

## Striving for genuine connections: men's experiences of living with hearing impairment

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Hearing impairment affects 16–17% of the Swedish and Danish population, where 6–8% is affected during their working life. This study aims at describing what a hearing impairment means in men's daily life. Qualitative interviews were performed on two occasions with nine men aged 35–53 years with an acquired, moderate hearing impairment and who had taken part in rehabilitation and tried out hearing aids. Colaizzi's phenomenological method was used for the analysis. Living with limited hearing emerged as 'A never-ending striving for genuine connections...': '...to other people and the surrounding world'; '...to find personal strategies and technical aids'; and '...to transform one's personality and identity'. Men in mid-life experienced hearing impairment as a continuous process which included all aspects of daily life. In order to find balance in a changed life situation and avoid ill-health, support with different aims is needed.

**Keywords:** hearing impairment; middle-aged men; lived experiences; everyday life

### Introduction

We are surrounded by sounds, verbal and non-verbal, which help us understand and handle everyday life and communicate with other people. When we perceive these sounds, we give them meaning and context. A limited ability to hear is noticeable when conversations with other people and different sounds become unclear and are no longer as easy to perceive. Most people who are hearing impaired are affected as adults after hearing well and taking their hearing for granted. Hearing difficulty is considered a communication handicap, or as Jones, Kyle and Wood (1987, 35) say, it 'strikes at the heart of human life – communication' and thereby also affects people in the hearing-impaired individual's environment. Some degree of hearing impairment (pure tone average [PTA]<sub>0.5–4.0 kHz</sub> ≥ 25 dB hearing level) is a common obstacle to health and includes 16–17% of the Swedish and Danish population (Johansson and Ahlinger 2003; Karlsmose et al. 2001). Most commonly, individuals over 65 years of age are affected and the number of people between 35 and 55 years of age with bilateral hearing impairment (PTA<sub>0.5–4.0 kHz</sub> ≥ 25 dB better ear hearing level [BEHL]) is about 8% and has almost doubled in the past 20 years (Johansson and Arlinger 2003; Statistics Sweden 2006). Twice as many hearing-impaired individuals have reduced working capacity and are on sick-leave for longer periods compared with people of the same age with other ill-health conditions. Early

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retirement owing to ill-health is twice as common for hearing-impaired individuals compared with others of the same age (Statistics Sweden 2003). The reasons for ill-health and sick-leave have been fatigue and stress owing to working tasks and environment (Danermark and Coniavitis Gellerstedt 2004; Kramer, Kapteyn and Houtgast 2006).

The consequences of limited hearing have been studied in different groups using self-rating tools. They have included questions about how sounds and speech have been perceived in different conditions, as well as items about emotional response, self-esteem and social life (Hallberg 1998; Helvik, Jacobsen and Hallberg 2006; Stephens, Gianopoulos, and Kerr 2001). Self-ratings have shown that hearing-impaired individuals are often limited when it comes to activities and participation, which might lead to ill-health. The connections are weak between the audiometrically measured hearing ability and the hearing-impaired individuals' own experiences of their difficulties (Erdman and Demorest 1998a, b; Hallberg, Hallberg, and Kramer 2008; Kramer et al. 1996). The results of the rehabilitation are affected more by non-audiological variables, such as gender, age, personality and social support than by audiometric variables (Kricos 2000).

A deeper understanding of what limited hearing means in daily life has emerged through qualitative studies where people of different ages and with different forms of hearing impairments are allowed to express their experiences. A Swedish study (Hallberg and Carlsson 1991) showed that hearing-impaired middle-aged men and women strove to maintain a normal identity and avoid being seen as different in the interplay with other people. Similar results emerged in Canadian studies where hearing problems were associated with a negative self-image and a striving to reduce or deny the hearing problems (Héту 1996). Gullacksen (2002) and Herth (1998) describe how middle-aged women and men go through a long and demanding process to integrate their hearing losses and the changes these brought to their lives. For older women and men, the experience of hearing loss could be connected to identity and existence (Karlsson Espmark and Hansson Scherman 2003).

Since research concerning the consequences of hearing impairments to a large part has been based on the impairment itself, we know less about how gender, age and life situation have affected the experiences. From a general psychological and social life perspective, there are obvious differences between gender and age groups (Statistics Sweden 2006). The middle-age life-span (35–59 years of age) is in many ways different from other life phases. It is an eventful period which includes a balancing between several different and complex roles. During those years, we succeed or fail to reach personal goals, have a professional career and hold a family together. Children grow up and move away from home, ageing parents might need help and support and we start to develop age-related ailments ourselves (Lachman 2004). Few studies have shown how women or men, respectively, experience and handle a hearing impairment developed in that life phase. In existing studies, there are no clear emerging gender differences, but earlier studies (Garstecki and Erler 1996; Demorest and Erdman 1987) suggest that men have reacted with more denial and fewer emotions than women. Age-related consequences of limited hearing have shown that younger individuals often find it harder to accept it and report more handicaps and more demands on communication than older individuals (Erdman and Demorest 1998a, b; Garstecki and Erler 1996; Gordon-Salant et al. 1994; Kricos et al. 2007).

