2012

# Inclusion of Hard-of-Hearing Persons in Group Events: Senior Housing Best Practices

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**Inclusion of Hard-of-Hearing Persons in Group Events:
Senior Housing Best Practices**

by
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An action project submitted in partial fulfillment of the requirements
for the degree of
Master of Arts in Organizational Leadership at
St. Catherine University
St. Paul, Minnesota

May 10, 2011

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## Abstract

Hearing loss is a prevalent health concern worldwide, especially among older adults.  The purpose of this research was to improve the inclusion of hard-of-hearing individuals in group events in senior housing settings.  Accessibility legislation, transactional models for rehabilitation interventions, and the philosophy of universal design all inform the context of this study.  Qualitative interviews of hard-of-hearing seniors gathered rich data about their lived experiences, applying appreciative inquiry to focus on what works best at group functions.  Three main themes – the prominence of hearing aids, the impact of hearing loss on participation, and the downplaying of needs – informed the recommendations for staff- resident collaboration in advancing the relevant knowledge and skills of the high-rise community and shifting cultural norms to embrace inclusion.  Ongoing feedback loops about communication effectiveness are crucial for the fullest possible participation by hard-of-hearing residents.

*Keywords:* age-related, hearing loss, accessibility, participation, universal design

# Leadership Action Project

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# Purpose

The scene is the monthly community meeting at a senior citizens' apartment complex. One of the residents, Mabel (pseudonym), expresses her concern about the safety of a situation with the sidewalk out in front of the main door to the building, afraid someone will trip over the broken edge. The staff member facilitating the meeting seems very understanding of Mabel's concern; speaking into the microphone, she says "Thank you, Mabel. I'll take care of that right away." Her words are meant to reassure. However, Mabel does not use a microphone when expressing her concern, nor does the facilitator repeat or summarize Mabel's comments before responding. Unable to hear anything that Mabel had said, nearly a third of the residents in attendance are left wondering: take care of *what*?

Situations like the one depicted above are common in the mostly-senior high-rise where I work. Regularly, I see ways that our residents who are hard of hearing fall between the cracks. Interpreter services are of no benefit to them, yet their hearing no longer serves them adequately, at least not consistently, for full participation in meetings and other group programs within the building. I believe there is more that we as staff can do to make such events more accessible (user-friendly) for people who are hard of hearing.

A number of adaptations can readily enhance participation by individuals who are hard of hearing. These address factors in the immediate environment such as seating arrangement, placement of the main speaker, lighting, background noise, and the use of amplification systems – also aspects of meeting facilitation such as the appropriate use of the microphone (repeating comments/questions, as necessary) and managing turn-taking. All of these adaptations are easy to make, usually at no cost – so why don't we do these things, simply as a matter of course? I

trust that the people facilitating meetings and programs in this setting don't mean to leave out some of the residents who wish to participate.  However, they do – by neglecting to adapt the environment and meeting habits in ways that would enable residents who are hard of hearing to participate more fully, with greater ease.  Possibly, staff members are not aware of the difference that such strategies can make.  Additionally, the residents most directly affected may lack the information and/or confidence to advocate for their own needs or may have resigned themselves to being left out.

The immediate purpose of this research was to understand the lived experience of seniors who are hard of hearing as a way to inform needed changes in their environments.  Such information is crucial for enhancing the inclusion of hard-of-hearing residents in the group gatherings – informational, educational, and recreational – that are the fabric of community life within many a senior housing facility.  Establishing optimally inclusive conditions can require changes in individuals' habits as well as in the overall organizational culture.  For example, as the opening scenario demonstrates, having a microphone in the room is not, in itself, enough; a missing piece was conveying Mabel's concerns to others in the room via the microphone before responding.

The primary stakeholders in this project were hard-of-hearing residents for whom fuller participation in meetings was possible.  In addition, their improved understanding of environmental and behavioral factors contributing to more effective communication can transfer to other situations – group or one-to-one – with family, at church, etc.  As my mother has often pointed out, communication is a two-way street.  Any change to improve the inclusion of hard-of-hearing residents also benefits everyone else in their immediate environment.  Other residents at the high-rise could learn strategies for the more successful engagement of their hard-of-

hearing peers in resident-run functions such the Tenant Council, committees, and floor meetings. Staff members could gain a better understanding of the needs of customers who are hard of hearing and approaches for meeting those needs more effectively – also from seeing a likely decrease in misunderstandings, frustration, anger, and withdrawal among residents who are hard of hearing.

A clear challenge to improving the inclusion of hard-of-hearing residents is to make changes sustainable over the long term.  What we learned from this study may have an impact on how we run meetings and programs in the immediate future.  It will be critical to determine ways to carry the benefits forward, beyond the actions of the people directly involved in the research process.  Learning about the lived experiences of people who are hard of hearing is the factor likely to have the biggest impact on changing our norms and informing our key decisions for running group discussions. Their stories increase our understanding of why it is important to address these issues and the impact of our efforts. The desired outcome is not just about specific ways staff can adjust the environment and run meetings. Ultimately, the desired outcome involves energizing participants and creating a supportive environment – one that goes beyond mere permission to self-advocate, to inviting and expecting community members to speak up for their needs and request reasonable accommodation.

## Analysis of the Conceptual Context

The topic of age-related hearing loss is important and relevant both to society as a whole and, potentially, to each of us directly.  The hidden disability of hearing loss is common throughout the world.  World Health Organization (WHO) figures for 2005 included an estimate of 278 million people with disabling hearing impairment, and another 364 million with a mild hearing loss (World Health Organization, 2006, p. 11) – together, almost ten percent of the world

population (Danermark et al., 2010).  The WHO calculates the social and economic impact of

diseases and chronic conditions, and now includes adult-onset hearing loss in its assessment of

the *global burden of disease* (pp.11-12).  Here in the US, with the demographic trends both of

people living longer and of the Baby Boomer generation approaching retirement age, we are sure

to see an increase in the number of people e experiencing age-related hearing loss who reside in

senior housing settings.  Social engagement and participation in the activities that give one's life

meaning are important contributors to health at any stage of life, and are easily disrupted by a

hearing loss.

**The Senior Housing Setting**

The population of primary interest for this study is *senior citizens* – defined differently

for different purposes, but throughout this paper I will use the term, or simply *seniors*, to refer to

the age cohort of 62 and older.  A range of housing options, meeting all levels of care needs of

senior clientele, includes independent living, housing with services, assisted living, and care

center or nursing facility.  For purposes of this project, I use the term *senior housing* to refer to

apartment living in a congregate setting primarily intended for seniors (with or without

additional services to the individual as needed), and the term *resident* to refer to any tenant living

in such a facility.

My primary work site is an apartment high-rise with 200 units, all subsidized by HUD.

The building is mostly seniors; our specific agreement with HUD allows for three categories of

eligibility:  age 62 or older; uses a wheelchair (age 18 or older); deaf (age 18 or older).  The

specific group events available will vary by facility, reflecting differences in staffing and other

resources as well as differing interests of each resident community.  Still, a look at the programs

currently available in our building offers a sampling of the kinds of events that are part of life

within such a setting. Some of the opportunities are more business-oriented, such as involvement with the Tenant Council (serving as officer or floor representative, or as member of any of its committees) and participation in monthly all-tenant meetings with the building management. The wide range of other regularly occurring activities cover the realms of entertainment (most often music), creative arts (watercolor classes), lifelong learning programs, health (support groups), faith (Bible study, weekly Vespers), recreation (Wii bowling), and volunteer service opportunities (delivering meals on wheels, clipping coupons for veterans).  In addition we have certain holiday events and occasional other special functions.  Some of the group events are led by staff members or guests, some by tenants.  Each of these opportunities within the community life of the building carries its own specific challenges for the hard-of-hearing person who wishes to participate fully.

