

From Isolation to Communication: Connecting Adults Who Have Hearing Loss With Their Communication Partners

Abstract

As Baby Boomers enter the late adulthood stage of life, hearing loss continues to be one of the most prevalent, chronic, and isolating conditions facing older adults today. Research has focused on the negative consequences of hearing loss on the health and the person's well-being, but it is equally important to recognize that hearing loss also leads to communication loss. The resulting social isolation and the collateral effects of hearing loss on the communication partner are the focus of this mixed-method study that explored the hearing loss-related quality of life for both parties. Five overarching themes emerged from the analysis, presenting salient features of the hearing loss-related quality of life for both participants. Moreover, self-reported assessments revealed that communication partners significantly underrated their spouses' social/situational effects of hearing loss compared to their spouses' ratings. The findings showed how the participants' quality of life had been shaped by the challenges of communication as exacerbated by hearing loss. The participants remarked that the interview process served to increase their awareness of needed communication strategies to reduce social, emotional, psychological, and communication isolation, and improve quality of life for both parties.

Introduction

The capacity to connect with others, share thoughts and ideas, participate in activities, and attend to one's surroundings is essential to an older adult's overall well-being. When such capabilities are impacted by age-related hearing loss, the potential to communicate and participate in social activities becomes limited (Dalton, Cruickshanks, Klein, Wiley, & Nondahl, 2003). Moreover, negative social and emotional consequences associated with hearing loss may include social isolation and depression (Dawes et al., 2015; Gates & Mills, 2005; Heffernan, Coulson, Henshaw, Barry, & Ferguson, 2016), poor social functioning (Weinstein & Ventry, 1982), diminished psychological well-being (Dye & Peak, 1983), cognitive decline, dementia, anxiety, and depression (Dawes et al., 2015; Lin et al., 2011), low self-esteem (Gates & Mills, 2005; Harless & McConnell, 1982), and reduced quality of life (Dalton et al., 2003; Mulrow et al., 1990a; Mulrow et al., 1990b). Mick, Kawachi, and Lin (2014) noted that older adults with hearing loss who experience social isolation may die at younger ages than socially isolated adults without hearing loss. Dewane (2010) described this hearing loss condition as resulting in "psychological solitary confinement" (p. 18). Kramer, Kapteyn, Kuik, and Deeg (2002) examined the association of hearing loss and chronic disease with psychosocial status in older adults. Their findings revealed that older adults with hearing loss were found to have more depressive symptoms, lower self-efficacy, feelings of loneliness, and a smaller social network compared to peers without hearing loss. Yet, many older adults deny their hearing loss as well as the isolating impact it exerts on their quality of life. Acceptance of hearing loss, when viewed as a natural part of the aging process, can be an obstacle to seeking appropriate evaluation and treatment (Schulz et al., 2016).

The denial of hearing loss is often attributed to stigma (Davis et al., 2016; Wallhagen, 2009) and ageism (Wallhagen, 2009). Davis et al. (2016) described the process of age-related hearing loss,

referred to as presbycusis, as gradual and subtle. Presbycusis affects the detection of high-frequency sounds with persons experiencing difficulty understanding conversational speech in noisy environments, but not in quiet situations. Consequently, delays in recognizing and seeking professional help for hearing difficulties are common. Although presbycusis has no known cure, technologies such as hearing aids, cochlear implants, and hearing assistive devices improve hearing threshold levels (Davis et al., 2016). Davis and associates further emphasized that health care for persons with hearing loss (PHL) and their communication partners (CP) requires education and counseling, behavioral change, and environmental modifications. Frequently viewed as an invisible condition, the consequence of hearing loss on communication and interaction with family members, healthcare practitioners, and members of the helping professions often goes unrecognized.

Few content-valid data collection instruments exist for gathering information from PHLs and CPs regarding perspectives of their own and each other's hearing loss-related quality of life (HLQoL). HLQoL scales exist for assessment of the person with hearing loss (Tye-Murray, 2015); however, few hearing-related questionnaires have undergone thorough content evaluations (Smith, Pichora-Fuller, Watts, & La More, 2011). Utilizing an interprofessional practice approach, Delich and Roberts (2019) developed the Interview Questionnaire for Persons with Hearing Loss and Their Communication Partners, a 40-item content-valid instrument designed to gather information regarding the communication needs, communication management skills, and HLQoL for both PHLs and their CPs. The questionnaire is organized to explore four domains: (a) PHL's experience of his/her own HLQoL, (b) CP's experience of his/her own HLQoL, (c) PHL's experience of CP's HLQoL, and (d) CP's experience of PHL's HLQoL. A panel of 15 experts evaluated the items on the questionnaire for content relevance and content clarity. Experts were certified/licensed clinicians, researchers and university professors in the fields of audiology, deaf education, rehabilitation counseling, social work, and speech-language pathology with a deep understanding of hearing loss within their particular disciplines. The overall scale for content relevance of the 40-item questionnaire was .99; whereas, the content clarity was .85. These results suggested a high content validity for the instrument. Delich and Roberts recommended that this questionnaire be used in future studies to collect information regarding the HLQoL experiences for both PHLs and their CPs.