Few studies were found where working women or men with moderate hearing impairments and in similar life situations have shared, in their own words, their experiences of living with limited hearing. This would be valuable knowledge as that period in life (mid-life) often contains many activities and responsibilities for others; an acquired hearing limitation may have different consequences than among elderly. The amount of persons in mid-life developing hearing problems has increased strikingly during the past decades, a time with big and rapid changes in society and working-life. The purpose of this study was to describe what a hearing impairment means in daily life for middle-aged men. A study of women's experiences is on-going.

### **Materials and methods**

A qualitative descriptive design was chosen, as the purpose of the study was to gain a deeper understanding of what the phenomenon of living with an acquired hearing impairment means in daily life for those affected. The chosen approach was interpretative phenomenology, which is based on descriptions of people's lived experiences, while the researcher's pre-understanding is identified and bridled (Dahlberg and Dahlberg 2004) to the greatest extent possible (Colaizzi 1978) in order for the phenomenon to emerge. In recent years, phenomenology has been very important for increased understanding of different conditions related to health and ill-health.

### ***Informants***

The choice of informants was carried out using purposive sampling. The inclusion criteria were working, middle-aged men, affected by a moderate, audiometric hearing impairment (40–70 dB BEHL) which had arisen during the past few years. Informants had to have taken part in rehabilitation and received technological aids. Exclusion criteria were non-Swedish speakers.

Names of possible informants were gathered from a centre for hearing rehabilitation in central Sweden. Written information describing the purpose and carrying through of the study, as well as a request for consent to participate, was sent to 11 men who matched the inclusion criteria. They were also informed that the interviews would be tape-recorded, that the information they gave would be treated with confidentiality and that participation was voluntary and that they could discontinue their participation at any time. No contact could be established with two men, but nine gave their consent to participate in the study. All had moderate hearing loss. Five to seven years before the study started, they had received their first hearing aids and had been offered rehabilitation. The informants' educational background, working life, social situation and possible additional illnesses included a broad spectrum. Demographic information is presented in Table 1.

### ***Data collection***

Data were collected using informal and conversational interviews (cf. Fog 2004). The informants were asked to describe freely everyday experiences from their lives at home, with family and friends, at work and in their spare-time. Follow-up questions were asked to make the stories clearer and deeper. The informants had no problems following the conversations because of their hearing impairments. The interviews

Table 1. Descriptive data for men in the study group.

Informant	Age (years)	Education level	Significant others	Occupation level (%)	Hearing loss (dB) <sup>a</sup>	Problem duration (years)	Additional disorders
A	39	University	Family	100	40	5	
B	35	University	Single	100	32	7	
C	52	Senior high	Spouse	50	39	7	Arthritis
D	42	Senior high	Single	0 <sup>b</sup>	37	6	Ménières
E	38	Senior high	Family	100	41	5	Ear deformity
F	50	Elementary	Family	100	46	8	Epilepsy
G	53	Senior high	Spouse	100	44	6	Heart disease; tinnitus
H	47	University	Spouse	100	— <sup>c</sup>	10	
I	53	Elementary	Family	100	45	8	Tinnitus

Notes: <sup>a</sup>Audiometric pure tone average (PTA)<sub>0.5-4.0 kHz</sub> better ear hearing level; <sup>b</sup>sick-listed; <sup>c</sup>unilateral deafness.

took place on two occasions, two weeks apart, with each informant. They continued for about 60 minutes, were tape-recorded and transcribed verbatim. In total, 18 interviews were carried out and the transcribed text corresponded to 214 pages with single spacing, font size 12.

### **Data analysis**

The text from the transcribed interviews was analyzed using Colaizzi's (1978) phenomenological method. This includes a seven-step analysis:

- (1) The text from each interview was read through in order to get a sense of the whole
- (2) Significant statements relating to the current phenomenon were highlighted
- (3) Meanings were formulated based on the significant statements
- (4) The formulated meanings were ordered into themes and comparisons were made between the transcriptions and themes in order to ensure credibility
- (5) Themes were integrated in an exhaustive description of the phenomenon
- (6) The fundamental structure of the phenomenon was formulated
- (7) Descriptions of themes were supported by quotes from the interview transcriptions.

