



## DOCTORAL THESIS

### Being 'heard' in the counselling relationship. An investigation into the experience of hard of hearing clients

Knight, Sarah

*Award date:*  
2011

*Awarding institution:*  
University of Roehampton

#### **General rights**

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal ?

#### **Take down policy**

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

**Being 'heard' in the counselling relationship. An investigation into the experience of hard of hearing clients.**

**by**

**Sarah Knight**

*A thesis submitted in partial fulfilment of the requirements for the degree of PsychD.*

**Department of Human and Life Sciences**

**University of Roehampton**

**2011**

*For Mum*

## **Being 'heard' in the counselling relationship. An investigation into the experience of hard of hearing clients.**

### **ABSTRACT**

This qualitative study concerns the notion of being 'heard', with a focus on the counselling relationship. The term 'hearing' is used as a metaphorical concept and its definition forms part of the investigation. The study initially focuses on the hard of hearing client and their position between the Deaf and hearing worlds. Hard of hearing people are viewed as an important client group whose needs are frequently overlooked. There is a review of the literature relevant to the hard of hearing individual and disability in the counselling relationship. This is followed by a broader consideration of the meaning of 'hearing'. Included in this literature is 'hearing' from the perspective of developmental psychology relating to non-verbal communication, 'hearing' through language and 'hearing' the other. Following a methodological discussion, an adapted Foucauldian discourse analysis is applied to interview data from nine hard of hearing participants. The findings illustrate dominant discourses in action and also discourses of resistance. The dominant discourses suggest the power and politics involved in the counselling venture and the resistance shows the alternative subject positions the participants created and their agency in the process of being 'heard'. Following this analysis, a discussion develops, which involves ideas around embodied and ethical 'hearing' in both the research process and within counselling. The study does not aim to provide any stability to the notion of 'hearing' in the counselling relationship, but contributes to the field of counselling psychology in creatively exploring the ambiguous term.

## Chapter 1

### INTRODUCTION

A description of the development of the research question introduces this study and provides context for the subsequent chapters. Within the research question, hard of hearing clients have continually been a focus, but the theme of being 'heard' in the counselling relationship in a general sense, is something which gradually emerged. This resulted in the hard of hearing clients being conceptualised as an example group to aid the exploration of 'hearing' in the counselling relationship. There was a progression from initially wanting to explore how hard of hearing clients can be understood as a client group with distinct needs, to using the concept of 'hearing' as a metaphor to describe the therapeutic process. From this, the concept of 'hearing' emerged as an increasingly complex and ambiguous term when observing literature about the counselling relationship. Therefore in addition to a focus on the hard of hearing client, the concept of 'hearing' gained precedence in what was to be investigated.

The impetus for this study has its roots in a combined personal and professional concern. The researcher's mother defines herself as hard of hearing. Subsequently, the researcher has become curious about her individual experiences in the world, which includes being a client in the counselling relationship. What has emerged from attempts to understand life for her is the dilemmas faced when standing between the Deaf and hearing worlds, which often results in a double exclusion. As someone who does not rely on sign language, she is not fully part of the Deaf world, whilst in the hearing world her difficulty with following speech means she faces a different type of segregation. With reference to the counselling relationship, her fear

prevails that in this scenario her experience will be misunderstood or her needs will be unmet, which may be partly as a result of the dominant forms of knowledge connected to hearing and deafness which are so ingrained within society and are therefore likely to be held by the counsellor. Also, in a therapeutic dyad in which a hard of hearing person meets a hearing counsellor, practical communication difficulties may be involved which might increase the opportunities for the counsellor to misunderstand the needs of the client. Therefore the specific experiences of hard of hearing clients and their individual communication needs might especially challenge the counsellor's ability to 'hear'.

Within this study the broader concept of 'hearing' in the counselling relationship is taken into consideration. It is likely that every client has the desire to be 'heard' and not just those individuals who might fear their experiences are more difficult to understand or manage due to a specific disability. This is matched with the predominantly unchallenged assumption from the other side of the therapeutic dyad that 'hearing' the client is an integral element in the counselling process, suggesting it is ultimately achievable. The therapeutic relationship is frequently defined as developing through the counsellor's empathic attunement, indicating the client's experience is being increasingly understood. For example, in a description of counselling delivered by the British Association of Counselling and Psychotherapy is the statement:

*'By listening attentively and patiently, the counsellor can begin to perceive the difficulties from the client's perspective.'*

(<http://www.bacp.co.uk/education/whatiscounselling.html>).

There may be specific difficulties in the counselling process for the hard of hearing client, but there can also be challenges against the assumption that any client is able to be 'heard' and what this process of 'hearing' actually means.

