"Turn it up!" Exploring the Factors that Affect the Acquisition of Hearing Aids

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Abstract

The purpose of this interdisciplinary research is to examine the impact of identity and identity processes on whether an individual acquires a hearing aid(s). Using a qualitative design, twenty-three adults were interviewed about their hearing loss and their use or non-use of hearing aids. Several themes emerged that focus on how individuals recognize the hearing loss, the role of trust related to audiologists, the fear of stigmatization, and the importance of social support. In the case of hearing aid acquisition, we argue that identity theory provides a framework for understanding how an individual decides as to whether they will purchase a hearing aid or not. Structural factors, such as job support, rewards, and costs, cognitive factors, such as reflected appraisals and social comparisons; and commitment factors, such as affective commitment, affect how an individual decides whether or not to make a purchase.

Keywords: Hearing loss, Identity theory, Affect control theory, Stigma

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Introduction

The National Institute of Deafness and Other Communication Disorders reports that 15% of American adults over the age of 18 have some degree of hearing loss, making hearing loss one of the more prevalent disabling conditions in adults (NIDCD). The diagnosis of a hearing loss can occur at any time during the life course. However, it is most common among the very young for those who have a congenital hearing loss and among those whose hearing deteriorates over age. For those who are young, growing up with a hearing impairment comes with challenges related to having a disability. But for those who acquire a hearing loss due to hearing deterioration, the effect on the adult identity could be significant. This paper utilizes a qualitative design to examine the factors that affect whether or not an individual accepts or minimizes the adult social identity related to hearing loss.

Background on Hearing Loss Among Adults

Hearing loss can be either sensori-neural (in the cochlear [inner ear] or auditory nerve) or conductive (in the outer or middle ear). Most hearing loss in adults is acquired, they develop the hearing loss after birth. Although this may be due to genetics, more typically, causes are noise exposure, trauma, medicine, and the aging process (presbycusis). Presbycusis, the most predominant cause of hearing loss, typically begins in mid-life, develops slowly over time, and typically involves both ears equally. Noise exposure is the second most predominant cause and is created by prolonged exposure to noise at levels that damage the hair cells in the cochlea. Nine percent of adult-onset hearing loss is likely attributable to

occupational noise, with a higher incidence for males than females (ASHA, n.d.). The incidence of hearing loss rises with increasing age, with persons 75 – 79 years of age having an incident rate of 45.6% for persons 70 – 74 years of age and rising to 67.9% for persons just 5 years older, 75 – 79 years of age (Lin et al. 2011).

Both presbycusis and noise-induced hearing loss harm an individual's ability to understand speech. As these types of hearing loss damage the hair cells that transmit high frequencies to the auditory nerve and brain, this damage interferes with individuals' ability to hear key frequencies associated with consonants. As a result, adults with hearing loss complain of having a difficulty understanding speech, especially in noisy environments. As these persons essentially have normal hearing in the lower frequencies, which correspond to the frequencies of most vowels, they often ignore the hearing loss for years.

The use of hearing aids by persons with hearing loss does not match the incidence of the disability. For example, although 45 – 68% of persons over 70 have a hearing loss, only 32% of adults 70 years of age and older report they have used or currently use a hearing aid (Healthy People 2020 2013). The more the individual perceives the presence of a hearing loss the more likely the individual is to seek assistance and use amplification (Knudsen et al. 2010).

Although the experience of hearing loss is different for everyone, some common characteristics in adults have acquired a hearing loss due to presbycusis and noise exposure. These individuals had normal hearing during their childhood and early adult years, forming an identity that did not include hearing loss. Their occupations and social situations were formed reflecting an individual with normal hearing. The loss of hearing over time can be disorienting and easily dismissed as problems with other people or the environment. Hearing loss due to presbycusis can be dismissed as part of the aging process, which, by itself, can be grievous to some individuals. However, the difficulty in maintaining conversations with people often results in depression, anxiety (especially in noisy situations), frustration, and social isolation. The process of listening with hearing loss can be exhausting, manifesting itself in an individual's fatigue (ASHA n.d., Kaland and Salvatore 2002). The presence of hearing loss can influence relationships with others for a variety of reasons. The person with hearing loss may ask them to repeat themselves, interrupt because they do not hear the person, or turn up the volume on the television, radio, or phone.