When the first interview with an informant had been transcribed, an analysis was performed relating to Colaizzi's first three steps (1–3). The preliminary meaning analysis was a base for deepening and development in the second interview. After the second interview had been performed and transcribed, the interview analysis of both interviews continued, using all of Colaizzi's steps. The analysis procedure was repeated for the data of each informant. Finally, all interviews were woven together through a continuous process of comparisons between similarities and differences, between parts and the whole of the entire data text, and between the steps of analysis

with the purpose to validate the analysis and understand the meaning of the phenomenon under study.

**Trustworthiness**

To ensure trustworthiness in this study, standards for rigour in qualitative research, credibility, auditability and fittingness were applied, as described by Sandelowski (1986).

The authors strove to be aware and have a critical approach to the phenomenon under study by holding back their own pre-understanding to ensure that the informants' experiences had precedence in the study (credibility). Both authors read through the interview texts separately and made a preliminary analysis, which was then compared and discussed until a mutual understanding of the text was agreed upon. Quotes are used in the findings to enhance the meaning of the themes. To facilitate review (auditability), the research steps were carefully described and Colaizzi's (1978) method was followed as carefully as possible during analysis. The interviews were transcribed verbatim by an independent transcriber, whereafter the tapes were listened to and compared with the texts by the interviewer (IJ) before the analysis began. The choice of informants was aimed at working men of different ages, civil status, life situations and experiences in order to have a broad spectrum (fittingness). In the discussion, the results of the study are compared and related to qualitative studies with similar phenomena.

**Ethics**

Participation was voluntary and participants and materials were treated confidentially. The study has been reviewed and approved by *Regionala etikprövnings nämnden* in Uppsala, Sweden on 18 January 2006.

**Findings**

The informants' descriptions of living with limited hearing emerged as one essential structure and three inter-related themes which, to some extent, were ever-present in the informants' daily lives. The essential structure was 'A never-ending striving for genuine connections...' and the inter-related themes were: '...to others and the surrounding world'; '...to find personal strategies and technical aids'; and '...to transform one's personality and identity' (see Figure 1).

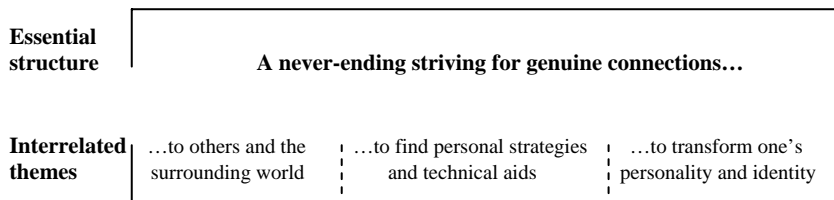


Figure 1. Men's experiences of living with a hearing impairment.

*A never-ending striving for genuine connections. . .*

To acquire and live with limited hearing meant a never-ending and uncertain struggle to be in connection with and have natural contact with other people and phenomena in everyday life. The uncertainty was based on not being able to trust what was going on in the auditory world, nor one's own emotional reactions. Existence could unexpectedly be experienced as risky even in familiar circumstances. In order to avoid problems in the contact with the surrounding world, careful preparation and technical aids were needed before expected situations and meetings. In situations when the environment could not be controlled and unexpected events occurred, the inner self-image could be challenged and threatened.

One informant expressed this:

. . . You feel incomplete. . . mutilated. There are a lot of people that you might want to have contact with, and that you can't have contact with. There's no connection, you can't hear. Well, it actually becomes part of your self-esteem as well.

*. . . to others and the surrounding world*

The hearing impairment had changed their living conditions. These changes had either come gradually and discreetly over several years, or more abruptly. In favourable situations, conversations and exchanges with the surroundings could take place almost as before, when hearing was normal. In other situations, big problems might arise, both when it came to perceiving conversations and surrounding sounds, even if the outer circumstances were not markedly disturbing to others.

Difficulties in perceiving and fully participating in conversations with others were a daily occurrence. This might happen when someone spoke unclearly or during conversations with others when there were surrounding noises. Above all, the limited hearing had an impact on conversations in social circumstances, at work, during spare time or privately.

. . . you can't hear what people are saying if there are several conversations going on at once. . . or if the pace is very high. . . you're always. . . a couple of sentences behind, and then you can't really be active in the social situation.

If work required that separate words had to be perceived correctly in contact with others, a great uncertainty arose. It was less strenuous at home, where demands on perceiving correctly were lower. A specific challenge was meetings with unfamiliar individuals with whom the informant wanted to establish contact, professionally or privately. The conversation was then not only meant to run smoothly, but the informant also wanted to make a good impression on the unfamiliar person. Most often it was coincidence that decided if a meaningful contact was established. Casual meetings with acquaintances or neighbours seldom led to anything else, as the outer circumstances were too demanding. Even telephone conversations posed a risk for misunderstandings, depending on the other person's tone of voice or articulation.