The chapters following this introduction are as follows: Theory, Chapter 1, will define the terms of the research question and summarise a literature review with the aim of contextualising the study. The literature will initially relate to the hard of hearing client and disability in the counselling relationship, and then explore wider literature concerning the notion of 'hearing' another. There is a deconstruction of the concept of 'hearing' as it is traced back to a starting point in developmental psychology, as the seeds of communication and relationship are planted in the first stages of life. Childhood development is positioned in relation to an adult therapeutic encounter and how different modes of communication may aid or limit 'hearing' the other. The literature develops to introduce the functions of language including an observation of its power as an organisational system (Hui & Stickley, 2007). This leads to a more thorough exploration of how members of society are separated, the role of language in an achievement of this and whether counselling must be an element of this dominant social process. This is shown to have relevance for all clients who may face normalising judgements whether they have a disability or not. Alongside this literature is a philosophical debate about the nature of reality and whether the 'truth' of another person can be 'heard'. The notion of 'hearing' also expands to incorporate the idea of 'otherness', involving the challenge that difference and the recognition of a true 'other' is necessary to 'hear' in an ethical way.

The Methodology follows in Chapter 2, in which the journey as to how to research the concept of 'hearing' is explored. There are methodological arguments against positivism and phenomenology and language emerges as the most appropriate focus of analysis. This is partly due to a criticism of how the role of language is often ignored in research and also the power of language being recognised in the Theory chapter in relation to how individuals are classified and grouped. Therefore discourse analysis, based on the ideas of Foucault, was the chosen Method. This was in contrast to attempting to access any truths amidst what was spoken about in the interviews and enabled an observation of the discourses available to the hard of hearing clients. In addition to the traditional Foucauldian discourse analysis, the methodological arguments develop to justify incorporating additional analysis involving the potential resistance of the participants in response to the dominant discourses. This development of method allowed for the consideration as to whether clients can be 'heard' beyond the dominant discourses available to them. The subsequent Method is Chapter 3, which will document the practicalities of the data collection, including any ethical considerations, and summarise the analysis process.

Chapter 4 follows, with a thorough description of the analytic process and a consistent link provided between data from the hard of hearing clients and any individual in the counselling relationship. Chapter 5 presents a discussion. This chapter includes a summary and development of the data analysis, together with an extensive consideration of alternative ways of 'hearing' in counselling and research that emerged through reflection and criticism of the research carried out. This involves a consideration of less conventional therapies that do not place the verbal as the dominant source of communication and encourage 'hearing' with greater



depth. Literature on embodied therapies results in a critical stance towards a counsellor only 'hearing' their clients through words, but this additional form of therapeutic communication is viewed as providing alternative constructions of the client's reality, as opposed to accessing any truths of their experience. This also generates suggestions as to further possible research using refined methods of discourse analysis in which the body and non-verbal communication can be an additional focus of study. Also within the discussion is an acknowledgment of the limitations of the research, and suggestions as to the study's contribution to the field of counselling psychology.

## Chapter 2

### THEORY

This chapter will firstly define the key elements of the research question to provide greater clarity to what is being studied, before summarising the related literature. The literature will document other pieces of research relevant to this area, therefore providing a clear context for this study.

#### Definition of terms

##### Hard of hearing

According to the Royal National Institute for the Deaf (RNID) ([www.rnid.org.uk](http://www.rnid.org.uk)), the label 'hard of hearing' is used to describe people with a mild to severe hearing loss and usually individuals who have lost their hearing gradually, although this is not always the case. There are differences between people who have lost their hearing in later life and those who are born hard of hearing. Also, two individuals may have a similar biological hearing loss, but the one who is born into a hearing family might identify themselves as hard of hearing whilst the other born into a deaf signing family might describe themselves as Deaf. By convention, 'deaf' refers to an audiological condition or absence of hearing, whilst 'Deaf' means culturally deaf and implies membership of a community (Luey et al., 1995). The RNID ([www.rnid.org.uk](http://www.rnid.org.uk)) refers to the Deaf community as encompassing people whose first or preferred language is British Sign Language and those who consider themselves part of the Deaf Community may describe themselves as Deaf with a capital 'D' to emphasise their Deaf identity. These designations will be used throughout this study.

### **The counselling relationship**

The term 'counselling' can relate to several disciplines, but in this study it refers to the therapeutic encounter between a psychological therapist and their client. The focus of this study is the therapeutic dyad of counselling, psychotherapy and counselling psychology and the use of the term 'counselling' will refer to all of these.

### **Being 'heard'**

As opposed to the term 'hearing' referring to the audiological ability, this study uses it as a broad description of a process involved in a human encounter, and more specifically in the counselling relationship. A variety of suggestions as to the meaning of being 'heard' are explored throughout this study and this may generate possible definitions for this ambiguous term.

### **Literature**

The literature review is divided into two sections. The first deals with the more clearly definable parts of the research question, namely the hard of hearing client, and disability in the counselling relationship. This will involve an explanation as to why hard of hearing clients have been specifically chosen to be investigated. This client group is then placed in the context of disability and how disability connects to the counselling relationship, which includes literature debating the type of counsellor required.