Resistance to Hearing Loss

Here we treat the onset of a hearing loss and the decision to acquire a hearing aid(s) not just as a biological function but also as a social process whereby an individual can accept or reject the hearing loss identity. Denial or rejection of devices to support the disability is a common theme among those who have acquired a disability and those with a disability. The process is similar to the process for an individual experiencing loss (Kubler-Ross 1969). The acquisition of the hearing aid is framed as first an acceptance of the loss of a body function. Then a decision must be made as to whether the individual will acquire a device that returns the individual to some socially acceptable level of bodily function.

The social model of disability is situated in the notion that the disability itself is not a problem; that the differences in body type and functionality are not the issue (Fougeyrollas & Beauregard 2001, Smart 2016). Rather, the differences in the body's functionality limit one's access to social resources and full participation in social life. Therefore, it is not the disability that is the problem, but the societal structures in place that create barriers for the individual with a disability to the full participation on societal life granted to those with bodies that do not have a disability (Shakespeare and Watson 1997).

Structural conditions set up to benefit the "normal" body make it difficult for individuals with hearing loss to navigate their social world. For example, within the workplace, those with a hearing loss often report difficulties participating in meetings, professional activities, and training functions (Punch 2016). Additionally, those with a hearing loss report high levels of workplace fatigue and stress that come with having to navigate the workplace while also trying to hear colleagues (Punch 2016). Attitudinal research indicates that those within the workplace and family members, often do not know how to react to someone with a hearing loss, choosing to ignore often the person: (Hetu et al. 1994).

Identity theory provides a framework to understand how social and attitudinal rejection can lead to resistance to acquiring a hearing aid (Stryker and Burke 2000). An identity is an understanding of oneself within the larger social world, and the various identities of an individual situate the person within the larger social structure (Stryker and Burke 2000). As aspects of the self, identities are a recognition and a formal acceptance of who we are in relationship to others. To identify as an individual with a hearing aid means that there must be people who do not have a hearing loss against which comparisons are made. The identification as an individual with a hearing loss and, subsequently the decision to acquire a hearing aid, then, is a negotiation that one has with oneself as the person figures out whether to identify as such.

Individuals, therefore, can reject the notion that they have a hearing loss and subsequently decide not to acquire a hearing aid. Here, aspects of the identity process help determine whether an individual will acquire a hearing aid.

Culturally, many communities reject those with a hearing loss, especially hearing loss among the young (Eriks-Borphy and Whittingham 2013; Kushalnagar et. al 2011). People who develop hearing loss in their early adult years may be less likely to seek out assistance for their hearing because of the cultural expectations and stigmas associated with the normal body and that hearing loss is seen as an "elderly" issue (Beckner and Helme 2018; Most 2007). It is this rejection of those with a hearing loss that would often prevent individuals from acquiring a device that indicates that one has a hearing loss.

Methods and Data

This research explores the factors that influence whether or not someone acquires a hearing aid. For this study, we used a qualitative design to examine the experience of individuals diagnosed with a hearing loss. Students in a graduate aural rehabilitation class interviewed an adult with acquired hearing loss. This research was conducted over two consecutive spring semesters, spring 2016 and spring 2017. As the students were enrolled in a Communication Sciences and Disorders graduate program, students were taught how to do qualitative research from a social science perspective.

Upon obtaining university review board approval, twenty-three respondents were recruited for this study using a convenience sample. Respondents ranged in age from 45 to 90. During the first iteration of this study, students were given the option to ask an individual whom they knew if they wanted to participate in the study. If students had no one, they were assigned an individual known to one of the authors from the client pool at the university speech and hearing center. During the second iteration of this study, all students were assigned an individual known to the second author from the clinic client pool. Students then contacted the potential participant to request an interview and to set up a time to meet. Students interviewed each individual, recorded, and transcribed their interviews.

The interview protocol focused on four areas of the hearing loss experience: acquisition, daily life (work, social, etc.), relationships, and experience with professionals. During the interviews, respondents were asked a series of initial questions within each category, then the interviews followed an open format that allowed the interviewers to probe specific areas. Because graduate students were conducting the interviews, these students were provided with a series of probing questions that they could use to help guide the conversations within each area. There was initial concern about the data collection because, as will be mentioned further in the limitation, several students engaged in providing advice to the respondents who had not acquired a hearing aid. However, in the three cases that this advice was provided, all the advice was provided after the respondent provided answers to the questions. Therefore, we do not believe there was any significant effect on the respondent's answers nor attempts to severely bias the data.