The uncertainty as to whether or not everyday sounds like telephones, door-bells and fire alarms had been perceived could cause worry, especially if the informants were alone and hearing aids had been removed. Sounds that previously had created a sense of security, such as low noises from electrical appliances and clocks, were

difficult to hear. Even unexpected, louder sounds from the environment could cause different kinds of problems:

...difficulty to trust my perception. I can't interpret where sounds are coming from and what causes them. I don't know if it's an airplane above me or a car, or if it's thunder or someone who has dropped something behind me. All those possibilities might be true... the hardest thing is the social consequences, when I react in the wrong way and cause a deviant reaction.

*...to find personal strategies and technical aids*

During the years that the informants had lived with their impaired hearing, they had received tips in their hearing rehabilitation, but above all developed their own strategies to be able to hold a conversation and participate in a social situation. Next of kin, the wife especially, had also developed strategies to facilitate for the hearing-limited husband, such as lowering noise or holding back a conversation for later in situations that demanded listening. A common way for informants to perceive and participate better in conversations with others was described as: '...focusing on one person when there are several talking at once... I have to look at the person the entire time...'.

Another strategy was to move to a quieter environment along with the conversation partner, and also tell or remind others about the hearing problems and ask them to repeat themselves. However, these strategies had limitations, especially if the use of them was felt to be brief: '...you feel unfair... you can say sorry a few times, but not too many times... and then you just agree... although you haven't really heard what they have said...'.

Strategies that others were unaware of included reminding oneself of previous conversations with the individual or, if the encounter was more formal, to read documents and notes, etc., that might facilitate and predict the contents of the coming meeting. Another strategy could be to:

...not consciously listen to everything that is being said. It's easy for me to enter into my own world and close my ears, because I listen consciously much more now than I used to. It is a conscious process to understand what is being said, and it's strenuous.

The change that the hearing impairment brought for the men had demanded big changes in life. An obvious change was to adapt working tasks so they demanded less exact hearing, or completely change career. The informants had often made the decisions themselves, as they no longer felt content with how their tasks could be carried out. The uncertainty as to whether or not they had made the right decision became too much, as well as the daily strain of trying to listen and understand. Changing profession might sometimes be a drawn-out process and they felt that society put unnecessary obstacles in their way. The risk of becoming unemployed because of shortage of work was especially worrying, as the chance of getting another job was small because of the impairment. Having a job, preferably full-time, was important to all men. They were driven by the possibility of stable finances, social contacts, stimuli and the wish to be like others and have a normal life.

Before the hearing problems became apparent, some of the men had suffered illnesses, such as disabilities or heart attack, which had demanded changed living habits or change of work. That experience might help them endure and adapt to the

new hearing condition: ‘...there are no obstacles, only possibilities. Even if something befalls you, there is always something else beyond it’.

The informants had used hearing aids and other technical tools for a few years and felt they came in handy in everyday life, especially in quieter environments. In situations with too much noise, they could turn them off. The hearing aid had given them the chance of a normal life. Some informants had also had a chance to hear surrounding sounds, sometimes unwanted but also enriching, such as bird song. The several years of experience of daily use meant that some felt ‘handicapped’ without aids: ‘the hearing aid is a part of me... come back to a more normal life... I can stay in environments that were difficult before, when I couldn’t hear’. Other technical aids such as conference aids and adapted mobile phones could be experienced as difficult to handle and could be distracting during conversations, but conference aids could also make a big difference:

[a meeting in the workplace]. . . was amazing, I could hear everything, everyone who sat further away and commented. . . I always missed that before. Now I heard them all. I could participate in a completely different way. Instead of sitting crouched up like this, I could participate and have a discussion. It was an enormous difference. . . It was completely different to be able to participate in the entire conversation.

### *...to transform one’s personality and identity*

When the hearing impairment was a fact, it could cause different experiences. It could cause crises with denial and great worry, be received with relief and a confirmation of what the informants suspected and had sought help for, or more reflective, as:

...I was a bit worried that I would end up in avoiding behavior and withdraw too much. . . I wanted to try to adapt to my problem and live with it. . .rather than let it have too much influence on my life.

Realizing that one has a permanent hearing limitation could cause sadness over having lost important parts of oneself and one’s identity, such as spontaneity and ability to make contact with others, and not being able to live fully in the future.

The experience of being an outsider was not only caused by the personal difficulties with hearing; the hearing problems could also cause anxiety among acquaintances, which hampered them in these contacts. Sometimes the communication difficulties seemed to make some conversation partners bored, which led to a break in contact. Less social contact and fewer acquaintances were common experiences for all informants.

A recurring experience was the obvious uncertainty and worry that contact with others usually entailed. Even after a conversation, doubts might arise as to whether they had actually perceived everything correctly. The uncertainty could make them withdraw and become passive because they lost the train of thought and were unable or unwilling to find it again.