Consequently, the aim of this study was to explore the lived experiences of PHLs and their CPs in relation to their HLQoL using the Interview Questionnaire for Persons with Hearing Loss and Their Communication Partners. Qualitative data were collected through semi-structured interviews with both PHLs and CPs to understand their HLQoL experience. In addition, quantitative data were collected with PHLs completing self-reported assessment measures to evaluate their own HLQoL. CPs completed self-reported assessment proxy measures to evaluate the HLQoL of the PHL as perceived by the CP. The research question was: "What is the lived experience of PHLs and their CPs in relation to their HLQoL?"

Methods

Participants

Institutional Review Board approval was obtained by the California State University, Fresno Department of Communicative Sciences and Deaf Studies prior to initiation of the study protocol. Purposive sampling was used to select participants for this study, and participants with hearing loss were recruited through flyers and electronic communications at the university as well as clinics in the community. Hearing aid users between the ages of 55 and 85 years with at least three months of experience were invited to participate in the study. Inclusion criteria for PHL participants consisted of the following: (a) acquired hearing loss during adulthood, (b) an audiological evaluation within the past year, (c) scores within the normal range (≥ 24 points) on the Mini-Mental Status Examination 2 (MMSE 2; Folstein, Folstein, & McHugh, 1975), (d) corrected binocular visual acuity of at least 20/40 (Hardick, Oyer, & Irion, 1970), and (e) involvement of a CP with whom the participant regularly communicated and who was willing to participate in the study. Inclusion criteria for CP participants included: (a) spouses and caregivers who interacted with the PHL on a regular basis, (b) no known hearing loss, (c) scores within the normal range on the MMSE 2; (d) corrected binocular visual acuity of at least 20/40, and (e) no known psychiatric history. Volunteers were screened for these predetermined inclusion criteria prior to study enrollment.

Data Collection

A convergent parallel mixed-method design was utilized where quantitative and qualitative data were collected concurrently, analyzed separately, and merged in a final interpretation (Creswell & Plano Clark, 2011). Quantitative and qualitative data were collected over a two-month period.

Quantitative assessments. Prior to interviews with each couple, the PHL participants completed the Hearing Handicap Inventory for the Elderly (HHIE; Ventry & Weinstein, 1982) and the CP participants completed a version of the Hearing Handicap Inventory for the Elderly - Spouse (HHIE-SP; Newman & Weinstein, 1986, 1988). Completion of these self-assessment measures ranged between 15-20 minutes.

HLQoL assessment for persons with hearing loss. Self-report assessment instruments can help professionals understand the impact that hearing loss has on their clients' perception of HLQoL. The HHIE is an assessment instrument used to measure HLQoL in older adults (Ventry & Weinstein, 1982). This measure is a 25-item questionnaire developed for adults, aged 65 years or older, and has two subscales: a 13-item subscale regarding the emotional adjustments to hearing loss and a 12-item subscale concerning the social and situational effects associated with hearing loss. Participants are asked to indicate the extent to which they agree with a question about their perceived hearing handicap, with each response assigned a score (yes = 4, sometimes = 2, no = 0). The sum of a client's scores indicates the degree of participation restriction experienced, with higher scores indicating more hearing handicap (0-16 = no self-perceived handicap, 18-42 = mild-to-moderate perceived handicap, 44-100 = significant perceived handicap). Thus, a score of 18 or greater is indicative of a perceived impairment in HLQoL (Ventry & Weinstein, 1982).