While the interviews focused on a variety of different aspects of the hearing loss process and hearing aid acquisition (See Appendix), we focused specifically on those questions that asked individuals about the acquisition of hearing loss, the relationship of the respondent to professionals, and the role of support in dealing with the hearing loss. We focus on those as they directly speak to the processes whereby an individual decides as to whether they will acquire a hearing aid.

We used a grounded theory approach to analyzing the data (Strauss and Corbin 1990, Glaser and Strauss 1967). This approach had us begin with the questions asked and determine the initial responses for each question—these categories were then analyzed to determine common themes between these initial responses. Finally, we utilize identity theory and affect control theory to help explain the thematic categories developed.

Results

Recognition of Loss

The first theme that emerged from the responses was that acquiring a hearing aid requires recognizing hearing loss. In examining the recognition of hearing loss, respondents mentioned several factors that affected that recognition. The difference between the incidence of people with hearing loss and the use of amplification devices such as hearing aids suggests that many adults with late-onset hearing loss have either not recognized their loss or are not yet ready to seek assistance. For example, three respondents admitted that they were unaware of the loss and that it was not until a significant other (family, friends, or co-workers) persisted in telling the person that something was "wrong" and that the person should go see an audiologist. Additionally, the lack of awareness was often preceded by changes in the day-to-day activities of the individuals. For example, several individuals mentioned that their partners kept complaining that the

television was turned up too loud or that they had to repeat themselves multiple times to be heard.

Social support appears as a response that can be connected to the theme of recognition. Here, social support refers to how others influence the individual as to whether or not they have a hearing loss. Particularly, support from significant others influences whether or not individual recognizes that they have a hearing loss and subsequently purchases a hearing aid.

Several individuals stated that one of the reasons that they went and got a hearing test and subsequently purchased a hearing aid was because they saw others in their community who had hearing aids. Another way this social support occurs is for those who are younger. In this case, it is the parents who recognized that the individual had a hearing loss and took their child to a professional who eventually recommended hearing aids. "My parents kept trying to talk to me, and I was not responding. They took me to an ENT."

Embarrassment emerged as a significant response to explain whether or not someone recognized the loss. Several individuals responded that they were embarrassed to admit that they had a hearing loss and felt the embarrassment of acquiring a hearing aid. An individual of working age resisted seeing an audiologist for fear of being perceived differently from their coworkers. This was especially common among younger individuals, those under the age of 65 and who were often still working, who rejected the hearing loss diagnosis for fear that their "different" body would be seen as stigmatizing. For those with hearing loss, the embarrassment of not living up to the normative body results in many people denying and rejecting the hearing loss diagnosis.

Embarrassment hinders identity development as it disrupts the reflected appraisal process. That process, the idea that our identities are developed by our understanding of how we think others see us, is significantly affected by embarrassment. Affective commitment is the positive or negative emotions that reinforce the identity. According to affect control theory (Smith-Lovin and Heise 1988), emotions are a central part of our decision-making process. These emotions then affect whether one will engage in actions related to the identity. Individuals with positive emotions regarding the hearing loss are more likely to acquire a hearing aid. For example, many people resist hearing aids because of the stigma associated with hearing loss. Here the individual experiences a potential increase in their levels of affective commitment or a more positive emotional connection with the identity.

Age also was a significant category in the recognition of the loss. The age range for this study ranged from 45 to 75. For these categories, we define anyone under the age of 65 as "young" while those older than 65 as "older" (Dong et al. 2019). We use these designations as they are often used within the audiological field to denote an individual who may be more at less at risk for a hearing loss based on their age. Respondents younger than 65 were more resistant to the idea of a hearing aid. In some respects, this can connect to the idea of social support as well. As one ages, they are more likely to lose their hearing. It is not uncommon among older individuals to have a hearing aid. In terms of social support then, hearing loss is a common and accepted part of the aging community and, therefore, less of a potential embarrassment than for those who are younger.

Recognition of Services

Several respondents indicated that, while they knew about audiology as a service, the knowledge of how to access that service was less known. Some respondents believed that acquiring a hearing aid was done through their Ear, Nose, and Throat doctor (ENT). For those respondents, the ENT was the first step in acquiring the hearing aid. The ENT referred the client to the audiologist. It was only once with the audiologist that there was a discussion between the client and the audiologist about the process for getting a hearing aid. This knowledge of how systems work and the processes to access services (audiological or otherwise) is known as cultural capital (Bourdieu 1986). Knowing who to go to for a hearing loss and how to acquire a hearing aid requires that one know how the audiological system works.