The worry about worsened impairment in the future was not allowed to affect everyday life. Those who had experience of markedly more impaired hearing for the past few years lived with the knowledge and had started to learn sign language. One of the informants described his situation:



...this is a journey and I don't know where it ends, so... it's very hard and difficult, but also interesting and rewarding... difficult to know how one handles different situations, maybe mentally above all. If you see it as possibilities or threats. During the whole process, I have had high hopes that I will be able to see possibilities rather than threats. But there is always a constant feeling that this won't work. It pops up and I try to push the feeling away and be over it and handle it. My goal is to overcome the feeling eventually and feel that my feet are steady under me.

Changes on a personal level were described as reserved behaviour and passivity in social contexts, which had not been typical for them as individuals before the hearing limitation. Their possibilities for spontaneity and improvisation had lessened, such as making jokes and contributing to a good mood. In spite of trying to fend off these changes, informants were still forced to accept the conditions that the hearing impairment set for their self-image.

...I tried to care as little as possible... it's not an identity you want. Much later I understand that my entire personality is characterized by the impairment... in all social contexts and the consequences thereof, how I am perceived and even how I perceive myself, it has become part of my personality.

Problems with communication and contact could lessen self-esteem. In relations with family and close friends, whose voices and conversation topics were well-known and the points of contact were numerous, changes were not as prominent. For some informants, plans for future work and career had been cut short by the hearing impairment. However, the forced changes were not only negative. They had meant that new insights and skills had emerged, such as improved ability to listen actively and remember things, or handle stress. Informants had changed their priorities based on what was important in life, such as: '...thinking about what the purpose of life is... it is more important to feel close to others and friends than work and career and things like that'.

## **Discussion**

The purpose of this descriptive study was to gain a deeper understanding of what an acquired, moderate hearing impairment meant in daily life for middle-aged men. The informants in this study constituted a heterogeneous group regarding education, occupation, family relations and other health problems. They shared a period in the lifespan – mid-life – and had reached a social and professional base and had acquired quite a lot of life experience. On the surface, their lives were similar to other men's lives, with duties towards family and society. When the hearing limitation appeared, often from nowhere, they were completely unprepared. Hearing problems and consequences thereof were not part of their life plan and the purpose they had given their lives. Experiences of living with the impairment, how life had previously turned out and how changes had affected them were well described in the interviews. Out of their lived experience, the meaning of living with hearing impairments emerged based on three inter-related themes.

A 'never-ending striving for genuine connections' was embedded in the men's descriptions. Uncertainty about what was actually going on around them shaped their everyday life. The personal strategies and technical aids were not always enough and they could neither control the speaker's way of expressing him-/herself, nor the

surrounding sounds. The three themes that emerged were inter-related so that flaws in exchange and contact with others motivated the use of personal strategies and aids. This increased the exchange of conversation in many situations. If no meaningful connection was created, emotional responses might arise, especially if the contact was considered important. Previous experiences of conversations that were difficult to perceive, and the disappointment felt then, could hamper the tries to make contact and the use of different aids. This caused a vicious circle. The results of the present study can be compared to a phenomenological study by Herth (1998), where the core theme was formulated as the metaphor ‘dance with. . .’; i.e., a constant movement with different contents and an uncertainty about the next step. The themes of the dance were constituted by, for example, loss, fear and courage to change on the way to integrating the hearing loss in one’s life. Both studies show that hearing impairment might cause insecurity and multi-faceted adaptations for many years.

This period in life – mid-life – implied for the men a lot of social activities in work, family and leisure time, encountering well-known people and strangers in different situations and surroundings (Lachman 2004). This demanded much sensitivity of hearing and flexibility. Support from technical aids was often not available in different settings. Expectations from significant others, some even dependent on them, and personal demands in handling the many and shifting roles, could be stressful and cause disappointment. Support from a partner and shared responsibility in daily businesses and general welfare could facilitate living with a hearing impairment; men who lacked support from a partner and were unemployed, seemed to focus more on the hearing impairment and seemed to be more vulnerable.

The insecurity that the hearing impairment causes is based on the fact that the men have shared meaning with others through spoken language. When this natural oral kinship is disrupted by the hearing loss, the exchange between individuals is affected, as this means ‘meeting half way’. When both the verbal facts and the relationship between individuals, which are essential parts of communication, are affected by one of the individuals’ hearing problems, the exchange is decreased for both. For the affected person this can result in anxiety, stress and fatigue (Boström 2008; Danermark 2005). However, hearing aids can, in many situations, improve the exchange and also reduce the psychosocial strains for the hearing-limited person (Kricos et al. 2007).

The connection with others can, according to the phenomenologist Merleau-Ponty (2002, 228), be explained as follows:

As soon as man uses language to establish a living relation with himself or with his fellows, language is no longer an instrument, no longer a means; it is a manifestation, a revelation of intimate being and of the psychic link which unites us to the world and our fellow men.

