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Counselling clients with acquired hearing impairment: Towards improved understanding and communication

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Abstract. This article seeks to bring to the attention of counsellors and counselling psychologists specific knowledge and awareness in working with clients with adult onset hearing loss. The need for improved awareness of the needs of these clients is argued, the experience of hearing loss explored, and psychological issues at the core of the disability discussed. Practical matters about communication that need consideration in the counselling setting are examined. It is presented from the vantage point of an experienced counselling psychologist who is herself hearing impaired.

Introduction

Counsellors and counselling psychologists are a professional group with a commitment to improving the quality of people's lives. With knowledge and awareness they could assist clients with acquired hearing impairment to improve theirs. Unfortunately, however, they are frequently ill-prepared for this task, in spite of the increasing incidence of people with this disability in client populations.

The disability being considered requires definition. The spectrum of impairments covered by the common label, "deaf", is a broad one, varying with the timing of the acquisition of the hearing loss (congenital or acquired later) and its degree (total loss to mild loss of hearing). To some extent, the experiences and needs of the people with impairments that spread over this spectrum overlap but it is generally agreed that those people who acquire a hearing loss in adulthood have few needs in common with those who are born deaf, the prelingually deaf. The latter are likely to use a signing language and, as a group, increasingly choose to eschew a disability identity and view themselves as a minority linguistic community. This article is concerned with the first group, adults who acquire a hearing loss but maintain their lives in the hearing community, relying on a combination of residual hearing and visual cues for communication, sometimes assisted by hearing aid use.

A common but hidden disability

With the increased exposure to noise in our industrialized societies and the aging of our populations consequent on improving life expectancies, such hearing impairment is an increasingly common disability. Difficulties in definition and under-reporting make accurate statistics of incidence hard to determine, but a safe conservative estimate can be made that about 1 in 10 of the population are hearing impaired, with the majority having adult onset hearing loss (U.S. Department of Education, 1993; Davis, 1995). It can be a profoundly handicapping disability, attacking communication and much of the enjoyment and quality of life. In the eighteenth century, Doctor Samuel Johnson called deafness "*the most desperate of human calamities*" (Jones, Kyle & Wood, 1987, p. 18) and this remains true, in spite of the modern development of technical aids and devices that assist with, but cannot cure, the problem. Even mild hearing impairment can interfere with communicative ease. And extraordinarily it remains a very hidden disability, its sufferers often seeking to keep their impairment concealed and denying or minimizing its impact on their lives. Many never approach rehabilitative services, and those who do, often realize only limited benefits from them.

The need for counsellor awareness

This article is not directed to rehabilitation specialists but to mainstream counsellors working in health settings and other agencies throughout the community. Such counsellors rarely receive training in working with the hearing impaired, and the growing literature on the topic is generally confined to the rehabilitation or self help sectors. However, there are several compelling reasons why counsellors in the community need to have a better understanding of hearing impairment.

The first goes to the heart of the philosophy and politics of disability. Increasingly, disability is construed as residing not in the impairment possessed by the individual but in the interaction between the individual and his social environment and the environment at large (Bickenbach, 1996). Building on the work of Zola (1989), Bickenbach goes on to argue that disability disappears if environments are fashioned according to universal design, i.e. constructed to interact effectively with the full range of human variability they are likely to encounter. Noble and Hetu (1994), in what they term an ecological approach to hearing impairment, also direct attention to an analysis of the interface or coupling conditions between the hearing impaired person and the environment, both the physical and the social. They focus on the potential for these conditions to be disabling or enabling and what needs to be changed to make them enabling. Noisy background music and hard sound-reflective surfaces in a situation where he or she is attempting to converse is an example they provide of a disabling condition in the physical environment for a hearing impaired person. Obviously, encountering a counsellor ignorant about hearing loss and how communication can be facilitated would represent another disabling condition – this time in the social environment. I am proposing that education of counsellors in the needs of these clients is necessary as a means of creating a more enabling interface in the counselling setting. It can also be construed as a positive step towards universal design of counselling services.

