Counseling Older Adult Hearing Instrument Candidates

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This article examines the nature of counseling as it relates to the hearing health care field. Three studies are discussed which examine: 1) the effect of hearing loss on communication and emotional adjustment to hearing loss; 2) factors that influence adherence with the hearing care professional; and 3) the potential benefit of brief counseling in motivating hearing instrument candidates to acquire hearing instruments. The need for further academic and clinical preparation in counseling is outlined along with specific counseling/instructional considerations.

Counseling provides an opportunity to obtain and convey information, facilitating understanding of and adjustment to hearing loss. It includes identification of personal strategies to modify communication behavior and the communication environment. It involves development of coping mechanisms and systems for emotional support.[1] Counseling may be the most important clinical service that hearing professionals can provide.

Within the framework of hearing instrument dispensing, counseling goals typically have focused on orientation to care and use of hearing instruments. Wilkinson[2], for example, listed content areas to address in counseling new hearing instrument consumers which center on improved understanding of the hearing instrument, its care and its use in everyday communication situations. The practical value of such information cannot be denied. However, O'Neill[3] questioned whether emphasis placed primarily on "product movement" was misdirected. Instead, he admonished hearing health professionals to determine why viable candidates fail to accept and use hearing instruments. Smedley and Schow[4] surveyed adult hearing instrument candidates in this regard and found that non-use may be due to idiosyncrasies of the presenting hearing condition, technological factors and unrealistic expectations from hearing instrument use. In addition, some unsuccessful users reported their hearing instruments were "worthless in noisy settings, a damn nuisance, making them nervous, making them feel uncomfortable." So, clearly, there is a population for whom personal adjustment counseling is warranted and hearing instrument dispensers may be uniquely positioned to either provide this service directly or initiate an appropriate referral.

When a person counsels others from a perspective outside the counseling profession, that person is said to be a "non-professional" counselor.[5] Attorneys, physicians, and clergy, as well as hearing care professionals, serve as "non-professional" counselors, sensitive to the comprehensive needs and experiences of individuals and willing to address concerns beyond the scope of the primary practice of their professional discipline. The non-professional counselor's purpose is not to resolve all conflicts that may be present or to diminish his/her primary professional identity. However, non-professional counselors who dispense hearing instruments should be prepared to provide ongoing and effective support to those requiring more than content counseling.

Counseling as a professional service is based on a well-patient model. Candidates typically are psychologically normal individuals who are confronting, and trying to cope with, disruptions in their lives. The goal is to bring about changes that will lead to reduction in self-perceived handicap.[5] A concern is that many professionals who engage in hearing instrument dispensing have limited academic preparation or practical experience in counseling theories and their application.[6,7] As a result, individuals with personal adjustment problems relating to their hearing loss or use of hearing instruments have little opportunity for professional guidance.[8]

Prime candidates for personal adjustment counseling are older adults with acquired hearing loss. These individuals typically have spent the greater portion of their lives with normal hearing. Gradually, they experience loss of signal perception. They learn to compensate by mechanical means (e.g., increasing volume controls) and social manipulation (e.g., asking others to repeat words). As time and/or hearing loss progresses, older individuals may experience

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decreased ability to cope/adjust successfully to problems related to hearing.

Theoretically, the potential for minimizing problems associated with hearing loss is improved with successful use of hearing instruments. Individuals age 18 years and over with impaired hearing who do not own hearing instruments are estimated to be 78% of all potential users.[8] Approximately 43% of all adults age 65 years and over, the fastest growing segment of society, experience self-reported hearing loss, yet 61% of those who might benefit do not own hearing instruments.[9,10]

To underscore the personal adjustment counseling needs of older adults, results from three related studies are presented. The first examines the effect of hearing loss on communication and emotional adjustment to hearing loss. The second identifies factors that influence adherence with professional advice to use hearing instruments. The third reviews the potential benefit of brief counseling in motivating hearing instrument candidates to acquire hearing instruments.