**Hearing Loss Terminology**

My work as a sign language interpreter has sensitized me to a number of things: inclusion/exclusion issues, the power of language (terminology, labels,) and the very personal matter of self-identity.  Under the Americans with Disabilities Act (ADA, 1990, and the ADA Amendments Act, 2008) we interpreters are *auxiliary aids* (ADA Title III Technical Assistance Manual, 2010, Sect. 4.3300) – tools to provide communication access to meet certain needs.  Our customers often prefer the capitalized word *Deaf* to identify themselves, denoting a cultural identity associated with the community of people who use ASL (American Sign Language).  The personal and political statement of claiming Deafness as a defining aspect of identity defies the more common meaning of deafness centered on the inability to hear. Deafness is not about what they can't do, but about who they *are*.

In contrast, many people lose some or all of their hearing later in life, having lived through much of adulthood with the ability to hear and to participate readily in the predominantly-hearing world. Such individuals are culturally *hearing,* likely to have taken for granted the ability to hear until it becomes significantly more difficult. Harlan Lane, in his examination of the two dominant constructions of deafness – as a disability or as a linguistic minority group – noted that "no one disputes the claim of the hearing adult become deaf from illness or aging that he or she has a disability and is not a member of Deaf culture" (1995, p.173). Chen (1994, p. 22) differentiated between *hearing loss* (diminished acuity) and *hearing handicap* (the impact on everyday life). The functioning of a person with a hearing loss, as with any disability, is more restricted in some circumstances than in others.

The lowercase term *deaf* refers to audiological status versus cultural identity. The phrase *hearing impaired* was used several decades ago both euphemistically, because *deaf* has historically carried a stigma, and as the umbrella term in an effort to be inclusive. However, there are such distinct differences in matters of identity and preferred or effective communication modes that, in the 1980's, many of the organizations with names that referred to providing services *for the hearing impaired* changed to using *for deaf and hard of hearing people* as the inclusive phrase. More recently, some have extended it to include *deaf-blind* as well. The terms *hearing impaired* and *hearing impairment,* still used frequently, particularly in the medical field, are anathema to many Deaf people because they do not perceive themselves as impaired.

The specific impact of hearing loss varies widely, depending on an array of factors: degree of loss, age of onset, language access and/or specialized language interventions, education, etc. In this study, I will touch very little on audiological measures of hearing loss and the established categories of mild, moderate, severe, and profound hearing loss defined by

measured decibel loss.  Instead, I will use the functional distinction:  *deaf* signifies the person is

unable to hear sufficiently for understanding speech; *hard of hearing* means the person has

enough hearing for partial comprehension of speech.  This study focuses on people in the latter

category, and factors that support their inclusion in group functions.

**Age-Related Hearing Loss and its Impact**

Many people are already deaf or hard of hearing before reaching age 62.  However, the

most common form of hearing loss among seniors is *presbycusis*, or *age-related hearing loss* –

typically a bilateral sensorineural loss characterized by a loss of hearing acuity in the higher

frequencies, interfering with the comprehension of speech (Weinstein, 2003, p. 16).  Changes

common to this life stage, such as retirement or the death of a spouse, mean fewer day-to-day

communication demands.  Thus, a partial loss of hearing, gradual in onset and progressive, can

go undetected for years (Gordon-Salant, 2005, p. 18).  Many hard-of-hearing seniors are unaware

of a change in hearing – it is often first detected by the others around them such as the friends

and family for whom communication has become increasingly frustrating (Rawool & Keihl,

2008, p.30).

Communication difficulties have a negative impact on a person's emotional and social

wellbeing (Chew & Yeak, 2010), and "are far from being trivial" (Trychin, 2003, Introduction

section, para. 3).  The potential mental health impact of hearing loss is huge, including social

isolation, depression, and withdrawal from life activities (Dewane, 2010, Psychological

Implications section, para. 6; also Gates, Murphy, Rees, & Fraher, 2003, pp. 56-57).  Dewane

stated the risk strongly:  "Hearing loss can create a psychological solitary confinement" (para. 7).

Furthermore, the psychosocial impact cannot be predicted from audiometric findings alone

(Chew & Yeak, p. 840).  Difficulty following conversations can contribute to tension in family

and other significant relationships (Chew & Yeak; Dewane; Tolson,1997; Trychin, 2003);

Tolson cited findings that "the magnitude of the problems did not seem to be closely related to

the level of impairment" (Cowie et al., as cited in Tolson, p. 1153).

**Treatment**

The traditional medical model for treatment of age-related hearing loss entails an

audiological exam usually followed by the application of amplification technology – most often

the fitting of hearing aids, with cochlear implants increasingly found to be an effective treatment

option for older adults (Gordon-Salant, 2005, pp. 18-20).  Hickson and Worral (2003) noted the

inadequacy of this approach so reliant on technology; many people who get a hearing aid don't

use it or complain of poor results, and the majority of seniors with a hearing loss don't even seek

treatment (p. 2584).  Behind these all-too-common phenomena are complex reasons which

research has found to include denial, perceptions of hearing aids as ineffective, and the shame

and stigma associated with hearing loss (Gordon-Salant; also Tolson, 1997).

Hickson and Worrall (2003) and Trychin (2003) emphasized the need for additional

forms of intervention, especially education and in-depth counseling about the specific nature of

the individual's loss, realistic expectations of hearing aids (and/or other amplification), and

coping strategies.  Gordon-Salant (2005) also saw counseling as necessary for seniors to fully

experience the benefits of amplification technology.  In the literature I encountered terminology

that appears to be interchangeable – *audiological, auditory,* or *aural rehabilitation* – referring to

interventions that go beyond technology by also examining the interaction of the person with the

environment.  Stephens, Gianopoulos and Kerr (2001, p. 294) defined audiological rehabilitation

as "a problem-solving exercise aimed at minimizing the difficulties which the individual has as a

result of their hearing impairment."

Communication always involves at least two people and so, as Dewane pointed out, "is not the sole responsibility of the older adult" (2010, Working With section, para.3).  Tolson (1997, p. 1155) cited works by Shadden (1988) and Erber (1988) that emphasized "the need for and role of a compatible, skilled, regular communication partner who is sensitive to the specific difficulties experienced by the hearing impaired person."  She stated this in the context of nursing interventions with patients who have age-related hearing loss, but it echoes the point made in the literature from other disciplines.  Dewane (2010) and Trychin (1993, 2003) both emphasized the importance of education and counseling not only for the person with a hearing loss, but also for the people who in essence need to become such communication partners.  Learning to cope with a hearing loss is an adjustment process for all parties involved.

In our senior housing facility, rehabilitation interventions are a private matter, generally concentrating on the individual's ability to perform ADL's (activities of daily living) in the home environment.  Following a fall, surgery, or other health incident, a resident might have a home evaluation by occupational or physical therapy (OT or PT) to check for safety and prescribe equipment or other adaptations, possibly also recommending additional support from family members or home health services.  Similarly, to my knowledge, rehabilitation related to hearing loss focuses primarily on the individual and the family or other household members.  This project, however, focuses on accommodations related to meetings, presentations, etc.  in common areas of the building – environments that can be altered to increase their "user-friendliness" for a population sure to include people who are hard of hearing, whether or not they are yet aware of it themselves.