This can be understood in the sense that the exchange and connection with other individuals may have a meaning besides that of the spoken language and thus explain the urgency of good enough hearing. Difficulties in hearing weaker everyday sounds, which give a feeling of security, may interfere with the feeling of being connected to others and the world. In order to have better and more secure contact with the audible and elusive world, hearing aids were essential for the men, and were considered a part of them. From a phenomenological approach, the hearing aid can

be seen not only as an object, but as an extension of the body and a means to extend and reshape the life-world, much like the white cane for a blind person (Merleau-Ponty 2002).

In the present study, there were occasions when existence had faltered and thoughts had occurred about what the future would be like for participants as hearing-impaired persons. Existential thoughts were especially prevalent during periods of uncertainty about the progression of the impairment or when chances to solve everyday problems in life seemed exhausted. Feelings, such as apparent worry, anger and resignation could be linked to these lived and threatening occasions. To become an outsider to working life owing to the impairment, with everything that it entails financially and socially, was also experienced as a threat to existence. Such periods are similar to recurring crisis reactions. Even if there are differences between the handicaps of blind and hearing-impaired individuals, their experiences can be compared. Jeppsson Grassman (2000) showed, in longitudinal studies of seriously sight-impaired and blind persons, that they went through recurring crises in life. The constant adaptations or phases of life changes, which had emerged in the studies of hearing-impaired people, could also, in a life perspective, be seen as a consequence of recurring crises (Gullacksen 2002). The common crisis theory which describes a course of concurrent phases related to a personal trauma is not applicable to the hearing-impaired men in the present study, as they are constantly part of a process of adaptation and change.

The men in the present study had made changes which had increased their contact with the surrounding world. They had developed different personal strategies and used technical aids daily. They were prepared for the fact that the future might require further changes from them. Family and next of kin, as well as participating in hearing rehabilitation, might have given them cause and support for changing and restructuring of their lives. The threats to the social identity and the shame and stigma of being hearing impaired that have been shown in other studies (Hallberg and Carlsson 1991; Héту 1996) were not prominent in the current study other than as temporary, emotional responses. Neither was behaviour in difficult listening situations, which was required to uphold a normal identity; i.e., to control or avoid the social stage, apparent in the men's experiences over time (Hallberg and Carlsson 1991; Héту 1996). Both structural and person-related differences could have affected the results in the present study. The information about sound, hearing and hearing limitation is much more widespread today compared with 20 years ago when the referred studies were carried out, and this fact may have a positive influence on both those affected and their significant others. Furthermore, the education level in the studied groups may have been different. In the present study, the level of education was high and comparable with the population in the region, which is among the highest in the country (Statistics Sweden 2006). Also Helvik, Jacobsen and Hallberg (2006) found that hearing-impaired men with higher education had fewer difficulties in comprehending sounds and speech and a more varied use of coping strategies such as verbal, non-verbal and maladaptive. Planning for contacts and conversations was a form of conscious strategy for the men in the current study, which increased the exchange and the meaning. Choosing not to start or follow through a conversation which they could not change the conditions of was also a conscious choice in some situations. This way of acting was similar to the finding in a study by Andersson and Hägnebo (2003) where hearing impaired men and women reported frequent use of planned problem-solving and self-controlling coping strategies and less frequent use

of escape/avoidance strategies. When escape/avoidance coping was reported, there was also a high sensitivity to anxiety reactions. In the present study this is comparable to the 'vicious circles' that experiences of disconnection could cause and then give rise to avoidance.

Since the hearing impairments had been acquired and had lasted for a few years, there was also a time perspective – before the hearing impairment, the first few months, now and the future. In that perspective, the men felt that their identity and personality changed. The difference was that contact and conversations with others meant an extra dimension beyond the performance itself. Many frequent and spontaneous meetings within a limited time-span were strenuous and tiresome. Daily life increased demands for preparation for change and adaptation both for the hearing-impaired person and the next of kin (Fredriksson 2001; Herth 1998).

From a phenomenological approach, illness can be seen as an unhomelike being-in-the-world, based on the theories of philosophers Heidegger and Merleau-Ponty, according to Svenaeus (2000a, b). The afflicted body, which is oneself, becomes uncanny and unhomelike. The meaning patterns with the surrounding world through feelings, thoughts and actions, no longer work. The experienced body is comparable to a broken tool which disrupts the exchange. To feel homelike again and to find a new way of being-in-the-world then becomes a long process, especially with chronic illness and physical handicaps (Svenaeus 2000a, b). The striving for stability, to find homelikeness, as a person with a hearing impairment was an unfinished task in the men's experiences in the present study. It could mean periods of relatively good balance in everyday life, and other more turbulent periods that threatened their existence. They also described how the changes meant that new skills developed in time, which changed their attitude towards life and also enriched their existence. Similar findings of a threatened existence and a changed life-world were evident in other studies (Herth 1998; Karlsson Espmark and Hansson Scherman 2003).