The second part of the review covers literature relating to the more ambiguous term of 'hearing'. As there is no universally accepted definition, it is put into context through a selection of literature relating to particular conceptualisations of 'hearing'.

This rests on the researcher's interpretation and 'hearing' could have been talked about in alternative ways to provide background to this study. In order to put the notion of 'hearing' in the counselling relationship into perspective, any person 'hearing' another person provides the starting point. This begins with literature which explores how communication develops from birth, including the importance of the non-verbal and language. This leads to a summary of philosophical literature on 'hearing' which challenges the notion of truly understanding another, suggesting communication only enables constructions of reality.

From this grounding of the concept of 'hearing', the focus shifts to 'hearing' in the counselling relationship and literature that describes the various ways this might be attempted. As part of this, is a critical perspective that suggests the importance of difference in a therapeutic encounter which introduces the theme of being 'heard' in relation to the 'other', and 'hearing' as an ethical practice.

### **The hard of hearing client**

The hard of hearing client has been selected as the focus of this research due to their somewhat ambiguous status between the Deaf and hearing worlds. There is a lack of research relating to deaf people in counselling (Feldman et al., 2006), but significantly less involving hard of hearing people who do not associate themselves with the Deaf world. The label 'hard of hearing' encompasses a variety of hearing levels, but such individuals can be conceptualised as a group with specific needs due to their shared position between the Deaf and hearing worlds. It has been described as a common social error to assume that being hard of hearing simply means 'less deaf' or 'almost hearing' and in addition to this the hearing public often

use the word 'deafness' as an umbrella term to cover all forms of hearing loss (Harvey, 1989). The hard of hearing individual's 'state of limbo' between the Deaf and hearing worlds has been recognised as a key element to this study when considering the potential effects on the therapeutic relationship in which the field of counselling might suggest such experience can be 'heard'. This situation for the hard of hearing individual will continue to be described in the following related literature.

The psychological effects of being hard of hearing have been shown to be very distinct from the hearing population, but also seem to be qualitatively different from the effects as a consequence of deafness (Harvey, 1989). Hard of hearing people have been suggested to have worse social relationships and are usually more isolated than the Deaf in their signing community (Fellinger et al., 2007), as whilst Deaf people often have an identity rooted in sign languages and the Deaf culture, there is no distinct hard of hearing identity, mainly due to the wide variations in hearing problems and the fact that social interactions remain mostly verbal, as opposed to using sign language (Laszlo, 1995). The Deaf world provides an opportunity for empowerment and self-actualisation as Deaf values have developed which have become part of an adaptation that challenges the majority hearing perspective (Cohen, 2003), and all of this is unattainable for hard of hearing individuals. Research has suggested there needs to be a stronger emphasis on mental health care for this group (De Bruin & De Graaf, 2005), but a lack of common identity for hard of hearing people has been shown to confuse society's perceptions of hearing loss and therefore negatively influence efforts to intervene (Laszlo, 1995). The individual might describe their disability in many different ways and the difficulty

with the definition can become a barrier, as they may be grouped with others who share the disability but experience it in a vastly different way (Corker, 1995). To illustrate the diversity, Byre (1998) lists the many factors that influence individual experiences, such as personal perspective on hearing loss, the family constitution, age at onset, hearing function and use of technology, such as hearing aids. Overall, this suggests hard of hearing people are in a situation where they seemingly require support due to the unique nature of their experience of disability, but added to this is evidence that this group is less likely to ask for help (De Bruin & De Graaf, 2005). People who have been hard of hearing since birth may have been encouraged to deny the inevitable implications of hearing loss and developed a pseudo identity as a hearing person (Harvey, 1989) which might partly explain a reluctance to ask for support. Another assumption is that the hard of hearing individual might predict any intervention would not be provided successfully and therefore they would not ultimately be 'heard'. Overall, the literature predominantly suggests that the hard of hearing individual is unable to fully access the hearing and Deaf worlds, which is a position that is often left unrecognised.

### **Disability and the counselling relationship**

Hearing loss has been described as having a subtle relationship with disability, mainly due to it being an invisible impairment (Corker, 1995), but disability in relation to counselling has been deemed an important area of literature to explore as it provides greater context for the hard of hearing client when observing the counselling relationship. The term 'disability' is associated with dominant social attitudes that often result in the relevant individual being defined by their 'impairment', which is arguably labelled as such due to our constructions of

normality, and people with disabilities have been shown to frequently conform to such attitudes (Dixon, 1977, as cited in Rosenberg, 1997). This describes the medical model of disability which emphasises the biological deficit of the person and does not recognise the barriers and prejudices within society which people with disabilities may face (Ong-Dean, 2005). The medical model has been criticised as being 'the greatest source of prejudice and stereotyping' (Read, 2001, as cited in Hui & Stickley, 2007).

