaining good communication with your wife. I suspect that there have been many more examples of you not backing down to the pressure of the hearing loss.

As I mentioned in our discussion today, I am hopeful that we can work together to discover additional resources that you might take advantage of in successfully coping with the hearing loss. I think that the new digital hearing aids that you chose may be one of those resources that you may find useful.

I am looking forward to seeing you again in two weeks.

Sincerely,

Dr. Jan A. Johnson

**APPENDIX B**

***EXAMPLE OF A THERAPEUTIC DOCUMENT  
TO RE-TELL EMERGING STORY***

PROFESSIONAL HEARING SERVICES  
255 Kelly Lane  
Wichita, KS 67260

Mr. William Smith  
25 White Court,  
Wichita, KS 67220

June 10th, 2006

Dear Mr. Smith,

I enjoyed visiting with you today and hearing about your continued efforts to challenge the effects of hearing loss on your everyday life. Your stories about your grandchildren were a delight! I am so glad that you were able to organize to spend time with them individually so that you could hear them better. What a great example of that resourcefulness and problem-solving that we have been talking about! It also appears that tackling the regular church service was a very positive move. Your proactive move to sit at the front of the church, along with using your new hearing aids, seems to have worked well – you even got to help out Kathy one time with something she had missed!

I hope that you continue to challenge yourself to find new ways to deal with the problems associated with the hearing loss. I have enjoyed working together with you and your wife.

Sincerely,

Dr. Jan A. Johnson