Secondly, given the increasing numbers of hearing impaired people in our societies counsellors are inevitably going to encounter them as clients in general practice. After all, hearing disability does not make them immune to all the other difficulties that bring people to counsellors. If when they get there, counsellor ignorance of their needs combines with client reluctance to disclose them – "*It's almost universal among the deaf to want to cause hearing people as little fuss as possible . . . we can be self effacing and diffident to the point of invisibility*" (Kisor, 1990, p. 224) – the communication process at the very least will be difficult. The risk of the counsellor misunderstanding or misinterpreting the client's behaviour could be high. More confident clients may try to educate the counsellor, but may also become resentful that their therapeutic time has to be spent that way, particularly if they are paying for it (Simmons, Rosenbaum & Sheridan, 1996).

In addition, clients could well be unaware or resisting awareness of the way that their deafness is contributing to the problem that brought them to counselling. It is vitally important then that the counsellor know what to look for, and be sufficiently informed in order to be capable of what has been described as "*keeping a weather eye out, in more general practice, for hearing problems as underlying family relations problems, mood disorders, or psychotic symptoms*" (Noble, 1997, p. 106).

And finally, the presence in the community of professional counsellors competent to identify the psychological issues intrinsic to the disability and communicate understanding to their hearing impaired clients is very much needed. To be sure, the impairment in this disability is clearly a physical one and as such requires medical, audiological and technical rehabilitative interventions. But how it is managed in the person's life is often bound up with how successfully he or she deals with the painful personal and emotional issues that inevitably seem to accompany hearing loss. Failure to deal with them can prevent the person's approaching these rehabilitation services at all and benefiting from these interventions. That is why it is desirable that not only rehabilitation specialists but general counsellors too should be equipped to detect these issues. Shame, anxiety, identity impairment, grief, anger and depression comprise everyday counselling material to most counsellors. Gaining an understanding of how they operate in the lives of hearing impaired people could yield important outcomes in terms of improved quality of life and more fruitful referrals to audiological clinics. Obviously, a good referral arrangement with an audiologist is a critical adjunct to therapy.

The experience of hearing impairment

The tendency to conceal hearing impairment means that many people, including counsellors, are unaware of what the experience of living with one is like. The concealment is certainly not because it presents only a minor disability. On the contrary, the painful consequences of living with restricted communicative abilities and the necessary efforts at adaptation required have been well documented in a wide literature, covering research, analytic commentary, autobiographical accounts and self-help books. Here are some views on the experience:

> It is the perpetual likelihood of breakdown in communicative performance . . . that makes hearing impairment so destructive to the basis of normal human existence (Noble, 1996, p. 7).
>
> An invisible condition without external evidence, such as signing, places people who are hard of hearing in limbo. They do not belong to deaf communities and they are often estranged from the hearing community of which they had been a part (Stone, 1987, p. 117).
>
> Be it vigilant or, as the years go by, dulled and weary, the deafened person's passage through the hearing world, oblivious to much that transpires, is characteristically guarded and uncertain, hoping to avoid but necessarily encountering pitfalls, surprises, misunderstanding, error, frustrations, irritation, embarrassment, pain, puzzlement, and a simple lack of comprehension (Orlans, 1987, p. 97).

Even among the self-help books, a genre committed to optimism, ever determined to frame difficulties as opportunities, the blunt reality of hearing loss must be stated:

> Being deaf does curtail activities; it does limit social intercourse; it is tiring, frustrating and depressing; it is the devil to live with (Brinson, 1986, p. 106).

Consequences of hearing impairment

Researchers in many countries have studied samples of hearing impaired people and have produced evidence of the adverse effects of hearing loss over many facets of their lives. Social life and interaction, enjoyment of leisure and cultural pursuits, intimate relationships and family life, employment and vocational aspirations, physical health and emotional well-being are all domains that have been demonstrated as being at risk for the hearing impaired person (e.g., Blaikie & Guthrie, 1984; Thomas, 1984; Orlans, 1985; Jones, Kyle & Wood, 1987; Stephens, 1987; Hetu, Lalonde & Getty, 1987; Hetu, Jones & Getty, 1993). While there seems to be no evidence to suggest a higher incidence of psychiatric disorder amongst the hearing impaired, Thomas (1984) did reach the conclusion that psychological disturbance was evident in his sample at a rate four times that of the general population. Furthermore the likelihood of such disturbance was substantially higher for those with very severe hearing losses.