Trust

A third theme that emerged from the responses to help explain whether or not someone acquires a hearing aid is the importance of trust between the client and the audiologist. The theme of trust emerged from responses related to the cost of the hearing aids and the perceived motive of the audiologist. Hearing aids can be purchased from various professionals, with vast differences in professional preparation. An audiologist has a doctoral degree in Audiology and diagnoses hearing loss and fits hearing aids. A hearing aid specialist does not need a college degree and is not licensed to diagnose hearing loss. Thus, individuals' experiences when seeking assistance for their hearing loss may vary significantly. This may result in a lack of trust for all hearing health care providers – ear nose and throat physicians, audiologists, and hearing aid specialists – an increased reluctance to address their hearing loss. As individuals often share their negative experiences, a friend or family member's experience can adversely influence individuals' response to their hearing loss.

Respondents also indicated that they were less likely to go to an audiologist if they did not trust the audiologist because they perceived the audiologist as profit-driven rather than client-driven. One respondent indicated that they thought audiologists were "money grubbing" professionals who were "just out to make a buck." Hearing aids are a significant investment if they are purchased through a certified audiologist, they can cost upwards of thousands of dollars. This idea that trust is an issue among audiologists stems from the field recently allowing hearing aids to be sold over the counter. As consumers become aware of lower-cost alternatives, they perceive that the certified audiologists are potentially "gouging" their customers. These over-the-counter hearing aids are designed for a very small percentage of the population with a very mild hearing loss: a hearing loss that can only be determined by a certified professional. Rewards and costs are also significant factors affecting whether one accepts the identity.

Cost

Hearing aids are costly. And acquiring a hearing aid can mean an investment of thousands of dollars. Several respondents mentioned that they simply could not afford a hearing aid. Identity theory may help explain the unwillingness to acquire a hearing aid. Individuals with perceived rewards or costs for identity are more likely to accept or reject the identity, respectively (Stets and Burke 2000). The acquisition of a hearing loss biologically rarely comes with rewards. Instead, the costs of accepting hearing loss are more important.

Stigma

The next general theme that emerged was the fear of stigma for many adults who acquired the hearing loss. A stigma is a visual mark that results that brings into question the humanity of the person (Goffman 1963). The humanity of the person comes called into question. In one's interactions with others, the stigma becomes the sole characteristic that members of society see in the person and those with visual, permanent disabilities are often stigmatized. The result is that the ability of individuals with a disability is often questioned in various social institutions, such as academic ability and ability to do a job.

This fear of the stigma results in the delay in talking to professionals. The stigma becomes a structural factor that creates the potential for resistance in those who may be diagnosed with a hearing loss but are unwilling to claim it as an identity. Adults who acquire a hearing loss at a relatively young age are often resistant to seeking a professional for fear of how it might change how people interact with the person. For example, one young man indicated that he hesitates to get hearing aids because he thought people would make fun of him. In contrast that older individuals are more willing to get a hearing aid because many of their friends have hearing aids. There appears to be less stigma related to hearing loss as individuals age. Part of the stigmatization process can also refer to the importance of social support among the community. For younger individuals, the stigma may be more apparent because the community in which one lives, works, and plays may not identify with the hearing loss. Alternatively, as people age and others around the individual also experience hearing loss and seek out services and devices, the perception of stigma may lessen.

Social Support

The final theme is the role of social support in purchasing a hearing aid. Interestingly, older adults were much more likely to go to a hearing professional and wear a hearing aid. As one older gentleman stated, "my wife got hearing aids a few years ago. She really liked them and it helped her a lot. I decided it was my time." Since many older adults have a hearing loss, there is less stigma since others in their social support group (usually other older adults) may also be experiencing the same issue. Reflected appraisals and social comparisons are two identity processes that influence how one negotiates with themselves about identity about others. Individuals are likely to acquire an identity if they compare themselves positively against others whom they consider important (Milne 2011; Felson 1985). Similarly, reflected appraisals occur when the individual believes that others see them positively considering that identity; for example, when hearing loss is treated not as a stigma but rather as a positive characteristic (Milne 2011).