**A Transactional Model**

Historically the field of occupational therapy has focused on the relationship between the person and the environment, looking to improve the "fit" between the two (Law et al., 1996). That model has evolved to consider also the demands of the specific activity or tasks, in the person-environment-occupation (PEO) model, a "transactive model of occupational performance" (Law et al., p. 10) that focuses on the interdependent dynamics between the person, the environment, and the occupation (task, activity). The area of overlap of these three factors represents *performance* – the effective execution of or participation in the task (occupation) (Law et al.) – a "sweet spot" that interventions aim to expand.
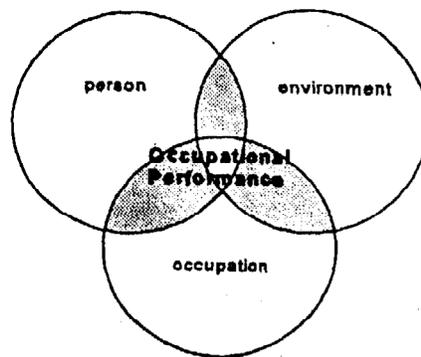


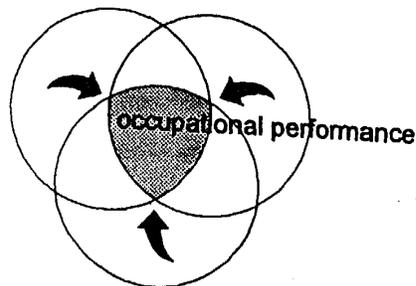Diagram1:  Interdependent factors of PEO model (from Law et al,1996, p. 19, Figure 4)



Diagram 2:  Maximizing fit also maximizes occupational performance

(from Law et al, 1996, p. 18, Figure 2)

The PEO model parallels the model used by Sam Trychin, Ph.D., as presented at a workshop, "Living with hearing loss: Considerations for people who are hard of hearing," (June, 2004, in St. Paul, MN). Trychin is hard of hearing himself, and has extensive experience in providing auditory rehabilitation counseling to hard-of-hearing people and their families. His approach focuses on three interdependent factors: the hard-of-hearing person, the environment, and the key other people who regularly interact with the hard-of-hearing person – friends, family members, and service providers. Law et al. defined *occupation* to be "clusters of activities and tasks in which the person engages in order to meet his/her intrinsic needs for self-maintenance, expression and fulfillment" (1996, p. 16). That third factor in Trychin's model, corresponding to occupation in the PEO model, is *other people* – a necessary element when the task involves communication.

Trychin's approach is useful to apply to the challenges of making our group events more inclusive of hard-of-hearing residents. In terms of the PEO model, our goal is to make the adaptations that improve performance – i.e., raise the level of participation that is possible for residents who are hard of hearing. Adaptations may be made in any or all of the three component areas (person, environment, or other people) to effect such a change (Law et al., 1996). Members of our staff involved with a given program are an integral part of two of the three elements, *environment* and *occupation*, as they are usually in a position to effect changes both to the environment (such as room setup and microphone availability) and to the communication demands of the interaction (such as through effective use of the microphone and managing turn-taking).

**Ethical and Legal Imperatives**

In senior housing, we have a responsibility to know and to respond appropriately to the needs of our customer base, senior citizens.  Tolson (1997, p. 1150) claimed, from a nursing perspective, "a professional and moral responsibility to maximize communication opportunities for older people," and later in the same paper concluded that "age-related hearing loss is an enormous but not insurmountable problem which requires treatment, at the least sensitive acknowledgement, by those who purport to care for older people" (p. 1156).  People may assume that we are the "experts," simply by virtue of our working with this population, and that we have incorporated this knowledge into what we do.  However, in my experience, most staff in senior housing come into their positions without any specialized education in working specifically with seniors.  More common is a specialized background developed from actual work experience. Certain positions such as social workers, rehabilitation professionals and nurses are most likely to have had some coursework related to the needs of seniors, whether or not it was integrated into work experience outside of school.  However, all staff have frequent interactions with the senior residents.  Our staff members include a social worker and a resident services assistant, an office manager, a receptionist, a marketing specialist, housekeepers, maintenance workers, and the building manager. Those without experience providing services to seniors learn by doing – some with an apparent innate sensitivity to working with the range of special needs, some not particularly engaged.

There are ethical implications to all of this.  Not everyone would agree, however, about what is the "right" thing to do, what is the best for all, etc. One coworker is adamant that we can't treat anyone differently; for him, fairness is about treating everyone equally, up front.

Some of us look instead at the outcome, understanding the need to do things differently in order to achieve equivalent impact – that is, accommodating some people's needs differently in order for them to have equal access to buildings, programs, and services. Such is the essence of providing accessibility. Without adjusting how we do things to provide supports or to allow greater ease when needed, we unintentionally exclude some people from participating in programs or from benefiting fully from our services – a phenomenon termed *disparate impact* in discrimination law (Nolo, 2011).

The term *accessible* "refers to a site, facility, work environment, service, or program that is easy to approach, enter, operate, participate in, and/or use safely and with dignity by a person with a disability" (from ADA Glossary of Terms, n.d.). Accessibility legislation – most notably the ADA – has raised society's level of awareness about matters of accessibility. Within the senior housing and care industry, however, I have repeatedly encountered the perception that the law applies to us (organizations) only or primarily as employers, not as service providers – i.e., a limited understanding of its relevance to our facilities, programs, and services. Furthermore, the general model reinforced by the ADA relies on the identification of a need (on the part of a disabled person) and a request for reasonable accommodation, leading to either an accommodation or an explanation of its denial. The current day-to-day reality – observed at my workplace, as well as reflected in the literature as typical – is that many seniors have a hearing loss that is as yet undetected or undiagnosed. Others are in denial of the existence or extent of their hearing loss. Do we logically wait for the request from our customers who are hard of hearing before we determine appropriate accommodations, when such needs are a "given" across the population we serve?

**Inclusive Thinking**

Accessibility-mindedness, in particular a framework relying on the ADA or other

accessibility legislation, falls short in meeting the needs effectively in the long run for several

reasons.  As with other human rights or civil rights legislation, the law provides backing to

ensure that we do the right thing in upholding individuals' rights.  Ideally, one invokes the law

only as a last resort, and doing so is inherently adversarial.  In addition, accessibility focuses on

changes to the environment in objective measures – building and design specifications, and the

provision of reasonable accommodations.  It lacks provisions for subjective information – does

the accommodation "work," is it effective?  In recent years I have generally preferred the term

*user-friendly* over accessible; I found a similar line of thinking in an article by Iwarsson and

Stahl (2003), who applied instead the term *usability* to focus more on functioning than on

disability (p. 64).  Finally, as Iwarsson and Stahl also pointed out, a focus on accessibility

separates us by its core assumption that there are two populations, people with and people

without disabilities, and perpetuates the stigmatization of the former (pp. 60-61).