The medical model is frequently applied to psychological therapy, which generates a wealth of challenges, contradictions and ethical dilemmas. The combination of medicine and counselling results in importance being placed on the practitioner's expertise and the use of an external frame of reference to determine what the client needs (Jenkins, 1999). Adopting the medical model, and therefore focusing on diagnosis and medication, prevents the challenging process of empathy and reduces attempts to deepen the understanding of a client (Breggin, 1999). It has been suggested that both client and counsellor are disempowered when the medical model dominates, as there is the communication that a human connection is inadequate to provide healing (Breggin, 1997). Medical diagnoses replace humanistic descriptions of 'problems with living' (Szasz, 1961, as cited in Breggin, 1997) and the counselling profession loses its grounding as an empathic service.

The use of the medical model suggests a powerful impact on counselling with clients with disabilities as the external frame in such a dyad would be a social climate in which deficits are labelled in contrast to our 'norm' (Harvey, 1989). If hard of hearing clients are viewed in this context, they become subjects (Feges, 2008) and there will

be an assumption that the 'problems' presented are consistently located within the client and can be 'treated' by the 'expert'. The patterns of discourse which relate to both disability and psychological therapy illustrate how people are divided from each other on the basis of different categories, which can be viewed as potentially oppressive in nature, but results in seemingly fixed social bonds (Parker, 2005).

Counselling is a broad term which encompasses a variety of ideologies and models (Jensen, 2006). Therefore this study embarks upon a greater exploration of the literature that attempts to define it. This is especially important as this study involves disability in conjunction with the counselling relationship, both of which have a variety of definitions, contradictions and complexities and their combination could become confusing. Counselling reflects the close relationship between medical and human science paradigms (Smith, 1997, as cited in Jensen, 2006). In many counselling approaches there are attempts to gain distance from the medical model as there is an appreciation of the personal, the subjective, the individual and the agentic (Allen, 1980; American Psychological Association, 1952; Howard, 1985, 1986; Meara, 1989, 1990; Thompson & Super, 1964, as cited in Howard, 1992) and the common factors approach, in which the relationship between counsellor and client is central, has been embraced by the counselling community (Wampold, Hyun-nie Ahn & Hardin, 2001, as cited in Mrdjenovich & Moore, 2004). The therapeutic relationship has been shown to be a key factor in change (Hovarth & Greenberg, 1994; Marmar et al, 1989, as cited in Lapworth et al., 2001) and accounts for dramatically more of the variability in outcomes than does the total of the other specific ingredients (Wampold, 2001). This has encouraged a 'relational' approach to counselling which requires the counsellor to not only conceptualise a client in terms of their relationships to others



and to the therapist, but to continually involve the self within the work. The relational approach has features which are not constructed from theory, but discovered and developed through the process of being with clients (Mitchell, 1988). As part of the field of counselling which this study is investigating, counselling psychology grounds itself as a science, in contrast to counselling and psychotherapy. But counselling psychology has been described as an approach that is defined by a relationship in which the client is an active partner (Tyler, 1961, as cited in Jensen, 2006), therefore a distinction from a medical model of practice is still provided.

If counselling reveals some distance from a medical model approach, this is evidence of a development of new discursive practice (Irving et al., 2005). The field of counselling has attempted to sustain awareness of society's oppression and so therapy with people who have disabilities has been shown to include more interpersonal considerations (Westwood & Nayman, 1981). There appears to be recognition that the way counsellors perceive disability can play a significant role in the therapeutic relationship (Rosenberg, 1997) and within the literature is much discussion around the essential balance between acknowledging the difference of the disability, whilst not allowing it to define the whole person (Westwood & Nayman, 1981). This is especially relevant for hearing impairment as it is an invisible disability which might encourage freedom from society's labels, but this could become detrimental when specific needs require recognition.

*'The client says, treat me like I'm not disabled, but don't forget my disability.'*

(Esten & Willmott, 1994, as cited in Rosenberg, 1997).

There is an emphasis on counsellors being aware of personal attitudes towards disabled people with an aim to see their clients as individuals to avoid stereotyping, and to view prejudices within society as problematic rather than continually viewing difficulties as rooted in the clients (Westwood & Nayman, 1981). This relates to the social model of disability that recognises how society is organised in terms of non-disabled people, which is the predicament that is viewed as problematic for the individual, as opposed to the individual themselves (Swain et al., 2003). Returning to hearing impairment, as there is no single 'psychology of the deaf' there is the suggestion that to fully understand the individual hard of hearing client there needs to be a thorough and deep understanding of the process that has led them to therapy which allows for the individual to be seen (Clark, 1998, as cited in Williams & Abeles, 2004). With an awareness of the potential problems associated with the medical model in counselling people with disabilities, an interpersonal therapy has been described as involving an element of 'sitting with uncertainty' (Blotzer & Ruth, 1995, as cited in Rosenberg, 1997) as there is mutual self-discovery between the counsellor and client when the role of 'expert' is removed. The counsellor is encouraged to reflect on themselves and challenge society's perceptions, and there might also be the recognition that in a therapeutic dyad where the client has difficulty hearing the counsellor, both can be viewed as disabled in some way (Harvey, 1989).