Concealment of hearing impairment

So why don't they speak up? On the face of it, it seems paradoxical that the hearing impaired are so reluctant to disclose or seek assistance for a disability that is such an incapacitating one. Commonsense might suggest that they should be outspoken in their requests for consideration and assistance. But there is plenty of evidence that they are not. The studies described above provide many examples of how the truth about hearing loss is concealed. Perhaps the essence of the manoeuvre is captured by the poet Wright in his autobiographical account of deafness:

> Unless I have to, I will not let the deaf cat out of the bag (Wright, 1990, p. 113).

Bluffing or trying to pass as someone with normal hearing is clearly common practice. Sometimes this can be rationalized as a reasonable practice, given that the likelihood of the hearing world knowing and then remembering how to assist with the communication difficulty is often very low (McCall, 1991). But its root cause must go deeper than that. For the price paid for the deception can be very high. While their not normal hearing goes undetected, hearing impaired people are at risk of having their behaviour regarded as very abnormal (Orlans, 1987). "Unfriendly", "stupid", "rude", "uncooperative", "snobbish", "socially unskilled", "no personality" are all judgments the deaf person is apparently prepared to risk. Apparently they are preferable to *deaf*.

Stigmatization of hearing impairment

Exactly so. "*Social incompetence is consistently felt to be a more tolerable negative identity than that of being viewed as a hearing impaired person*" asserts Hetu (1996, p. 14) in a persuasive analysis of the stigma attached to hearing impairment. He argues that it is this stigma and the consequent requirement to manage a "spoiled identity" (Noble, 1983) that explains the bluffing behaviour of hearing impaired people. Their efforts are directed at concealing a status that is experienced as shameful. In order to ask for the assistance that would improve communication and reduce the disabling effects of impaired hearing, they have to agree to take on this status and stigmatized identity. Most hearing impaired people seem to judge that it is not worth it. Many resist acknowledging the fact of their impaired hearing even to themselves (resulting in the familiar "everybody mumbles these days" explanation of the communication difficulties). For if they do admit to it, they are also likely to assume the burden of self stigmatization, having been part of the normal hearing world and absorbed its attitudes.

Assistance is not sought for problems that are not acknowledged. The most serious effect of the need to conceal and to avoid taking on the status of a deaf person is the obstacle it can place between hearing impaired people and rehabilitation. Noble (1996) reviewed data on the hearing levels of new clients approaching hearing aid providers in three countries and concluded that levels of hearing loss generally have to be severe before people seek help. Even then, those who do seek such assistance represent only about 20 to 25 percent of people with substantial impairment in the community. Thus many people who could benefit from hearing aids are not acquiring them.

Hetu (1996) concludes that de-stigmatization and restoration or "normalization" of social identity is a key prerequisite to the rehabilitation of the hearing impaired and he sets out a number of steps for this process to take place. On a community level, he recommends encouraging more tolerant attitudes by such initiatives as awareness programs for professional groups and the wider community to inform them about hearing impairment and how communication can be facilitated. On an individual level, the hearing impaired person must be helped to start disclosing and acknowledging the impairment in an environment where he or she can be confident of a positive response. Self help groups have an obvious role in this regard, though one needs to be ready to take on, or to have resolved, the stigmatized identity to join such a group. I believe that if counsellors in the community were knowledgeable about the stigmatized identity feared by the hearing impaired and vigilant in detecting its operation in the lives of the clients they encounter, they could provide this safe, supportive and confidential environment for work to begin.