In refreshing contrast is *universal design*, defined by the Center for Universal Design

(1997, p. 1) as "the design of products and environments to be usable by all people, to the

greatest extent possible, without the need for adaptation or specialized design."  Iwarsson and

Stahl (2003) noted that this paradigm, in Europe popularly called *design for all* (p. 61), is less

about measurement (p. 63) and more about "democracy, equity, and citizenship" (p. 62).  This

shift in thinking is congruent with changes in the WHO terminology, formerly centered on

*disability* (medical condition of the person) and *handicap* (impact of the environment).  The

2001 update of the WHO's International Classification of Functioning, Disability and Health

(ICF) reframed these phenomena, respectively, as *activity limitations* and *participation*

*restrictions* (Hickson & Worrall, 2003, p. 85), a change that Danermark et al. (2010, p. 257)

hailed as "merging a biomedical paradigm with a social paradigm into a wider understanding of

human functioning."  This newer framework highlights elements of the person-environment

interaction that restrict participation – the "societal dimension" (Iwarsson & Stahl, p. 62) –

pertinent to the focus of this study.

## Research Question & Methodology

In this study, I set out to answer the research question, ***What can hard-of-hearing senior***

***housing residents' lived experiences tell us about best practices to enable and support their***

***participation in group events?***  My work included the following steps:

- ➢ Review of literature

- ➢ Interviews with experts in provision of services to people who are hard of hearing (2)

- ➢ Interviews with hard-of-hearing residents in senior housing (5)

- ➢ Data analysis:

    - o Transcription of interviews

    - o Search for themes in interview transcripts

    - o Examination of all data for connections and disparities

- ➢ Development of recommendations.

Appreciative inquiry has been at the heart of my methodology – directing attention to

what "works," rather than the more customary focus on a perceived problem (Hammond, 1996).

One of the core assumptions of appreciative inquiry is that "what we focus on becomes our

reality" (Hammond, p. 20).  Akin to visualization techniques used in athletics, we focus attention on the positive things already being done and the desired outcomes, nurturing them to grow (pp. 29-31.). I designed my study to seek information related to what works effectively in practice (perspectives from experts), as shown by research (literature review), and from lived experience (interviews).

**Literature review and expert interviews**

My exploratory phase started with a review of the literature related to the prevalence and impact of hearing loss that occurs with aging, approaches to optimize the listening environment, and frameworks of thinking regarding disability and accessibility in general and hearing loss in particular.  Additionally, I interviewed two professionals with extensive relevant experience (over fifteen years, each) –  one employed by a state agency providing training and technical assistance to organizations serving deaf and hard-of-hearing people; the other providing education and counseling to people who are hard of hearing and their significant others.  I first contacted the two of them by email to explain my project and request to talk further with them. One interview was conducted face to face, the other transpired as an email exchange. I sought their perspectives on effective practices for enhancing communication with hard-of-hearing persons, particularly in group settings – also on current trends and challenges in this realm, particularly with a focus on the needs of seniors.

**Interviews of hard-of-hearing residents**

Data collection centered on five semi-structured face-to-face interviews with senior housing residents who are hard of hearing – one pilot interview and four subsequent interviews. The overall goal was to find out about factors within each of the three areas of the PEO model that contribute to the relatively unhindered participation by an individual who is hard of hearing.

In other words, what can be done to expand the point of overlap to increase occupational

performance – specifically, the ability of hard-of-hearing residents to participate in group

functions?  We can find out by *asking the people who experience it* -- to learn more about their

lived experience, both in and outside of the "sweet spot."  The book, *Qualitative interviewing:*

*The art of hearing data*, by Rubin and Rubin (1995), was a helpful resource for designing the

interview tool, conducting the interviews, and analyzing the data collected.

      **Selection.**  I consulted with a coworker in the resident services office of our facility to

generate a list of potential interview subjects fitting the following criteria:  residents of our

building, age 62 or older, known to have some degree of hearing loss (functionally hard of

hearing, not deaf), and not currently known to be facing debilitating mental health challenges nor

exhibiting signs of dementia*.*  We separated them into two categories:  frequent (more visible and

active) participants in the various group functions in our building, and infrequent participants

(less involved).  We discussed the likelihood of each individual on the lists to be able to provide

the type of information I was seeking. I initially selected two people within each category to

recruit for participation.

      **Recruitment**.  I first contacted selected individuals by printed letter, including a copy of

the consent form. In my follow-up contact with each of them, by phone or in person, we

discussed whether he or she was willing to participate and, if so, scheduled the interview.  I

initially sent recruitment letters to four residents.  As some participated in interviews and others

turned down the invitation to participate, I then contacted another two people, later three more,

and four more people in the final set of recruitment letters sent out.

      **Questions**.  I prepared an inventory of interview question that included open questions to

invite each subject to tell his or her own story, as well as questions that steered the focus to the

areas about which I most wished to gather information.  The overall design combined [was

informed by] appreciative inquiry and the PEO model, by asking each interviewee what "works"

to make it easier to participate in group events – in turn focusing on what he or she does (P),

factors in the environment (E), and what other people can do (O). I used additional questions as

probes or for follow-up as needed. After designing the questions, I asked several other people to

screen them for bias (my own).   I conducted one pilot interview to test the effectiveness of the

interview instrument I had developed.  The pilot yielded useful data which I kept.  Based on

what I learned from the pilot, in subsequent interviews (1) I made an effort to relax and slow

down my questioning, and (2) I watched for opportunities to probe further, inviting the

interviewees to elaborate on points already made, situations already described.

**Interviews.**  I conducted interviews on site in the senior housing facility where the

subjects live – one in a private meeting room, the rest in the individuals' apartments, according

to each interviewee's preference. Each interview lasted 30-40 minutes, and was audio-taped in

order to obtain a full transcript. My prior relationship with the selected residents, from my years

on staff, contributed to the necessary trust and rapport for conducting the interviews.  At the

outset of each interview, I clearly explained to the resident my role as researcher.

**Consent**.  I developed a consent form covering the purpose of the project, what

participation in an interview would entail, expected risks and benefits, compensation,

confidentiality and privacy measures, outside contacts, and that participation was voluntary.  A

copy of the form accompanied the initial recruitment letter that I sent to each resident selected

for an interview.  At the outset of each interview appointment, I provided another copy of the

form and reviewed with the resident all the information on it.  After answering any questions the

resident had, I asked him/her to sign the form to give consent before proceeding with the

interview.  I reminded each person of the options to skip any questions that he or she did not

wish to answer as well as to terminate the interview at any time.

   **Confidentiality and security of information.**  I removed identifying information from

all interview data recorded – handwritten notes, audiotapes forms, and print/computer transcripts.

Because of the possibility of recognizing an interview subject by voice, the audiotapes were

stored in a locked file drawer.  I kept no other information linking the data to the interview

subjects' identities.  All collected data stored will be shredded, destroyed, or deleted upon

approval of this completed project (by 12/31/2011).

**Analysis**

   I transcribed each interview tape within several days of the interview, and included

information from my own notes written during the interviews, particularly about gestures that

accompanied and clarified certain descriptive phrases (such as "this ear" or "this big").  On my

first reading of each transcript, I jotted in the margin a word or two to note the locations of data

that fit any of the predicted categories (such as technology, impact, environment).  Upon further

reading and the completion of additional interviews, other categories emerged. I analyzed the

data for patterns and themes, and examined them for correlations and disparities in relation to

findings from the expert interviews and the literature.