Communication Behavior & Emotional Adjustment in Older, Hearing-Impaired Adults

Using the Communication Profile for the Hearing Impaired (CPHI)[11], Garstecki and Erler[12] examined hearing loss management behavior and associated communication problems in over 300 older, advantaged, non-institutionalized adults with acquired age-appropriate hearing loss. The CPHI measures self-perceived hearing handicap in four content areas: Communication Performance, Communication Environment, Communication Strategies, and Personal Adjustment. It assesses the importance of effective communication. Results demonstrated a high degree of variability in performance across a relatively homogeneous group of older adults.

Participants reported little difficulty communicating in intimate or confined settings, particularly with familiar partners. In contrast, they were likely to experience difficulty in work-like or social settings. When asked about the importance of effective communication, these older adults indicated that effectiveness was most important in work-like settings and least important in social settings. This finding was expected because business communication (e.g., conversations with physicians or attorneys) may be directly related to one's well-being or livelihood, whereas social communication may be considered more discretionary.

Although there was a high demand for communication in daily activities, the physical characteristics of usual communication environments were not particularly challenging. When asked about communication partners, these adults were unlikely to report problems relating to the behaviors or attitudes of others. Participants demonstrated a hierarchy of communication strategy preference. Maladaptive strategies (e.g., dominating conversations) were rarely employed. Verbal strategies (e.g., asking for repetitions) were used only occasionally. Most often, they relied on nonverbal strategies to facilitate communication (e.g., watching the speaker's face).

CPHI items relating to personal adjustment to hearing loss revealed generally high self-acceptance and acceptance of hearing loss in the sampled population. These adults demonstrated little anger, discouragement, stress or withdrawal related to their hearing loss. Although, as a group, they displayed a tendency toward positive personal adjustment to hearing loss, a high degree of variability was apparent for measures of displacement and exaggeration of responsibility, anger and withdrawal. Overall, this suggests a wide range of reaction to hearing loss, even among a relatively homogeneous group of older adults.

Implications from this study have potential significance to hearing instrument dispensers. First, communication effectiveness was situationally dependent. Environmental and speaker variables weighed heavily in whether or not effective communication occurs. This suggests that it would be beneficial to survey the conditions of the older adults' communication environments during hearing instrument fitting and orientation. It also may be important to consider self-perceived problems specific to communication partners. This may lead to selection of hearing instruments that lend themselves to coupling with assistive devices to enhance their use in larger and/or noisier environments. It also may be useful to counsel the older adult in the use of communication strategies including ways to repair communication failure. Tye-Murray, Purdy & Woodworth[13] provide examples of such strategies.

A second implication is that the importance of interpersonal communication varies with lifestyle. Use of a self-assessment scale, such as the Hearing Performance Inventory[14], emphasizing self-perceived ability to communicate in diversified situations would provide important information in this regard.

A third implication is that advancing age does not diminish one's need to communicate. The benefit of hearing instruments, assistive listening devices and cochlear implants, as well as the potential benefit from participation in a rehabilitative intervention program, is likely to be high for older adults. However, other factors relating to the aging process, its influence on central auditory processing, physical dexterity and mobility, and one's financial resources may severely limit opportunities for benefit to certain individuals.

A fourth implication is that older adults prefer solutions to their hearing problems that tend to be more subtle and less intrusive. Essentially, they prefer not to become a burden to others. In this regard, personal adjustment counseling should emphasize solutions that are likely to be under the older adult's personal control. Devices that require assistance from others to operate should be recommended sparingly.

Finally, older adults are likely to demonstrate a wide variety of reactions to hearing loss. Although most are accepting of themselves and their hearing condition, it is common for many to experience negative emotional responses to hearing loss. When this occurs, the hearing instrument dispenser should not hesitate to refer such an individual for professional counseling.

Adherence to Professional Advice to Use Hearing Instruments

Garstecki[15] examined the importance older adult hearing instrument users and non-users assigned to factors potentially influencing decisions to acquire and use hearing instruments. More than 60 older adults who adhered with professional advice to use amplification and 70 who did not adhere with such advice completed a survey of educational background, income and health history. Intelligence was measured along with self-perceived hearing handicap and hearing instrument management behaviors. In general, participants were well-educated. Adherers tended to report higher incomes and better health.