HLQoL assessment for communication partners. Self-report assessment tools have been developed to provide insight into the impact of hearing loss from the perspective of CPs as established through proxy estimations. The HHIE-SP does not measure the HLQoL for the CP. Instead, a 25-item self-assessment HHIE-SP questionnaire was used to measure the CP's understanding of their partner's hearing-loss related participation restrictions and activity limitations encountered as a result of living with a hearing loss (Newman & Weinstein, 1988). This version is nearly identical to the HHIE except for the word "your spouse" being substituted for "you." The HHIE-SP is scored on a three-point ordinal scale (yes = 4, sometimes = 2, no = 0) in the same way as the HHIE with higher scores indicating more hearing handicap (0-16 = no self-perceived handicap, 18-42 = mild-to-moderate perceived handicap, 44-100 = significant perceived handicap). The same scoring and interpretation guidelines for the HHIE apply to the HHIE-SP (Newman & Weinstein, 1986, 1988).

Qualitative assessment. Semi-structured interviews took place with each couple together, focusing on the meanings, experiences, and views of the PHL and the CP within the context of their relationship. The aim of the research directed the topics used within the interview protocol. Open-ended items defined the area to be explored, with flexibility to allow for discussion of unexpected issues as they emerged during the interview process. Participants were encouraged to speak openly about their HLQoL experiences. Each interview was video-recorded and lasted approximately two hours. The interview protocol was based on established methods (Creswell, 2014), and included instructions for video set-up, opening statements, key elements to address, probes, and follow-up dialogue.

The Interview Questionnaire for Persons with Hearing Loss and Their Communication Partners consisted of a 40-item content-valid interview questionnaire that was used to investigate the experience of HLQoL challenges in four domains (Delich & Roberts, in press). First was the PHL's experience of their own HLQoL including their communication needs, communication management skills, and relationship with their CP. Second was the CP's experience of their own HLQoL including their communication needs, communication management skills, and relationship with the PHL. Third was the PHL's experience of the CP's HLQoL including their communication needs, communication management skills, and relationship with their CP. Fourth was the CP's experience of the PHL's HLQoL including their communication needs, communication management skills, and relationship. The interviews were conducted jointly by the researchers.

Data Analysis

Quantitative analysis. Using SPSS Statistics software, the data were analyzed using standard statistical procedures (Howell, 2002; Tabachnick & Fidell, 2012). An independent samples t-test was utilized to evaluate mean differences between PHLs and CPs using the HHIE and HHIE-SP Proxy self-report assessment questionnaires respectively.

Qualitative content analysis. All interviews were transcribed verbatim. The transcripts were checked against the original video recordings for accuracy. Transcriptions were then given a line-by-line analysis by noting relevant units of meaning and creating free codes independently

by both researchers. These lines were summarized in marginal text boxes using an open coding method. The free codes were then grouped into coherent themes. Responses were transferred to index cards to further examine information and create broader, intermediate codes. The index cards were rearranged using a selective coding method. The data were then organized and labeled into categories using descriptive terms based on the actual language from the participants. After grouping into appropriate categories, another analysis was performed. As needed, the recoding of data occurred based on the emergence of new categories. Once the categories were identified, they were integrated across participants to generate a list of overarching themes that captured the participants' shared experiences. The final level of analysis involved the examination of relationships and interactions amongst the overarching themes. Minor differences in the researchers' perspectives were resolved by mutual agreement.

Mixed-method analysis. Quantitative results were compared with the overarching themes derived from the qualitative data. An analysis and interpretation of the findings were made to determine if the results were comparable and convergent, and if the data expanded the understanding of the research question.

Results

Four couples (four PHLs and their CPs) participated in this study. Education, race, and income were not controlled. Table 1 provides the demographic, audiologic, and cognitive characteristics of the PHLs. As shown, all four PHLs were male, White, between 65 to 81 years old, retired from the work force with a minimal college education of a bachelor's degree, and had a bilateral sensorineural hearing loss, and wore binaural postauricular hearing aids. All four PHLs scored within the normal range (≥ 24) on the MMSE 2, suggesting normal cognitive function.

Table 1
Demographic, Audiologic and Cognitive Characteristics of Persons with Hearing Loss

Variable	PHL1	PHL2	PHL3	PHL4
Age (years/months)	75.07	65.10	81.10	81.0
Gender	Male	Male	Male	Male
Ethnicity	White	White	White	White
Education	Master's degree	Bachelor's degree	Bachelor's degree	Master's degree
Professional	Retired school administrator	Retired biologist/administrator	Retired university administrator	Retired school administrator
MMSE	25	30	30	28
PTA (dB HL)				