It may be hard at first to believe that shame and stigmatization is such an important issue in hearing loss, particularly if the development of tolerant attitudes towards difference has been part of one's professional training; but evidence of the stigmatization of hearing loss in the community is not hard to find. Deafness has long been associated with "dumbness" or stupidity, with incompetence, with difficulty and inconvenience and with aging (a diminished identity in itself). It is frequently the butt of jokes and mockery in social situations and in entertainment. It invites irritation and suspicion. "She hears when she wants to", "he won't make an effort", "he just refuses to listen", "she won't use a hearing aid" are all depressingly frequent accusatory statements made to or about the hearing impaired. The question "Are you deaf or something?" is rarely either delivered or received as an enquiry prompted by compassionate desire to assist! Ironically of course, the very efforts the hearing impaired person makes to conceal his problem can feed the stigma of social ineptness, or give rise to a new accusation "He won't admit that he is deaf"!

The causes of these negative attitudes are as yet inadequately studied but are probably many. Certainly the hearing impaired, in common with other disabled people, suffer the ill effects of the unfortunate human tendency to fear and denigrate difference. But perhaps hearing disorder arouses particularly strong negative feelings because of the way it interferes essentially with communication between people. Hearing impaired people inevitably sometimes fail to acknowledge or affirm with understanding the utterances of another speaker. Thus they can be a poor participants in the interpersonal ratification process basic to communication (Higgins, 1993). Perhaps too, the very ubiquity of hearing loss produces negative reactions springing from anxiety in normally hearing people that it could become their own fate.

Grief and hearing impairment

Woolley (1987) describes a liberating experience, 12 years after she was diagnosed deaf, of finally finding a counsellor who could perceive her need to express all the grief, fear and anger associated with her loss. Her account stands out in the literature because the recognition of this need is not common. Grief is often inadequately managed in hearing impairment. Given the number of losses that it can involve, it would seem inevitable that there is grieving to be done. But again if awareness of the impairment must be resisted, so must awareness of the grief, even as the losses mount up.

Even when the problem is named and rehabilitation is embraced, deaf people are rarely encouraged by those around them to give expression to any pain, sadness or anger they are experiencing. The commonly accepted Kubler Ross (1969) model, applied to people who have experienced a loss, suggests this must be done before they can reach acceptance and tackle problem solving and the reconstruction of a satisfying life. But the rehabilitative focus is usually overwhelmingly practical – acquiring a hearing aid, concentrating on speech reading, learning hearing tactics. Perhaps the urgency of finding ways to cope causes the need to grieve and reach some kind of psychological adjustment to be jumped over. I suspect this accounts for some of the failures in rehabilitation; unfortunately many hearing impaired people do give up and retreat into bitter solitude; many do purchase hearing aids and then rarely use them. Carmen (1983) examines this issue, linking the outcomes of a decision to acquire a hearing aid with the stages of the Kubler Ross model the person is experiencing. He highlights the risk, if rage or depression is still dominant, of transferring negative feelings about having a hearing loss to the aids. It might be better to wait until some adjustment and acceptance is achieved.

Again, the counsellor in the community should be vigilant to the possibility of problems resulting from poorly managed grief in their hearing impaired clients. Certainly, the need to grieve may be obvious in clients whose loss of hearing has been a sudden shock. But it cannot be assumed that because a loss of hearing has been progressive it has been accompanied by progressive acceptance. Frozen states of sadness or anger may be present and interfering with adjustment. Even in progressive hearing impairment, painful shock can be precipitated by sudden confrontations with the accumulating losses. Experiences that trigger awareness of such issues as the extent of withdrawal from previously valued activities, the vanished pleasure in favourite music or sounds, the necessary relinquishment of some aspirations for the future, nostalgia for the old easy participation in casual conversations, can set off once more the need to grieve and come to terms with the disability.

Practical matters in counselling hearing impaired clients

In favourable environmental conditions, most hearing impaired people can communicate quite effectively. The goal of this section is to provide counsellors with some basic information about the means of communication of such clients and some broad principles about how to provide the favourable conditions. Obviously each client is unique and the extent of the impairment will make a difference. This is not intended to replace close observation of such clients and sensitive discussion with them of their particular needs, if they are prepared to divulge them. Nor is it exhaustive. More detailed information and training is readily accessible in the literature references provided (e.g. Erber, 1993).

