

Aural Rehabilitation; Person Centred or Cost Effective?

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Introduction

Audiology services within the UK face the challenge of providing appropriate aural rehabilitation to an increasing population, within a restrained budget. In practice this means that many centres have attempted to address waiting lists by reducing aural rehabilitation services to provision of hearing aids with limited follow up. Following the recent introduction of open ear fittings and telephone reviews, clinics are now introducing “one stop” appointments where patients are assessed and fitted with hearing aids at the first appointment which, on average lasts 45-60 minutes with one additional follow up by phone. This has greatly reduced the amount of contact time with newly diagnosed clients. Such developments are welcomed by managers

because they enable redirection of resources to address waiting times. It does however raise the question about the impact limited contact time for aural rehabilitation may have on outcome. What remains unclear at present is the patients’ perception of a comprehensive rehabilitation plan. This study sought to explore patients’ concerns about acquiring hearing loss and their expectations of rehabilitation services.

Ethical consent was obtained from the relevant National Health Service ethics board and Queen Margaret University ethics committee. Subjects were selected from new referrals to one NHS Audiology Department. Six subjects were interviewed. Information about the subjects is given in the table below.

Subject No	Gender	Age	Noise exposure	Onset of Hearing Loss (years)	Person instigating referral
1	M	63	Y	2	Self
2	M	71	N	1	Medical staff
3	M	84	Y	3	Wife
4	F	84	Y	14	Daughter
5	F	71	N	2	Daughter
6	F	80	N	N/K	Husband

Table 1. Subject Details

All subjects had been referred by their general practitioner with a view to being fitted with hearing aid(s). Information letters and consent forms were sent to patients on the waiting list for this clinic, who met the following criteria. All subjects had to be new patients, able to attend the clinic for a minimum of two visits, and able to take part in a tape recorded interview lasting at least 1 hour. Instructions were given to return the signed consent form to the researcher in the pre paid envelope provided prior to attending the clinic. Open ended interviews were conducted, each lasting approximately one

hour. The interviews were conducted on the first visit to the clinic prior to any contact with Audiology staff. All interviews were carried out by the same researcher who was not directly involved in the subjects’ care. Following each interview the digitally recorded data was anonymised and transcribed verbatim by the interviewer, the content was then verified with the subject. The transcriptions were analysed using a grounded theory approach (Glaser and Strauss, 1967; Charmaz, 2006)

Results

Five core categories emerged from the interviews. Each of these categories is discussed and extracts from the transcriptions are provided.

Coming to terms with the onset of hearing loss

Reactions of the family

Coping with future social interactions

The ability to cope with hearing aids

The stigma attached to hearing aid use

In this small group of subjects there was some variation in the length of time between first noticing hearing loss and seeking help- or being persuaded to seek help. Each of these subjects displayed behaviours and ego defences such as denial, and anger (Nelson-Jones, 2005) which suggested they may be experiencing different stages in the grief process. (Kubler-Ross, 1997). Interestingly the subject who self referred for assessment was more accepting of the problem and willing to try hearing aids whereas the other subjects were still resistant to accepting changes in their personal construct. The effect of deafness on relationships was of great concern. Many expressed fears about losing control or taking on a less autonomous role in the family. Despite these fears, all subjects spoke of how they would have to adapt to fit situations rather than having changes made to accommodate them. Although all of these subjects were attending a clinic with the specific aim of being fitted with hearing aid(s), in the main there was a reluctant acceptance of hearing aids rather than a positive attitude towards them. The subjects had very low expectations of the services and seemed resigned to using their own resources to cope rather than embarking on a supportive rehabilitation programme.

Category 1; Coming to terms with the onset of hearing loss

Responses varied within the group. Some subjects still did not believe they had difficulty in hearing conversations despite their families' concerns. While others perceived hearing loss as inevitable. One subject felt he had started to exhibit what he called "Deaf behaviour" as soon as his hearing loss was brought to his attention.

"Somebody would be talking and I would say 'What'...even though I heard...I started saying 'What was that?'"

Category 2; Reactions of the family

Many of the subjects expressed concern about the reactions of the family, and how disclosure of hearing difficulties would be received. Where the subject felt support would be offered they were more amenable to trying hearing aids. However some expressed concerns or reported incidences where they had not felt supported.

"My daughter said I would be too proud to wear a hearing aid"

Interestingly this lady described herself as the "stubborn type" and had resolved to prove her family wrong, so in this case the lack of support had strengthened the subject's resolve.

A common issue within this theme was of the subject having to adapt and fit in rather than situations being changed to accommodate the hearing difficulties.

"The usual comments... 'deaf in your auld age' but they are quite tolerant"

Category 3; Coping with future social interactions

Subjects had concerns about the impact of deafness on their social life. Some had already started to use maladaptive coping strategies, such as avoiding situations or withdrawing from the situation. One subject looked visibly distressed as he recounted his last experience at a family gathering,

"You miss out on things, you just sit there"

Others were unsure what the future held and how they were going to adapt,

"I worry in case I go deaf altogether...I wonder if I should learn to lip read"

"Learning sign language...I never got down to it but it's in the back of my mind"

Category 4; The ability to cope with hearing aids

This was a cause of concern to all of the subjects many of whom were resigned to having to cope on their own. They did not expect ongoing support as part of the rehabilitation services. There were concerns about how they would appear to others if they needed help,

"I don't want a big one because it will be seen, but I don't want a wee one. In case it goes right into my ear. What if I get it wrong and they think I am stupid"

Category 5; The stigma attached to hearing aid use.

Despite the advances in digital technology and media hype, the main concern for this group was not that the hearing aid was digital but that it would be seen. In many cases the size of the hearing aid still influenced whether the subject would wear it.

“I don’t want it to be seen”

“I worry that it will be big and everyone will see it”

“It bothers me, people being able to see it.”

“I’m saying to myself “Folk will think I am deaf”

This last comment is indicative of the confusion felt by many subjects about being “deaf”. This was not yet part of their self construct and a label they tried to distance themselves from. The resistance to seeing themselves as a deaf person caused confusion and stress for some subjects, who were as yet unable to accept this change or alter their configuration of the self.

Discussion

Three particular questions emerged from the analysis of this data.

Do the stages of the grief process correlate with attitude and motivation in aural rehabilitation?

Could addressing ego defences and coping strategies as part of the rehabilitation process improve outcome?

Would a structured counselling programme prior to fitting influence the clients’ experience of coming to terms with hearing loss, and hence their acceptance of a new personal construct?

These subjects all displayed behaviours which suggested ego defences were being used as a coping strategy. I believe there is little evidence in the literature to conclude whether or not these ego defences, and indeed the grief process play a significant effect on the rehabilitation process in Audiology. If there is a significant effect then reducing contact time with newly diagnosed patients may not provide sufficient support to address these issues. Further work needs to be undertaken in this area.

Expectations were very low in this subject group. They expected to be fitted with a hearing aid and given no further help. The fact that they had been referred to a “Hearing Aid clinic” may have influenced their view of rehabilitation. In order to comprehensively explore the lived experience of acquiring

hearing loss, it is necessary to select subjects who are presently experiencing hearing loss but have not yet accessed services in order to explore their feelings and expectations about deafness.

References

- Charmaz, K.(2006) Constructing grounded theory; a practical guide through qualitative analysis. Sage
- Glaser,B. Strauss,A (1967) The discovery of grounded theory: strategies for qualitative research. Aldine. New York
- Kubler-Ross, E (1997) *On death and dying*. Simon and Schuster Inc (reprint edition.)
- Nelson- Jones, R (2005) The theory and practice of counselling and therapy. 4th Edition. Sage