Right ear	32 dB	51 dB	23 dB	42 dB
Left ear	37 dB	18 dB	23 dB	40 dB
Speech in quiet				
Right ear	90%	84%	80%	92%
Left ear	96%	92%	84%	92%
Type of hearing loss	Bilateral Sensorineural	Bilateral sensorineural	Bilateral sensorineural	Bilateral sensorineural
Amplification	Binaural BTE hearing aids	Binaural BTE hearing aids	Binaural BTE hearing aids	Binaural BTE hearing aids

Table 2 provides the demographic and cognitive characteristics of the CPs. The CPs for all four couples were spouses of the PHLs enrolled in this study. As illustrated, two CPs were White, one was Asian/Pacific Islander, and one was Hispanic. They ranged in age from 62 to 72 years and were retired from the work force with a minimal college education of a bachelor's degree. All four scored within the normal range (≥ 24) on the MMSE 2, indicating normal cognitive function.

Table 2
Demographic and Cognitive Characteristics of Communication Partners

Variable	CP1	CP2	CP3	CP4
Age (years/months)	68.0	62.03	63.09	74.01
Gender	Female	Female	Female	Female
Racial/Ethnic Group	Asian-American/ Pacific Islander	Hispanic	White	White
Education	Master's degree	Master's degree	Bachelor's degree	Master's degree
MMSE	30	30	29	30
Professional	Retired school administrator	Retired school teacher	Retired university administrator	Retired school administrator
Relationship to PHL	Spouse	Spouse	Spouse	Spouse

Quantitative Findings

The results of the HHIE total scores for the PHL participants and HHIE-SP total scores for the CP participants are displayed in Table 3. All CP participants under-rated their spouses' participation restrictions and activity limitations on the HHIE-SP compared to their partners' ratings on the HHIE as per scoring criteria (Ventry & Weinstein, 1982). Specifically, three CP participants (i.e., CP1, CP2, CP3) under-rated their spouses' total score on the HHIE-SP as having no disability in comparison to their partners (i.e., PHL1, PHL2, PHL3) who rated their total scores on the HHIE as having a mild-to-moderate handicap. One CP (i.e., CP4) underrated her partner's total score as demonstrating a mild-to-moderate handicap on the HHIE-SP in comparison to her spouse (i.e., PHL4), whose total score on the HHIE was rated as having a significant handicap.

Table 3

Results of the HHIE and HHIE-SP for 4 PHL and 4 CP participants respectively (N=8)

	PHL1	CP1	PHL2	CP2	PHL3	CP3	PHL4	CP4
HHIE/HHIE-SP	T=20*	T=10	T= 36*	T=18	T=38*	T=0	T= 58**	T= 34*
	E=6	E=2	E=14	E=2	E=18	E=0	E=24	E=20
	S=14	S=8	S=22	S=16	S=20	S=0	S=34	S=14

Note: T= Total, E=Emotional, S=Situational

HHIE/HHIE-SP: *Mild-to-moderate handicap, **Significant hearing handicap

An independent samples t-test was conducted to determine whether or not average mean ratings differed between PHLs on the HHIE and CPs on the HHIE-SP assessments. Table 4 shows the summary table of the independent samples t-test for average mean ratings between PHLs on the HHIE and CPs on the HHIE-SP. As illustrated, the PHLs ($M=20.00$, $SD=4.32$) scored significantly higher ratings on the HHIE social scale than their CPs ($M=7.00$, $SD=5.38$) on the HHIE-SP social scale, $t(7) = 3.606$, $p = .011$; $d = 2.546$, and were found to exceed Cohen's (1988) convention for a large effect ($d=.80$). Thus, these results indicate that the PHLs had significantly higher hearing handicap scores on the HHIE social subscale than did the CPs' hearing handicap scores on the HHIE-SP social subscale with a large effect size. However, there was no significant difference ($p > .05$) in the average mean ratings between PHLs on the HHIE emotional subscale and their CPs on the HHIE-SP emotional subscale. Moreover, there was no significant difference ($p > .05$) in the average mean ratings between PHLs on the overall HHIE total scale and their CPs for the overall HHIE-SP total scale. Thus, no difference was found between PHLs' ratings on the HHIE and CPs' ratings on the HHIE-SP for both the emotional subscale and total scale.