# Validity

   Any research findings are subject to scrutiny, and reasonably so. Careful examination of

how I as the researcher may be wrong adds strength and credibility to my resulting claims and

recommendations. Because I conducted interviews at my place of employment, my subjects and

I had pre-established roles and relationships, contributing to the potential of both researcher bias

and reactivity.  I aimed to minimize the threats to validity through several aspects of the design

of this research study.

Some degree of reactivity is unavoidable; as Maxwell (2005) notes, "what the informant

says is *always* influenced by the interviewer and the interview situation" (p. 109). As many

people at my workplace know, I have a passion for thinking inclusively, I readily take on the role

of accessibility advocate, and I place high value on asking the customer what is needed.  I

recognized that some of the subjects would likely come to the interviews with assumptions about

what, specifically, I was seeking from them in terms of content, or might perceive me as being

there to "hear their case" in order to go forth and advocate on their behalf.   I hoped to dispel any

such expectations by providing at the outset of each interview a clear explanation of the purpose

of the project and of my role as researcher.

I took several steps to minimize the impact of my own biases on the interviews.  In

advance, I asked several other people to screen the interview questions for any hint of bias, my

own agenda, or my potentially leading the respondents.  Additionally, I tested the set of

questions in a pilot interview.  Each interview was audio-taped and fully transcribed in order to

have a record of everything said, not just the salient points captured in my written notes during

the interviews. When analyzing the data, I asked two other people to review the transcripts and

assess them for patterns and themes, as a means of cross-checking and confirming what the

evidence was telling us.

In order to test the validity of my conclusions, I applied several of the strategies presented

by Maxwell (2005, pp.109-114).

**"Rich" data.**  The detailed data collected through qualitative interviews naturally reflected differences in the individual styles and perspectives of the subjects.  Furthermore, I selected subjects from two different categories – residents regularly involved in group events within the high-rise, and those seldom participating in group events – to ensure that differing perspectives were represented.

**Triangulation.**  I utilized multiple methods in this study:  a review of the literature, consultation with experts who provide services to people who are hard of hearing, and interviews with senior housing residents who are hard of hearing.  The inclusion of evidence coming from three different approaches lessened the threat of overly narrow or biased conclusions.

**Respondent validation.**  During each interview, I sought feedback regarding my understandings, at times repeating or paraphrasing back to the interviewee to confirm the accuracy of what I heard and understood about specific comments.

**Searching for discrepant evidence and negative cases.**  When analyzing the interview data, I watched for the outlier responses – those that didn't match up with responses from the other interview subjects or that differed from my findings from other sources.  This was to lessen the threat of my own biases leading me to focus only on confirming the patterns that emerged from the data.

## Key Findings and Themes

**The Interviewees**

I interviewed five residents of the senior housing facility where I work – four women and one man, ranging in age from 71 to 94.  A brief characterization of each interview, using pseudonyms, offers a glimpse of differences in their individual personalities and concerns.

- **Alma** described several examples of her relying on guesswork in order to keep up in a group setting, relying on watching for clues on the speaker's face and in other people's body language.

- **Brad** was particularly focused on his hearing aids, both within the interview (distracted by repeated buzzing) and in his talk of his everyday activities.

- **Cara** referred to her frequent use of saying "huh?" to inform or remind people, albeit indirectly, about her hearing loss.  She expressed determination not to let her hearing loss depress her, and claimed to laugh off the frequent miscues and misunderstandings.

- **Dawn** was very exacting about three things people can do to help in communication: speak up, enunciate, and hold up one's head.  She answered most of the questions in terms of what she does for others rather than what others could do that would be helpful to her.

- **Ella** demonstrated the greatest level of acceptance of having a hearing loss, and was the only one of the five to disclose to others, regularly and freely, that she has such a loss.

## PEO Factors – What Works?

My interview questions focused on the subjects' experiences, asking them what "works" to make their participation easier in group settings – in relation to things they could do themselves (P), aspects of the environment (E), and things that other people could do (O). Table 1 presents factors identified by the interviewees, compiled from all five interviews.

| Person (P) | Environment (E) | Other people (O) |
|---|---|---|
| Wear hearing aid(s)<br>- Working, with batteries<br>- Adjust settings | Amplification system ("loudspeaker") | Engage directly<br>- Face to face<br>- Animated |
| Seating choice<br>- Proximity to speaker<br>- Favoring the better ear<br>- Nobody behind | Limited or no background noise<br>- Side conversations, TV, music, wind, etc. | Voice strength/volume<br>- Speak up<br>- Don't drop voice at end of sentence |
| Face the speaker<br>- Watch mouth, face, eyes | Smaller room – closer seating | Speak slowly and clearly<br>- Enunciate<br>- Hold head up – don't mumble |
| Read contextual clues<br>- Others' reactions | Seating arrangement:  circle | Use microphone<br>- Know how to hold it<br>- Don't turn away |
| Concentrate | Room acoustics<br>- absorb?  "bounce"? | Use microphone for questions, comments from other people<br>- pass around mic<br>- repeat into mic |
| Use other technology if available<br>- assistive listening system<br>- captioning on TV | Assistive listening system<br>- Individual volume control | Consider alternate location to reduce background noise |
| Tell other person what helps | | Ask:  how am I doing?<br>- Confirm:  hear me OK? |
| Have someone else  "interpret"<br>- repeat, or write notes | | Write things down |

**Table 1:  P + E + O:  helpful factors (from interviews)**

**Person.**  The most frequent responses (repeated within a given interview, as well as raised by the most people interviewed) pertained to hearing aid use, seating choice, and watching the speaker's face.   Strategic seating decisions for proximity to the speaker came up in several of the interviews.  Two examples from Alma were: "I'm moving closer to the front of church all the time – I was sitting in the seventh row, now I'm sitting in about the fourth" and "When we're having films downstairs, or the all-tenant meeting, I sit as close to the front as I feel I can." Additionally, she described a strategy to favor her better ear: "Going out to eat with the church

group, I used to sit on the end, on this side [indicated with people to her left], because then nobody would be on the bad ear."

**Environment.**  The most frequent responses were regarding the availability of a "loudspeaker" (amplification system) and issues of background noise.  Several people mentioned experiencing interference from other conversations in the area, whether immediately behind them or across the room.  Age-related hearing loss involves not just a lessened hearing acuity (tested in a quiet environment), but also an increased difficulty in understanding speech in a noisy environment (Gordon-Salant, 2005, p. 11; Trychin, 1993, p. 4).  Regarding the impact of background noise of any kind, Ella said, "It just wipes away anything that you probably would have been able to hear.*"*

**Other people.**  The most frequent responses had to do with speaking up and enunciating, and with microphone use**.**  Dawn described the tendency of many people to drop the head when speaking, interfering with the clarity for the listener: "It seems like, when they do that, it just… goes in your clothes or something."  Regarding microphone use in a discussion at a class he attended at another location, Brad said, "When questions are asked, and … the microphone *isn't* passed around, then I can't usually hear what the question is."


**The Awareness Continuum**

Even across the interview sample of just five residents, there is evidence of a range of levels of awareness about their own hearing loss and suitable coping strategies. This indicates their different positions along the continuum that is reflected in the literature, ranging from denial/detection to acceptance:

*Denial > Detection > Testing > Treatment > Adapting > Acceptance/Self-advocacy*

Toward the middle of the continuum are variations in the degree to which amplification

technology is used effectively, the general understanding of the impact of hearing loss, and the

coping behaviors and adaptive strategies implemented.