The recognition of the hearing loss and the role of social support can be understood in terms of the structural conditions that often prevent people from developing an identity (Stryker and Burke 2000). Several individuals mentioned that they did not seek a professional because they did not see how the hearing loss affected their job. Often it required others to intervene before the person was willing to see a professional. Here the importance of social support for identity is key. Allowing the person to understand that hearing loss, while not necessarily valued, is not a devaluing characteristic for the person. The person engages in reflected appraisals, resisting the hearing loss identity because they do not see how others can see them in that identity.

Discussion and Conclusions

One limitation of this research was not directly related to the research itself but is an issue with the methodology. The students conducting the research are enrolled in a Communication Sciences and Disorders program designed to teach students how to be a Speech Language Pathologist. These students are being trained as practitioners. Knowing this, the second author recruited the first author to train the students on interviewing techniques for social sciences. One of the important tenants of interviewing students in the social sciences is to avoid intervening or offering to "help" the individual. During the first year of interviewing, this notion of not intervening was not taught to the students. The result is that in several cases, students offered explanations for the hearing loss and offered potential help to the individuals for their hearing loss. Seeing this occur during the first year led the primary author to address this issue during the second year. Despite being explicit that the interviewer was not to intervene, explain a behavior, or offer help, several students did just that. Rather than reprimand the students, we noted this as an interesting finding. That while these students were being asked to act as social science researchers, they retained their own identity as potential speech-language professionals. The identity that was most salient for them was the professional identity. We can offer that the salient identity of the identity can affect a variety of roles, even when they are being instructed not to display that identity.

Providing opportunities for individuals to recognize that they have a hearing loss will be one area where hearing professionals can work to help those who may need help in identifying whether they have a hearing loss. Public campaigns and free hearing screening tests may be one method to help individuals recognize that they have hearing loss in the first place. At the same time, generating trust in the audiology profession will be a key arena to address. Specifically, educating the public about the different types of hearing professionals as well as the advantage of seeing a certified audiologist will help. As well, helping the public to understand the high cost of hearing aids and the various ranges of hearing aid costs will help in generating that trust.

Managing the stigma of hearing loss is also an area to address, particularly among young people. Audiologists should work with schools and employers to develop educational materials that minimize the stigma of hearing loss, particularly demonstrating how a hearing loss and the use of a hearing aid would not only not affect the person's schooling or employment negatively but would enhance it. Finally, working with those close to the individual, their social support network, will help the individual to transition into the hearing loss identity.

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Appendix: Interview Protocol

Acquisition of the Hearing Loss	Initial Question: When did you notice something was different about your hearing? Probing Questions: 1. Probe for the nature of the experience that suggested the hearing was different. 2. Do you know what is believed to have caused it? (Ask for elaboration if needed) 3. Have you noticed your hearing loss changing over time? 4. If it has changed, what did you notice about the change?
Daily Life (work, social etc.)	Initial Prompt: Please take me through a day in your shoes Probing questions: 1. Are you currently working? a. Probe for the nature of work, if applicable. If not working, ask about their activities. 2. Probe for any additional activities on other days/at other times of the year. 3. What is the hardest part of your day? 4. Do you think your hearing loss has impacted these typical daily occurrences? (Probe for specific daily activities that are mentioned.) 5. You mentioned you have noticed a difference in ____. Can you elaborate on that? (Repeat depending on number of responses given in part a) 6. What about with your work/school life? (If not previously answered)
Relationships	Initial Question: How do you think your relationships with friends and loved ones seem altered by your hearing loss? Probing Questions: **1.** Please provide an example or two of how it has affected your relationship with ____. **2.** You mentioned it has impacted your relationship with ____ as well. Can you provide an example of that? **3.** What about people you interact with at _____ (church, clubs, home, work, etc.). Can you provide me with an example? (Repeat with applicable environments.)
Experience with Professionals	Initial Question: After you realized your hearing had changed and did you pursue any professional services? Probing Questions: **1.** Did you consult with an audiologist, a physician (primary care or ENT), a speech-language pathologist, a hearing aid dealer, or someone else? **2.** Can you explain that experience? **3.** Did you feel he/she answered all of your questions and concerns? **4.** Did he/she refer you somewhere else? **5.** Please tell me about your experience with the _____ (audiologist, hearing aid dealer, ENT, etc.). **6.** Did anyone recommend hearing aids or another form of amplification? (ask appropriate follow up questions).