Table 4

Independent T-Test Results for PHLs on HHIE and CPs on HHIE-SP respectively (N=8)

HHIE/HHIE Proxy	PHL		CP		T-value	P-value	Cohen's <i>d</i> :
	Mean	SD	Mean	SD			
HHIE/HHIE-SP Situational	20.00	4.32	7.00	5.78	3.606	.011*	2.548
HHIE/HHIE-SP Emotional	18.00	11.78	6.00	9.38	1.594	.162	
HHIE/HHIE-SP Total	38.00	15.58	15.50	14.36	2.124	.078	

* $p < .05$

Qualitative Findings

Table 5 presents the five overarching themes that emerged from the data analyses across the four couples. The overarching themes show salient features of the quality of life experience of both PHLs and their CPs.

Table 5

Overarching Themes Across 4 Couples from Collaborative Analysis

Theme 1: Gradual Hearing Loss is Part of Growing Older

Theme 2: Hearing Loss Creates Social and Emotional Communication Challenges

Theme 3: Learning as We Go Along

Theme 4: It is What It is: Acceptance

Theme 5: The Elephant in the Room: Benefits of the Interviews

Theme 1: Gradual Hearing Loss is Part of Growing Older

Participants talked about the slow onset and adaptation of hearing loss as they aged. This was evidenced by PHL2's statement,

"I guess you adapt to things because they came on over such a long period of time."

Adults may be taken back by a diagnosis of a hearing loss during the initial audiological assessment as illustrated by PHL1, "...it was through the testing that I was quite surprised that I did have a hearing loss."

Presbycusis is hearing loss associated with the aging process (Tye-Murray, 2015) and as PHL4 commented,

"I feel like (hearing loss) is a part of growing old. You know, I watched my mother, I watched my stepmother have these issues. As I've said, I see a lot of our friends who are my age, older than us, having these issues. And it's a part of life, yes, and you need a cane to walk, too, and yes, you need to hold on to the rail when you walk down the steps. It's like a process."

PHL3 shared PHL4'S frustration:

“Just in a minor way, it's a frailty, it's a negative...to really hear all the information, and I like to be accurate about what I hear, about how I respond. So...I feel a little inadequate.”

PHL1 disclosed how his spouse initially brought his hearing loss to his attention:

“I feel that my hearing loss...began very slowly. And I personally did not recognize it until [CP] began to tell me in a very gentle way that I was probably having a bit of a hearing loss. And then over a period of time, she began encouraging me to possibly see an audiologist and have my hearing tested. So, I really didn't realize that myself, and I can honestly say that I resisted having my hearing tested. [Laughter] And I felt that because that was kind of [CP's] area that it would be a wise thing for me to go in [Laughter] and see the audiologist.”

Theme 2: Hearing Loss Creates Social and Emotional Communication Challenges

The second overarching theme centered on social and emotional communication challenges.

PHL2 revealed avoiding a social challenge of conversing with competing background noise,

“We don't go out. When we do in a restaurant environment where there's background noise, it's sometimes very difficult. [It's] often difficult to carry on a conversation with people when the background noise is the thing that kind of washes everything out...I often find myself asking people to repeat what they said.”

Sometimes, communication challenges lead to emotional responses as shared by PHL3:

“I've had to ask (CP) many times, ‘What did you say? Would you repeat what you said?’ and I think some of these is because she speaks very lowly...I think that's a burden on her that I'm having to say, ‘Well, what did you say and repeat what you say?’”

PHL3 further divulged his embarrassment with communication situations at the golf course:

“They [acquaintances] don't know that I have a hearing loss, because I don't wear my hearing aids when I play golf. So, I've had the impression that certain people think I'm not quite with it, because I don't hear what they have to say or I may respond in a way that I may have misunderstood what they have said or asked.”

A commonly shared emotional response to communication challenges was frustration as exemplified by CP4,

“I have to raise my voice more to talk with him, then I get frustrated with it; I know that I have to try some different strategies.”

Recognizing that communication has become a challenge was noted by CP4's admission:

“I think I need to learn more patience...So, I've learned that I have to recognize more the challenges we've got in communicating and pay more attention to him; and I don't always do that.”

Theme 3: Learning as We Go Along

PHL3's comment summarized the approach most couples in this study used to figure out how to better communicate with one another:

"We just deal with it and we find ways. And we discard what doesn't work and we use what works."

The deliberate process of changing habitual communication patterns was exemplified by CP2's comment:

"I try to realize, 'Okay, he can't hear me.' I have to go and address it, look at him more — aware that I need to do that more. I'm not the best at doing that, but yes, I am aware that I need to be in the same room as him or not down the hall and ask him, and I still do that...I don't think that I need to have eye contact with him. I just need to be in the same room so he can hear me and — yeah, that's the thing I need to work on as far as I think."