Alongside this literature portraying counselling as an interpersonal venture that does not oppress, are suggestions that such a therapeutic approach is not always achieved. Therefore an interpersonal therapy is often viewed as an 'ideal type' amidst fluidity within the practice as there is a continuum between medical and interpersonal models within counselling (Jenkins, 1999). An appreciation of the

individual and the subjective does not rest easily with traditional forms of explanation in science (Howard, 1992) and there is therefore tension with the medical model. There is evidence of the medical model in the diagnosis of disorders in counselling and the focus on specific techniques as having efficacy connected to positive outcomes (Jensen, 2006). This has been shown to be especially evident in the practice of counselling psychology, which Wampold (2003, as cited in Jensen, 2006) speaks of:

*'We have roots in development rather than pathology, yet we hunger for parity with clinical psychology, adopt the language of medicine... desire prescription privileges, and envy those who bask in the scientific aura of the medical model.'* (p. 38).

Language has been suggested as one of the prominent reasons for the prevalence of the medical model in the field of counselling (Jensen, 2006). The particular words used often reveal or influence various assumptions, such as 'disorder', 'diagnosis', 'symptoms' and 'treatment', which are all medically based and are incorporated into the field of counselling (Perlman, 1982; Wampold, Ahn & Coleman, 2001, as cited in Jensen, 2006). This all suggests the presence of conflicts within the practice of counselling relating to how the client is depicted and according to the counsellor's theoretical framework.

In relation to disability, there have been several counselling approaches that have emerged in response to the power dynamics involved in counselling which have been associated with the medical model. These include feminist and multicultural

approaches (McLeod, 1998, as cited in Swain et al., 2003), but there are far less that incorporate the social model of disability (Swain et al., 2003). In fact, counselling for people with disabilities has often been shown to be based on what professionals think the client wants (Dixon, 1977, as cited in Rosenberg, 1997) and pre-understandings associated with a certain diagnosis are often imposed on the therapy (Greenwood, 2008). This may emerge in the form of oppression within counselling for the disabled client, such as a counsellor assuming any relationship problems are continually caused by the client's disability or being unable to understand refusal for surgical intervention to 'normalise' (Reeve, 2000, as cited in Swain et al., 2003). If the social attitudes relating to disability have been internalised by the client, it has been suggested that psychological conflict can develop with a fear that the counsellor will match the ingrained beliefs of society (French, 1996, as cited in Rosenberg, 1997). There also appears to be a fundamental tension between the social model of disability and the individualism of psychological therapy as when the client is viewed apart from their social context, the oppression of people with disabilities is disavowed (Swain et al., 2003). A social approach to counselling would recognise that:

*'...in a counselling relationship, a reliance only on psychological concepts and language restricts what can be said and the kinds of stories that can be told.'*  
(McLeod, 1999, p. 221, as cited in Swain et al., 2003).

Within the ideology of individualism that has been suggested to prevail in counselling, there is the possibility that the hard of hearing client's unique position between the Deaf and hearing worlds will be unrecognised if a social model of

disability is not involved. Therefore it seems that the counsellor's personal awareness and sustained efforts to recognise the individuality of the hard of hearing client alongside the group oppression that occurs from the rest of society is a goal that is not continually achieved. The way disability is viewed within society, together with the values of individualism and the medical model, can be argued to be the predominant ways hard of hearing clients are 'heard' in the counselling relationship.

Connected to the literature around the approaches to counselling that reduce the oppression of clients with disabilities, are theories about the influence of the type of counsellor involved. As there are few people with disabilities entering the counselling profession (Segal, 1994), there is likely to be a lack of specialist knowledge of hearing loss and therefore many cross-cultural therapeutic dyads. Tower (1995, as cited in Hales, 1995) describes culture as not just being related to ethnicity or race, but also disability, and it is not necessary to find agreement among people with disabilities for them to be identified as a cultural group, which can perhaps be associated with hard of hearing people who reveal so much diversity but have been conceptualised as a group within this study. This relates to literature that debates whether cultural competence is required for successful therapy (Weaver, 1999), or cultural sensitivity is adequate (Hatfield and Lefley, 1993). Research into counselling clients with disabilities often concludes that a certain type of counsellor is required in order to work most effectively. For example, Nosek, Fuhrer and Hughes (1991) found that counsellors with disabilities were rated more favourably by disabled clients, particularly when the content was about disability. If the counsellor does not have a disability, studies have suggested that cultural competency still needs to be gained. For example, Westwood & Nayman (1981) suggested that

although the personal needs of a client with a disability may not be significantly different to those of a non-disabled person, working knowledge of implications of disability will strengthen the therapeutic relationship. Also relating to the knowledge and skill of the therapist, Cohen (2003) observed the perceptions of the hearing impaired client towards mental health care and found there to be prejudices amongst providers and little cultural understanding of hearing impairment. Consequently, this study championed a need for integrated knowledge of the social stigma of deafness including specific challenges that impact identity and self-esteem, alongside an understanding of the meaning of the particular deafness for the client (Cohen, 2003). Finally, Robertson (1999) investigated counselling with clients who have an acquired hearing impairment and in line with the previous studies, specific knowledge and awareness were found to be important when working with such a client group. This final study is especially relevant as it involved clients who would not usually be part of the Deaf world and may define themselves as hard of hearing. These studies all suggest a particular counsellor would be able to 'hear' a client with a disability with greater success.