Increased knowledge of people's specific life situations is needed in hearing rehabilitation for individuals who acquire a moderate impairment in middle-age. Above all, the current and the referenced studies show that making work and life changes is a multi-faceted, complex and life-long process. The World Health Organization's (2001) International Classification of Functioning, Disability and Health cannot be expected to capture these processes on an individual level and in the capricious, complex environment. The hearing-impaired individuals and their next of kin can, at different points in life, have a need for psychological and/or psychosocial support in order to find new patterns of action and reshape their lives. Rehabilitation might, therefore, not aim to restore full functions, but more to give pre-requisites for as good functions and quality of life as possible during the entire life-span. In Sweden, as in many countries, rehabilitation has above all been aimed at compensating for the hearing impairment using technical aids and, marginally, at learning to live with it (Danermark 1998). Therefore, the access to psychological and psychosocial competence needs to be increased (cf. Danermark 2005) and support offered to men in mid-life with acquired hearing impairments in order to promote health and participation in working life and society.

### **Methodological considerations**

A limitation in the present study might be the sampling. However, like other phenomenological research the sample in this study was small and purposely

selected. The intention was to capture the essence of lived experiences of the phenomenon. The informants chosen were willing and able to share their daily life and the interviews gave rich data but we cannot claim that we have captured all possible perspectives of the phenomenon. As generalization is not relevant in qualitative studies the question is rather about fittingness. According to the sampling process, we assume that the findings can be applicable to other men in the same life situation.

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### References

- Andersson, G., and C. Hagnebo. 2003. Hearing impairment, coping strategies, and anxiety sensitivity. *Journal of Clinical Psychology in Medical Settings* 10, no. 1: 35–9.
- Boström, G. 2008. *Hälsa på lika villkor* [Health on equal terms]. R 2008:17. Östersund, Sweden: Swedish National Institute of Public Health.
- Colaizzi, P.F. 1978. Psychological as the phenomenologists view it. In *Existential-phenomenological alternatives for psychology*, ed. R.S. Valle and M. King, 48–71. New York: Oxford University Press.
- Dahlberg, K., and H. Dahlberg. 2004. Description vs. interpretation – a new understanding of an old dilemma in human science research. *Nursing Philosophy* 5, no. 3: 268–73.
- Danermark, B. 1998. Hearing impairment, emotions and audiological rehabilitation: A sociological perspective. *Scandinavian Audiology* 49: 125–31.
- Danermark, B. 2005. A review of the psychosocial effects of hearing impairment in the working population. In *The impact of genetic hearing impairment*, ed. D. Stephen and L. Jones, 106–36. London: Whurr Publishers Ltd.
- Danermark, B., and L. Coniavitis Gellerstedt. 2004. Psychosocial work environment, hearing impairment and health. *International Journal of Audiology* 43: 383–9.
- Demorest, M.E., and S.A. Erdman. 1987. Development of the communication profile for the hearing impaired. *Journal of Speech and Hearing* 52: 129–43.
- Erdman, S.A., and M.E. Demorest. 1998a. Adjustment to hearing impairment I: Description of a heterogeneous clinical population. *Journal of Speech–Language–Hearing Research* 41: 107–22.
- Erdman, S.A., and M.E. Demorest. 1998b. Adjustment to hearing impairment II: Audiological and demographic correlates. *Journal of Speech–Language–Hearing Research* 41: 123–36.
- Fog, J. 2004. *Med samtalen som utgångspunkt* [Using conversation as a basis]. Oslo, Norway: Akademisk forlag.
- Fredriksson, C. 2001. *Att lära sig leva med förvärvad hörselnedsättning sett ur par-perspektiv – om anpassningsstrategiers funktionella och sociala innebörder* [Learning to live with acquired hearing impairment seen from the perspective of couples – on the functional and social meaning of adapting strategies]. PhD diss., The Swedish Institute for Disability Research.
- Garstecki, D.C., and S.F. Erler. 1996. Older-adults' performance on the Communication Profile for the Hearing Impaired: Gender difference. *Journal of Speech–Language–Hearing Research* 42: 785–96.
- Gordon-Salant, S., J. Lantz, and P. Fitzgibbons. 1994. Age effects on measures of hearing disability. *Ear and Hearing* 15: 262–5.
- Gullacksen, A-C. 2002. *När hörseln sviktar. Om livsomställning och rehabilitering* [When hearing fails. On life change and rehabilitation]. Malmö, Sweden: Universitetssjukhuset MAS.