The participants often described the communication process as happening through trial and error as patterns of effective communication emerged through experience. CP4 articulated,

"You know, when you asked him that question, I thought, I don't think we've consciously agreed on much of anything. Like he said, we haven't sat down and said, I need you to do this, I need you to do this, how can I help? I think we kind of learned it by experience to some extent."

Couples also described the need to be within close proximity of each other to improve their communication. CP1 expressed,

"The strategy is when communicating with each other that we try to be in the same room — fairly close to each other. It's very, very helpful, so that we're looking at each other as we speak. Not only as our speech, but our body motions and basically expression and so forth to help in the communication being more effective. So, we're very conscious of this type of thing and we've talked about it and certainly, it's very helpful."

When the CP who participated in this study gains awareness and shows attentiveness to the PHL's communication needs, the PHL then assertively lets the CP know of his need for communication support. For example, PHL1 shared:

"I try to make sure that again those people understand the fact that I do have a hearing loss. And I ask them basically if they don't mind if I ask them if I don't hear the question, I will ask them to repeat it. And so, I try to manage those situations."

PHL2 had a similar sentiment, saying,

"I more frequently say, '[CP], I can't hear you because I'm in the living room and you're in the bedroom."

When using hearing assistive technology, benefits and challenges were presented for these older participants. PHL4 noted,

"If I have a complaint, it's I'm not adept at the new technology. And that's a challenge, I think, for many of us elders. Don't have to understand it, but how to use it."

PHL2 had a more positive experience with technology:

“I have this program of hearing aids and I can hear some of it (guitar). After I played around with that a little bit yesterday to see with the monitor off [and] how much a difference it was, I was startled! It was a remarkable difference.”

PHL2 commented on the supportive role of the hearing health professional,

“I find that through the audiologist that there’s a lot of assistance there,” echoing the sentiments of the other participants. CP2 volunteered how they began adaptation through use of hearing assistive technology, saying, “We have closed captioning on the TV all the time.”

Theme 4: It Is What It Is: Acceptance

“It is what it is” was a reoccurring phrase that conveyed increasing acceptance of shared communication challenges. PHL4 commented,

“The best adaptation that I’ve made is accepting what it is. It is what it is! And working with those in the environment to get them to cooperate with me so I can hear what’s happening...in terms of my emotional, psychological. I now recognize it as a handicap that I have to live with and work with.”

Meanwhile, PHL2 quipped, “It’s just like [CP] said, ‘It is what it is!’ So, it’s like I’ve wore glasses since fourth grade so, I never expected things to be perfect after I turned nine. [Laughter].”

Humor was an important part of accepting the shared inevitable communication challenges. CP3 commented,

“He still golfs three days a week. It’s nice that he doesn’t wear his hearing aids because there’s a lot of teasing and joking. If his friends are joking with him or trying to make fun of him or something, he can just not pay any attention to it. He can just hit the ball...it won’t affect his game.”

Humor was even found in miscommunication as noted by PHL1,

“I’ll hear her speaking, but I’ll mix up the words as to what she said...and we do laugh about it because it’s very humorous sometimes. [Laughter].”

Theme 5: The Elephant in the Room: Benefits of the Interviews

The interview process highlighted the impact of hearing loss on the quality of life for the four couples. The questionnaire also appeared to prompt participants to recognize the need for explicit and agreed-upon communication strategies that could improve their HLQoL. CP1 shared,

“I’ve learned a lot just listening to the questions, because sometimes, even though I think we communicate well, there are times when I’m getting to hear information that maybe we haven’t talked about before, and that’s good. I never have asked him, well, how do you feel about having a hearing loss? So, it’s kind of good to hear that information from him.”

CP3 commented,

“I think this was really the first time I’ve heard him say out loud to me that he considers [hearing loss] a frailty. So, I’m glad to hear that because that will just make me even try to be more sensitive to the hearing loss.”

PHL2 stated, “It’s interesting, because I don’t usually discuss a lot about this, have we?”

CP2 responded,

“Not much between us at all. I mean, we haven’t really discussed how I feel about his [hearing loss]. I think it’s kind of interesting; we talk about a lot of things. It’s like the elephant in the room you just don’t want to see.”

Discussion

The results from the quantitative and qualitative data sets contribute to a more comprehensive understanding of the lived experience of both PHLs and CPs in relation to their HLQoL. The four couples reported a wide range of effects on their quality of life, which had considerable impact on their relationships.