Specific to a client with a hearing loss are the practical difficulties involving communication in counselling which might suggest an increase in possibility of the hard of hearing client not being 'heard'. Communication problems have been shown to hinder the development of a therapeutic alliance and increase the likelihood of therapy drop-out (Halgin & McEntee, 1986, as cited in Williams & Abeles, 2004) and there is the possibility that patterns of misunderstanding and isolation are repeated for the hard of hearing client (Pollard, 1998; Schirmer, 2001, as cited in Williams & Abeles, 2004). The client may need to temporarily adopt a different role in the

therapeutic relationship if they are required to take responsibility in explaining to their counsellor how to communicate most successfully, which has the potential to change the dynamic (Rosenberg, 1997). Withers (1995, as cited in Hales, 1995) explains how some disabled clients report spending too much time educating their counsellor, and with an invisible impairment, the education required for counselling to be effective may need to be greater as any adaptations could be less obvious. Education might include practicalities within the therapy sessions such as lighting, distance between counsellor and client, and how to speak most clearly. In Robertson's (1999) study of clients with an acquired hearing loss, great importance was placed on the counsellor being able to adapt various practicalities in order to aid communication (Robertson, 1999). Hard of hearing people expend much energy focusing on the lips to maximise lipreading effectiveness and as this takes attentional priority, extreme physical and mental exhaustion is commonplace (Wax & DePietro, 1984), suggesting that a counsellor who is difficult to lipread will create increased pressure for the hard of hearing client. Therefore as well as the psychological experience of being between the Deaf and hearing worlds, the practical communication issues appear to be of great relevance in the counselling relationship for the hard of hearing client and a misunderstanding of their needs might appear to reduce the likelihood of an experience of being 'heard'.

Overall, the literature relating to disability in the counselling relationship suggests the field of counselling recognises the oppression that is associated with the dominant discourses operating in society and efforts are made to provide a type of therapy that is distanced from the medical model through an awareness of the individuality of the client together with a recognition of how a disabled person is segregated in society.

But the extent of this being achieved has been challenged in other literature. The ingrained dominant views within society have been shown to frequently prevail in the counselling situation and as hard of hearing individuals appear to have complex and diverse experiences of disability, alongside there being clear practical implications for communication, it seems possible they would face difficulties in being 'heard'.

The challenge that society's oppression and segregation exists within the field of counselling invites a more thorough exploration as to how any client is 'heard'. The literature has suggested that 'hearing' in the counselling relationship occurs through the use of certain frameworks and mental health theories and that being 'heard' might require a specialist counsellor to fit with a particular client. This has relevance for 'hearing' any client and not just those clients with particular disabilities. In a therapeutic encounter, every individual can be seen as being conceptualised in a certain way by their counsellor and developing a relationship with someone different to themselves. This idea can expand to include all individuals in relation to others and how 'hearing' occurs. 'Hearing' can therefore be explored as a broader concept that can be universally applied and this study will provide further context for the notion. There is much literature that allows the concept of 'hearing' to develop. This is based on a discussion around the development of human communication which then leads to a philosophical argument concerning 'hearing'. This will all provide the grounding for literature that investigates 'hearing' specifically in the counselling relationship, which will also incorporate the concept of 'otherness.'



**Attempts to 'hear'**

Exploring literature that involves universal ways of 'hearing' provides the background to 'hearing' in the counselling relationship. How someone can 'hear' another is conceptualised in this study as having roots from birth as communication can be viewed as performing an essential function for humankind. Developmental psychologists place great importance on non-verbal communication in the development of the individual in relation to others, before language is acquired (Beebe & Lachman, 2003). Within developmental psychology, the infant is predominantly conceptualised as having basic needs that need to be met in order to survive this period of dependency, but in addition to this is a more recent depiction of an individual entering the world predisposed to participate in social interaction and desiring a relationship with others (Fonagy & Target, 2003). These processes appear to rest on an ability to effectively communicate with a caregiver and during this initial stage in life an achievement of this is primarily non-verbal, with what is felt expressed predominantly through the body (Meekums, 2002; Stern, 1998). This non-verbal communication can be recognised as the first attempts in life to be 'heard' by another and this theme continues in the following literature.