- Hallberg, L.R-M. 1998. Evaluation of a Swedish version of the Hearing Disabilities and Handicaps Scale, based on a clinical sample of 101 men with noise-induced hearing loss. *Scandinavian Audiology* 27: 21–9.
- Hallberg, L.R-M., and S.G. Carlsson. 1991. A qualitative study of strategies for managing a hearing impairment. *British Journal of Audiology* 25: 201–11.
- Hallberg, L.R-M., U. Hallberg, and S.E. Kramer. 2008. Self-reported hearing difficulties, communication strategies and psychological general well-being (quality of life) in patients with acquired hearing impairment. *Disability and Rehabilitation* 30: 203–12.
- Helvik, A-S., G.W. Jacobsen, and L.R-M. Hallberg. 2006. Life consequences of hearing loss in terms of activity limitation and participation restriction. *Scandinavian Journal of Disability Research* 8, no. 1: 53–66.
- Herth, K. 1998. Integrating hearing loss into one's life. *Qualitative Health Research* 8, no. 2: 207–23.
- Hétu, R. 1996. The stigma attached to hearing impairment. *Scandinavian Audiology* 25, suppl.43: 12–24.
- Jeppsson Grassman, E. 2000. 'Man vet aldrig hur länge det håller!' Kronisk sjukdom och funktionshinder från ett långsiktigt perspektiv ['You never know how long it will last!' Chronic illness and disability in a long-term perspective]. In *Ett liv som andra. Livsvillkor för personer med funktionshinder* [A life like everyone else. Living conditions for persons with disabilities], ed. P. Brusén and L.C. Hydén, 182–210. Lund, Sweden: Studentlitteratur.
- Jones, L., J. Kyle, and P.L. Wood. 1987. *Words apart: Losing your hearing as an adult*. London: Tavistock Publications.
- Johansson, M.S.K., and S.D. Arlinger. 2003. Prevalence of hearing impairment in a population in Sweden. *International Journal of Audiology* 42: 18–28.
- Karlsomose, B., T. Lauritzen, M. Engberg, and A. Parving. 2001. A randomised controlled trial of screening for adult hearing loss during preventive health checks. *British Journal of General Practice* 51: 351–5.
- Karlsson Espmark, A-K., and M. Hansson Scherman. 2003. Hearing confirms existence and identity – experiences from persons with presbycusis. *International Journal of Audiology* 42: 106–15.
- Kramer, S.E., T.S. Kapteyn, J.M. Festen, and H. Tobi. 1996. The relationship between self-reported hearing disabilities and measures of auditory disability. *Audiology* 35: 277–87.
- Kramer, S.E., T.S. Kapteyn, and T. Houtgast. 2006. Occupational performance: Comparing normally-hearing and hearing-impaired employees using the Amsterdam Checklist for Hearing and Work. *International Journal of Audiology* 45: 503–12.
- Kricos, P.B. 2000. The influence of nonaudiological variables on audiological rehabilitation outcomes. *Ear and Hearing* 21, suppl. 4: 7–14.
- Kricos, P.B., S. Erdman, G.W. Bratt, and D.W. Williams. 2007. Psychosocial correlates of hearing aid adjustment. *Journal of the American Academy Audiology* 18: 304–22.
- Lachman, M.E. 2004. Development in midlife. *Annual Reviews of Psychology* 55: 305–31.
- Merleau-Ponty, M. 2002. *Phenomenology of perception*. New York: Routledge. (Orig. pub. 1945.)
- Sandelowski, M. 1986. The problem of rigor in qualitative research. *Advances in Nursing Science* 8, no. 3: 27–37.
- Statistics Sweden. 2003. *Funktionshindrade 1988–1999. Levnadsförhållanden* [Disabled persons 1988–1999. Living conditions]. Rapport 97. <http://www.scb.se/statistik/LE/LE0101/2000I02/LE97SA0301.pdf>
- Statistics Sweden. 2006. *Levnadsförhållanden* [Living conditions]. [http://www.scb.se/Statistik/LE/LE0101/\\_dokument/LE0101\\_BS\\_2006.pdf](http://www.scb.se/Statistik/LE/LE0101/_dokument/LE0101_BS_2006.pdf)
- Stephens, D., I. Gianopoulos, and P. Kerr. 2001. Determination and classification of the problems experienced by hearing-impaired elderly people. *Audiology* 40: 294–300.
- Svenaesus, F. 2000a. Das unheimliche: Towards a phenomenology of illness. *Medicine, Health Care and Philosophy* 3: 3–16.
- Svenaesus, F. 2000b. The body uncanny: Further steps towards a phenomenology of illness. *Medicine, Health Care and Philosophy* 3: 125–37.
- World Health Organization. 2001. *The International Classification of Function, Disability and Health, ICF*. Geneva, Switzerland: WHO.