Gradual Hearing Loss is Part of Growing Older

The gradual onset and awareness of hearing loss may have to do with the dual stigma of ageism and hearing loss, making it difficult for these participants to recognize the impact of hearing loss on their relationship and discuss this concern with each other. Although the participants did not explicitly mention the stigma of hearing loss and ageism, these factors may implicitly explain the avoidance of recognition and reluctance to use audiological intervention. Due to the intimacy of shared daily living, the spouses were notably the first to identify their partners’ hearing loss. The importance of relationship intervention, and not just individualized intervention, is supported by the fact that it was the spouse’s comments that often initiated help seeking. Most adults seek audiological intervention due to their partners’ persuasion over time (Manchaiah, Stephens, Zhao, & Kramer, 2012).

The dual stigma of ageism and hearing loss may have contributed to the participants’ HLQoL experiences, which reflected society’s view of older people (David & Werner, 2016). Butler (1975) first identified and defined ageism as, “a process of systematic stereotyping of and discrimination against people because they are old” (p. 894). Intimately connected to ageism, stigma is defined as the possession of, or belief that one possesses a trait or characteristic that communicates a devalued social identity within a specific social context (Crocker, Major, & Steel, 1998). Consequently, many adults who acquire hearing loss, a stigmatizing trait associated with aging, are devalued by other individuals (Southall, Jennings, & Gagné, 2011; Southall, Gagné, & Jennings, 2014). Common stigmatic behaviors include denial, non-use of hearing aids, and distance from communicative interactions (David & Werner, 2016).

Hearing Loss Creates Social and Emotional Communication Challenges

Govender, Maistry, Sooma, and Paken (2014) stated that the complexity of everyday tasks can often be compounded by hearing loss. In the current study, situational barriers such as communicating in noisy environments such as restaurants, meetings, and social gatherings were reported as challenging by the PHLs. Concurrently, their spouses disclosed that frustration with their partners' communication challenges needed to be tempered with patience. Consistent with the theme that hearing loss creates social and emotional communication challenges, the study's quantitative results revealed that all four CPs under-rated their spouses' participation restrictions and activity limitations on the HHIE-SP compared to their partners' ratings on the HHIE as per scoring guidelines (Ventry & Weinstein, 1982). Moreover, the CPs significantly underestimated the PHLs' level of hearing handicap for social and situational effects on the HHIE-SP in comparison to the PHLs' rating for social and situational effects on the HHIE. These results were consistent with other studies' findings with similar incongruence among couples in the perception of HLQoL scores (Newman & Weinstein, 1986; 1988; Preminger, 2002; Preminger & Meeks, 2010).

Preminger and Meeks (2010) reported that stress and mood may influence a person's perception of HLQoL. They stated that stress was related to affective responding, particularly to negative mood states. Watson, Clark, and Tellegen (1988) emphasized that low negative affect is described as a state of calm, whereas high negative affect is a general dimension of subjective distress that includes anger, nervousness, contempt, fear, disgust, and guilt (Watson et al., 1998), and could produce exaggerated perceptions of hearing-loss related limitations and restrictions (Preminger & Meeks, 2010).

Preminger and Meeks (2010) further reported that perception of hearing-loss related participation restrictions and activity limitations was highly correlated with the PHLs' negative mood ratings. Regardless of degree of hearing loss, PHLs with higher negative affect scores reported increased hearing handicap index scores. In addition, CPs with higher negative affect scores reported increased HHIE-SP proxy scores (Preminger & Meeks, 2010). These researchers further noted that in couples in which the CP underestimated the hearing handicap reported by their PHL, CPs tended to have low negative affect. In the current study, the CPs significantly underestimated the PHLs' level of hearing handicap for social and situational effects, which suggested a low negative affect in comparison to the PHLs' rating of their own HLQoL. Incongruent couples in which the CP underestimates their partner's perceived hearing-loss related participation restrictions and activity limitations may have better marital communication than congruent couples or couples in which the CP overestimates the hearing handicap proxy score (Preminger & Meeks, 2010). These results highlighted how divergent the perceptions of each member of the couple were as well as the importance of working with couples to develop communication strategies for dealing with difficult situational and emotional challenges.