As part of the developmental process, literature describes how the infant comes to understand the self as a separate entity in this early stage of non-verbal communication. In such theories, the self is conceptualised as only having an existence in the context of another person and therefore its emergence occurs through collective experiences of relationships (Fonagy & Target, 1997). From the close and completely dependent relationship with the mother or the main caregiver, a shift is described in which the infant begins to identify the other as a separate

person with separate needs (Jacobs, 2006) and different thoughts and feelings to their own, and therefore comes to understand their individuality (Fonagy & Target, 1996). As part of this developmental process, the mother or the main caregiver holds an essential role as the communication system develops, and she has been described as having the ability to modulate her infant's affective states by attuning her facial and vocal responses to accurately mirror, which ultimately provides the basis for emotional growth and personality development (Gergerly & Watson, 1996). The mother is seen as a container to accept, absorb and transform the infant's experiences into meaning (Bion, 1962, as cited in Lemma, 2003). This appears to suggest that if an infant's non-verbal communication is 'heard' by the caregiver, development is achieved as the infant comes to understand their experience through having it contained through the relationship with another. This ability to distinguish the self from the other (Jacobs, 2006), alongside the mother's containment of her infant's states, enables the internalisation of a thinking self (Fonagy & Target, 1996). This describes human development as a relational and embodied process.

This non-verbal conceptualisation of 'hearing' another can be linked back to literature about people with disabilities. The importance of non-verbal communication is highlighted in studies involving infants with a hearing impairment. People who are born deaf or who become deaf very early in life can experience severe language deprivation (Glickman, 2009). The majority of deaf children will become fluent in sign-language if they are born into a signing family, which usually provides a great advantage in developing the English language (Marschark, 1993, as cited in Glickman, 2009), however if spoken language cannot be heard through hearing aids and there is inadequate exposure to sign-language, language skills will not often

develop (Glickman, 2009). In such cases, non-verbal communication becomes essential for the infant to be 'heard'. Although studies on the perception of non-verbal messages have concluded that deaf people have no superior skills than hearing people (Sugarman, 1969; Weisel, 1985, as cited in Weisel & Hagit, 1992), non-verbal sensitivity has been shown to be an independent social ability to language in studies of deaf children (Weisel & Hagit, 1992). This suggests children who have not fully acquired language will be able to successfully relate through non-verbal communication and the two do not have to be in conjunction. This, alongside the developmental psychology literature, emphasises the integral function of non-verbal communication in being 'heard', the main features of which appear to be a containment of experience and coming to see the self as separate from the other. Non-verbal communication has therefore been shown to provide the essential foundations for subsequent language development as the child learns the mother-culture before learning the mother-tongue (Bullowa, 1976).

The introduction of language into ways of communicating provides another possibility for 'hearing' another. Language has been the focus of much research. The origin of language studies lies in the field of linguistics (Sarup, 1993) and observing such literature provides important context for how language is understood in terms of someone 'hearing' another. Saussure (1966) was amongst the first to see that language is a self-contained system with its different parts acquiring value through their relationship to the whole. It is not therefore conceptualised as a simple naming process, but a collection of interdependent terms with the value of each depending on the presence of another (Saussure, 1966). Saussure described the construction of language as essential to humankind as distinct signs are required to correspond to

different ideas, and are formed from an association between a signifier (sound-image) and signified (concept) (Saussure, 1966). This suggests the thoughts or ideas of an individual are able to be conceptualised into a corresponding sign to communicate to another. The association between signifier and signified tends to be invisible to speakers (Singh, 2004), therefore language appears to be a natural occurrence. Saussure (1966) suggested that before the emergence of language there were no pre-existing ideas and nothing psychological could be distinct from anything else. He viewed people's thoughts as a shapeless mass and the signs that are created through language are what enable distinctions between ideas (Saussure, 1966). Saussure's development of structuralism encouraged a search for the truth behind or within the language used and a belief in the human subject as being structured by language (Sarup, 1993). Without the development of language that aids human interaction, the individual would have no clarity of thought, suggesting language is what enables one person to be 'heard' by another.

Considering language in this way relates to philosophical literature that explores the nature of reality, and therefore what 'hearing' means for all people, which adds another dimension to the notion of 'hearing' and one which will now be explored in greater depth. This involves a debate as to what it actually is that can be 'heard', which rests on conflict between the idea that there is an external reality separate from what people communicate and the nature of reality being based on people's minds or ideas. The former realist perspective suggests that words allow a true reality of another to emerge that the listener is able to experience, and language is not viewed as an entity that can be understood in its own right but in the way it opens up reality to us (Collier, 1998). Realism also implies that some descriptions will be

more 'realistic' than others (Williams, 2009), suggesting people could get closer to 'hearing' the truth of another person. This is evident in claims that language has a more distant relationship to reality than other forms of engagement with the world (Collier, 1998) which raises the possibility of non-verbal communication taking precedence in methods of 'hearing'. However accepting the power of the non-verbal in this context requires an adherence to the realist viewpoint that there is a reality beyond ourselves and of what we speak.