Adherers demonstrated greater communication

effectiveness, particularly as measured by the At Home, At Work and Average Conditions scales of the Communication Profile for the Hearing Impaired (CPHI).[11] They preferred use of verbal over nonverbal strategies or maladaptive behaviors when resolving communication problems. Adherers demonstrated greater acceptance and less exaggeration of responsibility in their personal adjustment to hearing loss than non-adherers.

Hearing instrument management behaviors differed:

1) Adherers were not as concerned about their physician's perception of hearing instrument benefit as non-compliers. This suggests that some older adult hearing instrument candidates may choose to bypass the "medical funnel" and not seek their physician's advice regarding a hearing instrument purchase.
2) Adherers were less likely to associate hearing instrument use with aging than non-compliers.
3) Adherers were less likely to associate feelings of stress with wearing hearing instruments.
4) Adherers were less concerned about hearing instrument purchase and maintenance costs. Although this may relate to the complier group's higher income, this finding may indicate that some potential consumers continue to find the financial burden in owning hearing instruments is not outweighed by the communication benefit in their use.
5) Adherers were less concerned about the convenience of using hearing instruments, their comfort and problems relating to acoustic feedback than non-compliers.

Adherers in this study recognized the importance of hearing instrument use. With their hearing instruments, they reported experiencing effective communication. They took a proactive approach toward dealing with their hearing aid-related concerns. Adherers were less likely to perceive a stigma associated with hearing instrument use or to be negatively influenced by personal vanity. Finally, adherers were not troubled by hearing instrument costs. Results emphasize that many older adults who are candidates for amplification will require counseling to overcome negative perceptions about hearing instrument use.

Several implications may be drawn from this study that potentially apply to personal adjustment counseling. First, older adult hearing instrument candidates are more likely to react positively to information about potential benefits from use of hearing instruments in everyday communication than from information regarding such concerns as those relating to stigma, cost or other such factors. Counseling older adults in adjustment to hearing instruments should focus on how hearing instruments increase the likelihood of successful communication and ultimately help keep them from becoming socially isolated or dependent.

Another implication is that personality plays an important role in hearing instrument acceptance and successful use. As such, personal adjustment counseling procedures must be hearing instrument user-centered and flexible enough to accommodate a range of individuals. More study is needed to identify core components in the personal adjustment counseling process and alternate ways to reach the greatest number of individuals.

Counseling to Facilitate Compliance With Hearing Instrument Recommendations

In the typical course of hearing assessment and hearing instrument fitting, questions regarding the clinical procedure, hearing condition and hearing instruments are addressed. Other concerns may be reserved for follow-up sessions or simply ignored. Counseling program benefits, as measured by hearing instrument use and satisfaction, have been demonstrated[16], as have reductions in self-perceived hearing handicap.[17] However, little is known about the benefit of counseling intervention prior to audiologic assessment or hearing instrument fitting. Such efforts could potentially facilitate development of a trusting dispenser-client relationship, clarify expectations from hearing instrument use, and ultimately increase compliance with recommendations to acquire and use amplification.

Erler[18] provided a brief counseling session to older adults with age-appropriate hearing loss who were participants in a larger study of hearing loss management behavior. Each of the 100 participants received approximately 15 minutes of brief counseling that included discussion of the results of an audiologic evaluation and the effects of hearing loss on communication, interpersonal relationships and emotional well-being; discussion of expectations of amplification; and identification of resources for hearing-related assistance. No specific recommendations regarding hearing instrument purchase were included in these brief counseling sessions.

A three-month follow-up survey revealed that 22 of these individuals subsequently obtained hearing instruments. As a group, these individuals distinguished themselves from participants in the larger study who had already adhered with professional advice to use amplification, as well as from those who continued not to adhere. New adherers had poorer general health, less formal education and lower annual income than other participants. They demonstrated greater hearing loss than non-adherers. New adherers demonstrated higher regard for the opinions of others in making decisions to use amplification. They indicated greater awareness of problems associated with hearing loss and a greater tendency to expect communication partners to make accommodations for their hearing loss than non-adherers. When asked to rate their experience in receiving a brief counseling session, they were most likely to indicate it was informative and encouraging.