      **Awareness**.  Each interviewee was able to identify several factors for each category

(P, E, and O).  The four individuals who used hearing aids demonstrated not only awareness of

the capabilities of their current equipment (different settings and programming), but also

knowledge of other forms of technology either already of benefit, or of possible benefit in the

future as their needs change.  Only one person (Ella) reported regularly disclosing her hearing

loss to other people, as well as making specific requests of them to help the communication.

      **Denial?**  One interviewee (Dawn) questioned whether she had enough of a hearing loss

to qualify for this research.  Although she acknowledged that a hearing test had confirmed she

had some loss, she repeatedly minimized its impact relative to the hearing loss of other people,

including her late husband.  A possible sign of denial is her irritation with other people's habit of

dropping their heads when they speak, which could be interpreted as a variation of the common

complaint that "everybody mumbles," often an indicator of hearing loss (AARP guide, p. 4).  On

the other hand, consciously or not, her focus on what she does for the sake of others who are

hard of hearing exemplifies one of  Trychin's recommendations:  that hard-of-hearing people

"model the communication behavior they desire from other people" (1993, p. 50).

      Among the people I approached about participating in my research, several turned me

down because they did not think they qualified ("I'm not deaf enough;" "I don't have a hearing

loss").  This could reflect a wrong guess on my part, in deciding to approach them as suitable

prospects.  However, having generated with another staff member the list of residents we both

perceived as likely appropriate candidates, I can give more weight to the possibility that these

are, instead, examples of the all-too-common denial about having a hearing loss.

**Themes**

Several themes emerged from the data:

(1) The prominence of hearing aids in the interviewees' lives, as both benefit and burden;

(2) The impact of hearing loss on their participation in various facets of community life;

(3) The tendency to downplay one's own needs related to the hearing loss.

**Theme 1:  Hearing Aids**

Since none of the prepared interview questions pertained to hearing aids, my "research

surprise" was just how prominent a role hearing aids played in the interviewees' day-to-day

lives, both as a benefit and as a burden.  Hearing aids and other amplification technology can

contribute to the quality of life of a senior who is hard of hearing, as reflected in the literature

(Gordon-Salant, 2005; National Council on the Aging, 1999).  Several comments from the

interviews convey how helpful the hearing aids are, and how dependent those individuals are on

them.  In typical short-and-sweet style, Ella said of her hearing aid simply, "It's *won-der-ful!*" –

then added, "I still cannot hear music, but I can talk."  Brad has served on boards for community

organizations, and described the benefit of having hearing aids when participating in board

meetings of 15 to 20 people:  "We're spread out - and some of them have small voice, or, not so

strong.  So it did help, especially with groups."  Later, clearly proud of his part in a key decision

made on one board, he said, "The hearing aids helped, because I was directly involved more

personally – while sometimes, if there's people going at the other end, on either end of you, I'm not concentrating… good enough to follow everything."

More surprising was the level of burden associated with the ongoing care and upkeep of hearing aids.  Interviewees mentioned such concerns as:  keeping up with the need to replace batteries every two weeks (Alma); protecting the aid from damage caused by impact or wet weather and from getting lost (Brad); the need to get current aids adjusted, repaired, programmed, and/or replaced (Alma, Brad, Cara).  Contributing to the sense of burden may be the fear of not being able to afford a replacement.  The cost of hearing aids came up in four of the five interviews – likely looming particularly large for them as low-income seniors (residing in subsidized housing).  One person reported that her aids were paid for by the state; two others mentioned specific costs ($1500 and $3600, for the most recent set).  Even the one interviewee who did not use a hearing aid alluded to the high cost, in declaring, "My hearing would get pretty bad before I would invest in a hearing aid" (Dawn).

**Theme 2:  Impact on Participation**

We see in the interview data a number of examples of the real impact of hearing loss on each individual's participation in group interactions.  The group events mentioned by the interviewees (Table 2) included some within the building and some elsewhere, both formal (scheduled and/or structured) and informal.  Missing what other people were saying was a common experience; ongoing frustrations led to some individuals dropping out of groups or events they used to attend.

|         | Formal                 | Informal                 |
|---------|------------------------|--------------------------|
| On-site | All-tenant meetings    | Social group (coffee)    |
|         | Tenant Council         | Coffee hour              |
|         | Bible study            | Dinner (congregate DR)   |
|         | Vespers                |                          |
|         | Writing group          |                          |
|         | Prayer chain           |                          |
|         | Films                  |                          |
| Off-site| Church service         | Riding in car together   |
|         | Classes, lectures      | Grocery shopping         |
|         | Board meetings         | Out to eat with a group  |
|         | Music concert          |                          |
|         | Bible study at church  |                          |
|         | Adult Sunday school    |                          |

**Table 2:  Examples of group events (from interviews)**

Missing information, feeling left out, and the guesswork involved all amount to hard work, both physically and emotionally**.**  One resident described the writing class as the group where she had the most trouble:

> I'm always straining, sitting on the edge of my seat, when all the rest of them read their stories… [when a certain other member read aloud]  I didn't hear hardly anything she said.  And I *know* it was good, because [of] the response of the others.  But I couldn't hear it, you know – and I find that very frustrating.  (Alma)

Working so hard to hear is fatiguing, and one's concentration easily wanes.  Trychin (1993) noted two ways that a person with hearing loss might withdraw from a situation – by physically leaving, or by staying in place physically but withdrawing mentally (p. 19).  One interviewee described herself doing the latter:

> A lot of times I'm not hearing what's being said, so I just take myself out of that – I
>
> just… let it go. … People have noticed that I have this faraway look… I'm not hearing
>
> what's being said, so I take myself away from that.  (Cara)

She also sometimes chooses what Trychin termed *avoidance* (1993, p. 19):  "Sometimes I don't

go to lectures because I'm not hearing everything… A lot of times I get exasperated."  Ella told

of her experiences with one group:

> I used to belong to the prayer chain here. .. I found I would be interrupting somebody –
>
> 'cuz you're supposed to keep your eyes shut, you know – but they weren't done.  Or then
>
> I didn't know if they'd prayed about something, and I didn't want to repeat.  So I dropped
>
> out of that.

Several interviewees reported having learned from experience that certain group events were

only going to frustrate them, so they stopped going.

The nature of the groups mentioned in the interviews, along with the impact of difficulty

or loss of participation, point to some values in common among the residents interviewed.

Clearly, opportunities to socialize are valued – and are a benefit of living in a senior housing

setting such as ours, with plentiful social opportunities right outside one's door.  Also evident

was the value placed on service, whether through one's church or other outside organizations, or

via in-house involvement with activities of the tenant council or faith-centered groups such as

Bible study, vespers, or the prayer chain.  Participation in social and service opportunities gives

meaning to these seniors' lives; the loss or disruption of such participation, as noted earlier,

poses health risks.

A variety of findings in the literature describe mental health risks related to hearing loss.

Trychin lists common emotional reactions to include anxiety, depression, anger, and guilt (1993,

pp. 20-23), as well as the risk of  lowered or damaged self-esteem (p. 59) and the strain that

communication difficulties bring to one's relationships (pp. 49 and 53-59) – all of which are

echoed in the facets of mental health impact described by Dewane (2010).  A study by the

National Council on the Aging (1999) found *untreated* hearing loss to be a prevalent problem

among seniors, increasing their risk for "depression, anxiety, paranoia and emotional turmoil"

compared with older adults whose hearing loss was treated (i.e., who used hearing aids) (p. 7).