Learning as We Go Along

David and Werner (2016) reported that concealing hearing difficulties was the most common stigmatic behavior employed by PHLs. In contrast, happier relationships were associated with the PHL's acknowledgement of hearing difficulties and taking primary responsibility for

managing the consequences of the hearing loss (Anderson & Noble, 2005; Scarinci et al., 2008). Both the CPs' concerted efforts to improve communication and the PHLs' willingness to assert their communication needs exemplifies a two-prong approach to enhance communication between them. Scarinci et al. (2008) described a number of strategies CPs employed to cope with their partners' hearing loss, including face-to-face communication, increased volume of speech, positioning techniques, and repetition of words and phrases. In addition, the spouses coped with their partners' hearing loss by assuming responsibility and taking charge of communication situations, such as listening to their partners' communication exchanges and coaching them through group conversations. Moreover, CPs reported that PHLs' acceptance of their hearing loss reduced its impact on their everyday life.

It Is What It Is: Acceptance

Tye-Murray (2015) emphasized that adults experience psychological adjustments to hearing loss, which typically begin with shock and disbelief, followed by depression, anger, guilt, and acceptance. She further noted that acceptance occurs during the acknowledgement that life continues, although differently than before. Consistent with the theme of acceptance, the quantitative findings of this study revealed no significant difference between the PHLs' HHIE ratings for level of hearing handicap for emotional effects and the CPs' HHIE-SP ratings for level of hearing handicap for emotional effects. Newman and Weinstein (1986) noted that social/situational problems encountered by hard of hearing adults were more observable and thus, readily identifiable by the spouse compared to emotional responses. Moreover, they stated that the extent to which one shares his/her emotions was probably influenced by personality factors. Scarinci et al. (2008) reported that their older CP participants accepted their partners' hearing challenges due to the natural process of aging and demonstrated a heightened awareness of their spouses' hearing difficulties upon retirement with the increased time spent together. Moreover, they found CPs indicated that their partners' acceptance of their own hearing loss helped improve their shared quality of life. It is possible that the couples in this study had come to accept the need to live with hearing loss on an emotional level when addressing their communication challenges.

Elephant in the Room: Benefits of the Interviews

Anthony (2006) noted that the idiom of "elephant in the room" is used to signify that some issue that may be obvious to some is rarely discussed, and yet simultaneously cannot be avoided. Moreover, this expression implies a value judgment that the issue should be discussed openly. In this study, hearing loss was the elephant in the room that needed to be acknowledged by each couple. The elephant in the room was sensed whenever the topic of HLQoL was raised. The interview process, using the content-valid questionnaire during this research study, became an unexpected intervention in and of itself. The questionnaire items uncovered the presence of the elephant in the room by the couples' openly recognizing the impact of hearing loss in their relationship and encouraging discussion of communication strategies that improve quality of life for both parties.

Strengths and Limitations

This study had several strengths and limitations. First, conjoint qualitative interviews were undertaken as the open-ended nature of the approach provided emphasis to the meanings, experiences, and views of the PHLs' and CPs' quality of life experiences. However, the information provided may likely to have been affected by the participants' moods at the time of the interview, the ability to recall their experiences, and the level of comfort with the interview process. Furthermore, the presence of a member of the dyad during the interview may have inhibited some of the participants from talking freely and honestly about their beliefs and feelings. Second, the small number of participants from a purposeful sample could be a limitation in the assessment of the HHIE for the adults with hearing loss and HHIE-SP for their spouses. As such, there may have been reduced statistical power to find significant differences. However, despite the small sample sizes, statistically significant differences were found between the PHL and CP participants, with PHLs demonstrating significantly higher hearing handicap scores than CPs' hearing handicap scores on the social subscale with a large effect size. Third, although the data represented information from a relatively small group of participants, they provided detailed descriptions of their quality of life experiences within their relationship and revealed themes supported by other research. Replication of this study with larger, diverse samples, while employing various recruitment strategies, is recommended to address the current research gap that examine the shared communication loss and quality of life within relationships.

Conclusions

This study examined not only the adults with hearing loss and their spouses' perspectives of their own quality of life, but also how they perceived each other's quality of life. Understanding their quality of life experiences can assist professionals to become aware and sensitive to the couples' communication, situational, and emotional needs. Attending to their unique histories, distinctive relationships, and unanticipated outcomes are important considerations when providing psychoeducational groups on communication strategies. One implication of this study is the potential use of the content-valid questionnaire to gather information for assessment purposes and also as an intervention tool to increase awareness of needed communication strategies that can improve quality of life for adults with hearing loss and their partners. These findings support that gradual age-related hearing loss is a common part of living in a society that unfortunately stigmatizes both hearing loss and aging. Further research on intervention strategies that improves both partners' communication self-efficacy is vital.

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