A number of implications can be drawn from this study. First, there appears to be a measurable threshold level of hearing loss denoting when older adults perceive hearing instrument use to be vital. When this occurs, the influence of the cost factor in decisions to acquire hearing instruments is diminished. A second implication is that support and encouragement from family and friends may outweigh real and perceived drawbacks to the use of amplification. This suggests that adjustment counseling efforts should involve individuals within the older adult candidate's circle of family and friends. The older adult may consider these individuals as their primary communication partners and regard their input as important during hearing instrument acquisition and longer-term adjustment to its use.

A final implication is that brief counseling may provide an opportunity to expand one's familiarity with hearing loss and its impact. This appears to be an important component in the hearing loss management process for those not yet convinced of the benefits of hearing instrument use. Providing information relating to hearing loss and its self-management prior to hearing instru-

ment fitting may establish a person-focused—rather than product-focused—approach to hearing care. Ultimately, this approach may facilitate personal adjustment to hearing loss and reduce the need for clinical intervention.

Summary

Data from the above studies support the need for academic and clinical preparation of hearing instrument dispensers in counseling, particularly in the area of personal adjustment counseling. Currently, few clinical audiologists who may or may not dispense hearing instruments receive academic instruction and clinical practice in personal adjustment counseling.[6,7] Of the 30 semester hours of professional course work required for the ASHA Certificate of Clinical Competence in Audiology[19], none are specifically required in the area of counseling. Interestingly, the proposed AuD curricula highlight development of counseling strategies and techniques as an integral area of professional instruction.[20] ASHA requires that a minimum of 20 clock hours of supervised clinical practice in audiology must be earned in *treatment* of hearing disorders in children and adults. Treatment is defined as clinical management *and counseling*. Taken at face value, this suggests that a clinical audiologist's academic preparation in counseling is concentrated in the clinic setting and that the minimum level of supervised counseling experience is under 20 clock hours.

According to McCarthy and her colleagues[7], 70% of audiology graduate students take didactic courses in counseling, and 84% enroll in clinical practicum courses. However, most counseling courses are offered as elective rather than required courses. More than half of the counseling courses incorporated in McCarthy's survey were offered outside communication sciences and disorders departments and may not have included instruction specific to hearing loss. It is not surprising that only 12% of the surveyed department chairs considered the preparation offered to their students in the area of counseling to be adequate.

Quality and availability of counseling services to individuals with impaired hearing, including hearing instrument candidates, must be improved. To this end, there is a need for the following:

- Consumer input in determining counseling needs for all individuals with impaired hearing and their families. This information is necessary for definition of instrumental, informational and emotional adjustment counseling parameters, and development of client-oriented counseling services.
- Counseling process modeling. Program components must be identified and alternate delivery models need to be explored in consideration of limitations imposed by health care reform measures and increasing numbers of counseling candidates (i.e., older adults).
- Reliable, valid and economical self-assessment tools to determine counseling needs of individuals with impaired hearing and their families, as well as to measure progress in self-management of hearing loss.
- Attention to counseling-related issues of specific concern to minority and culturally diverse populations.
- Educational standards for hearing health professionals that specify instruction of the theoretical and applied aspects of counseling for individuals with impaired hearing and their families.
- Development of professional practices and procedures in supervision of counseling service providers.
- Professional service standards that ensure provision of, and access to, the highest quality counseling services by those who need them.

Through research examining the professional practice of counseling and the development of educational standards governing academic preparation of future counselors, our approach to meeting the counseling needs of individuals with impaired hearing and their families will be much improved. Professional standards programs that promote high-quality counseling service and quality assurance programs that monitor these services must be established. In the absence of such programs, there is no way to ensure that future hearing health care professionals will have the special knowledge and clinical skills necessary to develop clinical competence in any aspect of counseling. Although the immediate benefit from consistent, adequate training in personal adjustment counseling would be to better prepare clinicians, the ultimate benefit will be to individuals who experience hearing loss. Clearly, there is a need to prepare hearing care professionals to responsibly address the needs of hearing instrument candidates, facilitating their personal adjustment not only to hearing instrument use, but to hearing loss. ■

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