The client's communication

Hearing impaired clients usually rely to a great extent on gathering all the available visual clues to supplement what residual hearing they have. Their intent gaze may be disconcerting at first for the counsellor. They will be working hard to absorb facial expressions, body language and gesture, expressions in the eyes and other non verbal indications of emotion, as well as what they can glean by reading the lips. Contrary to popular belief, even the most skilled lip reading cannot detect more than part of the message, as many speech sounds look the same on the lips. Other clues are important. Knowing the topic or context of the conversation is often vital to interpretation of the visual clues.

These clients may present using hearing aids. This will be assisting their communication enormously, but does not mean that they have no further problems with hearing (Or that they would have no problems, if only they would get one). A popular misconception is that hearing aids restore normal hearing in the way that spectacles can restore normal vision. Hearing aids are simply devices to amplify the volume of the sound coming to the ear, albeit increasingly sophisticated devices these days, attempting to match more closely the amplification needs of the individual ear. But hearing pathology is complicated, often involving distortion of sound, and rarely remedied simply by the addition of volume. Furthermore, the process of learning to use a hearing aid is a challenging one, as the new user is plunged into a clattering maelstrom of sound, where the amplified speech sounds one longs to hear compete with all the other amplified noise. He or she must practice listening and distinguishing speech again and must painstakingly experiment to match appropriate hearing aid settings to the variety of listening environments encountered. Even an accomplished hearing aid user loses almost all benefits from the aids in situations of loud background noise. It is little wonder that many hearing impaired people do not persist in a difficult process in which the necessary support is often unavailable and those around them have unrealistic expectations. Hearing aids can at times be uncomfortable, unreliable, awkward to adjust especially for aged hands, prone to battery failure and feedback squeak at inopportune times, and of course a visible badge of stigmatized status. That being said, many people do gain enormous benefit from them, maintaining something approaching normal life by their use. But the hearing aided client will still be using visual cues and requiring the counsellor's careful attention to communication.

Hearing impaired clients may appear to fluctuate in their ability to hear what is being said or in their attention to the counsellor. This characteristic no doubt gives rise to the popular stereotype of the deaf being "able to hear when they want to", but there are a couple of good reasons for this apparent variability. Firstly, hearing losses vary a lot in patterns of difficulty over different frequencies and circumstances, so it is a fact that hearing impaired people do hear some sounds, some voices better than others. Secondly, as Kisor points out in his memoir of deafness, "listening" for the hearing impaired is extremely fatiguing. He describes the experience of those with normal hearing as "*soaking up auditory information as it washes over them*" (Kisor, 1990, p. 75). Contrast that with all the concentration on listening and perceiving, on searching out clues and making guesses and judgments required of the hearing impaired. Concentration and attention will waver for this reason. This can have a compounding effect, as fatigue and stress only worsens the ability to "hear" in such a complicated way. Hearing impaired clients may need to retreat into silence for a while to recoup their energies, or may simply be too fatigued to continue before the standard therapeutic fifty minutes is up.

The physical setting

Communication is optimized in a quiet space with good acoustic properties, constructed and furnished with sound absorbent rather than reverberant materials. Background noise is to be avoided. Techniques involving music as a background designed to relax will probably have the opposite effect on the hearing impaired client. The humming noise of fans, heaters, air conditioners can interfere, particularly if the client is using hearing aids as these devices will amplify the distracting noise.

It is important that the client be seated squarely in full view of the counsellor's face, so the placement of chairs is important. Classical psychoanalytical technique of therapist sitting at the head of the couch is definitely contra-indicated for the hearing impaired client, even if it is otherwise viewed as valuable. The room needs to be well lit, and care should be taken that counsellors are not seated with their backs to the window and their faces in shadow. The distance between counsellor and client may be a critical factor in the client hearing what is said, so chairs may need to be moved closely together, closer than counsellors are accustomed to. Thus, if the client edges towards the counsellor, the temptation to pathologise this as a sign of dependency, seductiveness or personal space intrusion must be resisted. Chair placement may also need to take into account the client's "best" ear for hearing.

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