**Theme 3:  Downplaying of Needs**

Shame and stigma have long been associated with hearing loss.  After mentioning her

efforts in the past to try to cover up her hearing loss, Ella explained, "I think you're *ashamed.*

And you want so much to please other people – and keep in the loop."  She later added, "I'm

sure that happens with many people… because you're kind of embarrassed by it."  Alma's

strategy to sit favoring her better ear did not enable her to hear all of the conversation around her,

but at least increased her success:  "That was the safest way – I didn't get embarrassed so often."

Several comments in the interviews hinted at the smile-and-nod behavior that is a common form

of bluffing in the hope of avoiding being exposed as having a hearing loss (DHHS training

materials, n.d., p. 3; Trychin, 1993, p. 18).

Attempting to hide one's hearing loss from others was only one of the ways that the

interviewees downplayed their needs.  Several indicated that they wished other people knew

what would help the communication and would make those adaptations, but they themselves

didn't make any specific request.  Brad chuckled at the idea of asking the other person to speak

louder or more slowly, framing it as "transferring the blame – not from myself, but to you."

Some of the interviewees expressed a desire not to impose on others, or the wish to avoid interfering with others' participation in the program at hand.  Cara noted, "I can't say to everybody, 'you're not talking loud enough!'  You know, somebody's talking real quiet – I don't want to *impose* on them, because they have a right to talk… the way they want to talk."  Some examples of downplaying one's own needs seemed rooted in sensitivity toward others, as in Brad's choice to sit to the back in church due to his height, not wanting to block the view for others.  When describing how a presenter should establish with the audience the raising of a hand or another similarly discrete signal when someone is unable to hear, Ella stated, "you don't want to *interfere* with what they're doing, and to hinder them for the greater audience, just because you happen to not be able to hear well."  However, with the examples in the interviews, it was impossible to separate out a genuine consideration for others from the tangle of personal perceptions and fears of negative reactions and the influence of social taboos (about bringing attention to oneself, or appearing to put one person's needs above the group's needs, etc.).

## Discussion and Recommendations

Recent statistics from the Hearing Loss Association of America show the strong relationship between age and reported hearing loss.  Among American adults age 45-64, there are 18% with a reported hearing loss.  For the 65-74 age group, that figure climbs to 30%, and for people age 75 and over, it is an astounding 47% (from an HLAA mass email, 3/28/2011, regarding a new partnership with AARP in an education campaign focused on people over the age of 50 at risk of hearing loss).  Note that these figures refer to *reported* hearing loss.  Several sources have confirmed the prevalence among seniors of hearing loss that has not been diagnosed, yet that may significantly impact an individual's relationships and participation in

groups (Gordon-Salant, 2005; Hickson & Worrall, 2003; Rawool & Kiehl, 2008).  For those of us in any capacity providing services to seniors, it is paramount that we learn the best ways to design and deliver our programs to meet the needs of our customers with hearing loss.

**What Works?**

To return to the overall research question around which this project was shaped:  *What can hard-of-hearing seniors' lived experiences tell us about best practices to enable and support their inclusion in group events in a senior housing setting?*  On the surface, it might seem that the lists of PEO factors identified by the interviewees as approaches that "work" (Table1) would provide the answers about best practices. The information gathered corresponds to recommendations in the literature and common to many training materials regarding communication with people who are hard of hearing – at any age, in any setting (DHHS Training Materials, n.d.; HLAA fact sheet, 2010; Trychin, 1993).  This points to both the validity of the interview findings as well as their potential generalizability to other group settings beyond our senior housing setting.  Those of us providing services to seniors must become familiar with these approaches and implement them whenever possible.  However, focusing on these findings alone is not enough, for several reasons.

**Nothing new.**  All of the information on PEO factors presented on Table 1 has been available for decades – dispensed by audiologists, taught by gerontologists, researched by hearing health specialists.  However, if such tips – some directed to hard-of-hearing individuals, some to the people communicating with them – have been known and available for awhile and yet aren't consistently being implemented, why should that change now?  This is not to dismiss

the importance of all of these approaches for improving communication; the interviewees' lived experiences confirmed that they can improve hard-of-hearing seniors' ability to participate in group events.  The challenge is to determine what more is needed to bring about the necessary change in people's habits in a sustainable way.

      **Feeding into denial.**  If we were to create optimal conditions by practicing each of the identified approaches for improving the communication conditions – and that's all that we were to do – yes, it would likely prove helpful for some attendees at group programs.  Ironically, however, we might also be helping to perpetuate the denial on the part of some individuals with a hearing loss.   By not yet recognizing the impact of their hearing loss, those seniors are not yet owning their part in everyday communication situations.  Audiologist Patricia Kricos used the phrase "lack of problem awareness" (2006, para.1) to describe the situation of many seniors not yet ready for hearing aids and further rehabilitation around hearing loss.  Our implementation of the approaches listed in Table 1 would primarily address the latter two of the three PEO factors – elements of the environment that are within our control to alter (such as the room arrangement and managing background noise), and behaviors that we adopt as the key other people involved (speaking clearly, appropriate use of microphone). We also need to invest attention to improvements related to the "P" factor – i.e., how well the hard-of-hearing individuals in attendance are equipped to do their own part toward most effective inclusion. Anything we can do to increase their exposure to relevant hearing loss information and support can assist their movement forward along the awareness continuum toward more effective coping behaviors, greater acceptance, and self-advocacy.

**Disconnects**

Two kinds of disconnect appearing in the interview data point to the complexities of improving inclusion for hard-of-hearing seniors. One was related to *gaps in information and insights.* Notable was how little recognition the interviewees gave to lighting conditions as relevant to effective communication. This was not mere oversight on the part of the interviewees; one of my probes (during discussion of factors in the environment) was about lighting and windows, to which Cara responded, "I never noticed that the lighting would have any effect, I don't think." Brad's answer was similar: "No, I've never been aware of the light being involved. I'm not conscious of it, anyway." The only acknowledgement of lighting's relevance was Alma's comment, "I haven't noticed, except if it would… create a shadow… where the person's face is. Then it would be a problem." In further discussion with Brad about our seating choices relative to the windows, he pointed out that he could see more clearly and easily when not facing the glare from the windows – yet he never seemed to connect this observation with his knowledge (stated separately) that it is helpful to be able to see the face of the person who is speaking.

The lack of awareness and insight among many seniors about their own hearing loss is a contributing factor in their ongoing difficulties and frustrations with communication. An understanding of factors in the environment that might be altered or managed in ways to enhance communication can better equip those individuals to address their needs. Complicating the picture, however, is the second form of disconnect appearing in the data, best captured by the title of an article by Trychin (2003): *Why don't they do what they should?* Several of the interviews reflected frustration that other people won't do things to help the communication, but the individual saying so in most cases admitted to not speaking up to self-advocate, even when

knowing what changes in speaker behavior could help.  In his article, Trychin examines ten

potential reasons for a hard-of-hearing person not taking effective action to address a

communication problem – each with a different root cause such as denial, lack of self-efficacy,

rules of social acceptability, or prior experience with punishing responses from others.  As noted

earlier regarding the theme of the interviewees' downplaying their needs, the social-cultural

environment is complex!

**Paradigm Shift**

Society continues to evolve.  Around disability in general, the focus is no longer

primarily on a person's medical condition. The advent of accessibility legislation signaled a shift

of focus from the physical, sensory, and/or cognitive limitations of the individual to the

environments in which he or she seeks to function, and a shift to embracing some responsibility

on the part of the broader community and society. With the WHO's updated ICF framework,

participation in everyday life activities is solidly embraced as a world health issue. Universal

design represents a shift to inclusive planning and design, taking into account the real-world

range of needs and abilities among prospective users or participants.

As the literature and results of this research confirm, hearing loss can have significant

impact on an individual's participation in meaningful activities.  Traditionally, the response has

focused on the hard-of-hearing person and on treating the hearing loss with the application of

technology – and the technology of hearing aids and other amplification technology has

advanced considerably (Gordon-Salant, 2005, p. 19-20).  The prominence of hearing aids in the

lives of four of the five senior citizens interviewed for this project may reflect the dominance still

of that older paradigm:  hearing aids may represent their "only hope" for continuing to function

in the world.

Among many health professionals and hearing care professionals, there has been a clear shift to a more holistic framing of the impact of hearing loss, with a focus now on the dynamic interdependence of factors contributing to effective communication. Several sources have cited a clear speech method that emphasizes enunciation and pauses to render a message more readily understood by hard-of-hearing listeners (DHHS training materials, n.d.; Kricos, 2011); the responsibility for effective communication does not rest solely nor even primarily on the person with a hearing loss.  In the more recent literature, the term *communication partners* has come into increasing use to refer to the other people who communicate with a person who is hard of hearing – the "O" in Trychin's version of the PEO model.  This new phrasing bears the built-in assumption that the communication relationship is collaborative.  Furthermore, several specialists have emphasized the importance and effectiveness of providing audiological rehabilitation in groups versus individually, and including hard-of-hearing individuals *and*  their communication partners (Hickson & Worrall, 2003; Kricos, 1997 & 2003; Trychin, 2003).  Thus, the people on both sides of any communication relationship not only learn new information and behaviors together, but also gain support and reassurance in finding they are not alone in what they experience – whether as the hard of hearing person, or as the friend, family member, or service provider.

**Recommendations**

How can we fast-forward such a change in thinking and attitudes, and bring this paradigm shift home to our senior housing community?  Trychin (2003) recommended education, practice, and the development of a more supportive environment as key interventions with the individual who is hard of hearing. My research supports his recommendations and their applicability to groups in senior setting.  Collaboration is the name of the game, and culture

change is the essence of the leadership challenge we face.  Based on the findings in this study,

I recommend that staff in the senior housing facility, along with residents (hard of hearing, and

not) and interested family members:

(1) Embark on a collaborative learning journey together with the goal of strengthening

their shared knowledge base regarding hearing loss, its impact, and effective

communication behaviors;

(2) Create and utilize opportunities to practice relevant new skills together, to increase

skills and comfort level;

(3) Work toward culture change, with greater acceptance and improved inclusion to be

reflected in the new norms.

An outline version of these recommendations, including specific possible components, is

attached as the Appendix.


## SUMMARY

The aim of this project was to identify best practices for including hard-of-hearing

residents in our senior building's programs in order to incorporate such strategies into our

everyday work – to shift to norms of thinking more inclusively, translating into action the

sensibilities of universal design.  To change a culture – habits of thinking and doing – is a

daunting leadership task.  In *The leadership challenge* (2002), Kouzes and Posner presented

focused on five practices of exemplary leadership:  *model the way, inspire a shared vision,*

*challenge the process, enable others to act*, and *encourage the heart*.  Several of the practices

have been integral to this research project.

**Challenging the process.**  My starting point was rooted in questioning the status quo.

Why do staff members apply the beneficial strategies only erratically, if at all? Why don't hard-

of-hearing residents speak up more about what they need?  What are the ethical and legal

imperatives for us to improve the accessibility and usability of our programs for residents who

are hard of hearing?  Furthermore, we must challenge our assumptions, because they "may blind

[us] to new solutions" (Kouzes & Posner, 2002, p. 138).

**Inspiring a shared vision.**  Woven throughout this project is the assumption that we can

do better, be more inclusive, establish new habits and norms – that we can bring about a culture

change driven by the ethical values of caring and equity.  Getting others on board to share such a

vision – residents as well as staff – is key to inspiring their commitment to learn and grow

together.  In John Kotter's eight-step approach to leading change (1996, 2002), the first step is to

*establish a sense of urgency* (1996, p. 20).  Regarding changes that could improve the inclusion

of people who are hard of hearing, there is nothing more powerful than to hear stories from the

people most directly affected.  Together with them we can commit to learning even more about

what works and practicing new skills together.

**Enabling others to act.**  The desired outcome of the project has been most tied to this

leadership practice.  My research identified factors that improve the inclusion of hard-of-hearing

residents.  We now need to establish protocols for event planning that take into account the range

of hearing abilities of participants (P), adjustable aspects of the environment (E), and the specific

format and delivery of a given program (O), seeking the most effective and inclusive overlap of

the three dimensions (P, E, O).  Additional information and educational programming to move

people further along the hearing loss awareness continuum will empower them to take care of

their own communication needs and those of their neighbors more effectively.   Furthermore, I

will share findings from this study within the senior housing industry so that staff members who

facilitate any kind of group programs can be better equipped to do so inclusively of their hard-of-

hearing residents.

We who work in senior housing, providing services to people age 62 and older, have a

responsibility to know about the nature of hearing loss and its significant impact on the quality of

life of many of our customers.  Communication is, indeed, a two-way street – and when working

with seniors, some of that communication needs to be about the communication.  Each of us is

reasonably in a position to become a sensitive communication partner to residents who are hard

of hearing.  The conscious and intentional application of insights gained through this study will

equip us to go forth, in the spirit of universal design, to create new norms that support fuller

participation by more members of any senior housing community.  As Paul Wellstone said in a

1999 speech (Wellstone Action), "we all do better when we all do better**."**

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## **Appendix**

## **Recommendations – Goals and Components**

**Collaborative learning that involves staff, residents, and family members**

→ hard of hearing (HOH) and not – sensitive communication partners and allies are important!)

**Goal #1:   Strengthen the shared knowledge base about hearing loss, its impact, and effective communication behaviors.**

Possible components:

➢ Open meeting of HOH residents (facilitated) to share tips and insights – what works?

➢ Presentation by staff from Metro DHHS office – what everyone needs to know!

**Goal #2:   Increase skill and comfort with new behaviors.**

Possible components:

➢ Clear Speech training – for tenants, their friends & families, & staff

➢ Microphone 101 – (hands on!) for resident leaders and staff, possibly separately

➢ Role-play sessions – practicing saying aloud the likely kinds of  requests, plus "gentle reminders" to help keep new habits on track

**Leading culture change**

**Goal #3:   Greater acceptance and improved inclusion reflected in community's norms**

Possible components:

➢ Gather stories, experiences – for shared sense of need & ownership of vision

➢ Build on values of social connection, consideration/respect, & service: *walk the talk*

➢ increase "permissibility" of speaking up to make requests;

➢ Resident-staff collaboration to come up with protocols for meetings & programs

➢ Devise regular/ongoing ways to check in, get feedback:  how are we doing?

➢ Establish mechanisms for conveying info (expectations, norms) to outside presenters