In an alternative conceptualisation of 'hearing', ideas around the search for truth beyond language have been challenged in much literature, often with reference to an idealist perspective in which the interaction between the listener and the words is stressed instead, with the view that different meanings can be created (Sarup, 1993). The signifier is dominant from this point of view, with no correspondence between it and reality (Sarup, 1993). From this stance, it is possible to deconstruct language and illustrate its temporal nature and reliance on metaphor (Derrida, 1973, as cited in Sarup, 1993). This idea of the unstable nature of language, giving rise to alternative meanings depending on who is speaking and listening, invites challenges as to the possibility of 'hearing' another through reliance on what is verbalised. This suggests that only a symbolic representation of experience has the potential to be 'heard' as opposed to it being a vehicle to the 'truth' of another. It is a debate over the primacy of spirit or nature, and where the realist perspective favours the latter, idealism prioritises the consciousness of people (Tolman, 1980). From this perspective, discovery is not seen as a possibility, as human constructions are all that are available (Tolman, 1980) and therefore language cannot be viewed as an expression of any independent reality (Baldwin, 2006). This relates to criticisms of psychology

and its frequent implicit suggestion that language is used to communicate from one head into another (Wittgenstein, 1953, as cited in Heaton & Groves, 1994). This indicates someone can 'hear' the meaning of another person in a seemingly straightforward process of listening to the words. This faces the idealist challenge that there is no pure thought as it cannot be isolated from language, and people inhabit the language they use (Wittgenstein, 1953, as cited in Heaton & Groves, 1994). This immersion in language, that does not allow it to be objectified, suggests it would be a mistake to view words as allowing any 'real' experience of someone to be 'heard' by another. Therefore a rejection of the realist perspective would result in 'hearing' another being described as reliant on what is constructed through communication.

Consequently, language can be thought of in an alternative way, with a role that often appears to be left unrecognised and has implications for the seemingly innocent attempts to 'hear' another. This sits alongside the challenges against realist ideas with the understanding that once reality is spoken about it enters the discursive realm of a representation of events (Potter, 1998). Therefore, language is not viewed as being used within a vacuum, but in a variety of discourse contexts which connect to the different ideologies of social systems (Singh, 1999). People's use of language is so ingrained that the words appear to become reality and therefore the perception of reality has the potential to become the focus of control (Wareing, 2004). The values and beliefs that people come to hold as norms and unquestionable facts can be revealed as constructs, developed through language.

Viewing language as a tool which aids the construction of a variety of taken for granted 'truths', relates to the ideas of Foucault. Foucault highlights the link between political action and personal conduct as the government of the individual is aligned with the government of a state (Fejes, 2008) as language is seen as having the potential to be manipulated by those in power to perpetuate their various ideologies (Singh, 1999). As a consequence, what is constructed places people in certain social groups, or becomes a method of exclusion (Thornborrow, 2004). For example, in Foucault's analysis of medicine and madness he illustrates the constructed positions of patient and madman, created through disciplinary techniques (Foucault, 1973). This could also be applied to the many contrasting theories which have developed relating to human psychology involving mental health and ill health, and recognising language as a malleable tool shows how these psychological 'facts' are socially constructed (Parker, 1998). This has relevance to the references within this study to the power relationships evident within the discourse of disability and mental health involving the many labels that separate certain individuals from the 'norm', and also within counselling generally, whereby an expert is created who claims to know what is best for the client.

This previous account of literature relating to 'hearing' another has documented a journey from the first ways of 'hearing' in life, to the acquisition of language, and the philosophical debate around what it is that can actually be 'heard'. The literature has illustrated the essential role of non-verbal communication, and the immense power of language. The use of language may suggest one person is able to truly 'hear' another, but much literature challenges this idea, suggesting all that can be communicated are various constructions and the words that might be 'heard' as

realities are no such thing. At this stage in the study, the notion of 'hearing' has evolved to be viewed as a complex term that involves different dimensions. These specifically relate to being 'heard' through non-verbal communication and being 'heard' through language constructions. This has placed 'hearing' within the counselling venture in a particular context and the following section will use further literature to build on these ideas in the specific area of the therapeutic relationship.

### **Attempts to 'hear' in the counselling relationship**

The non-verbal communication individuals innately possess and the language they socially learn has provided the background to 'hearing' another. This chapter will continue by documenting literature on the conventional counselling of the Western world in which communication is predominantly verbal, but it will also argue that clients can be 'heard' non-verbally (Feltham, 2008; Lemma, 2003; Meekums, 2002; Stern, 1998; Lachmann & Beebe, 1996; Rubin & Niemeier, 1992). To some extent, this will mirror the process of early communication between infant and caregiver previously described in the developmental literature. This will then lead to the suggestion that 'otherness' in counselling is an integral element of the therapeutic process, which also has similarities to the development of the infant in distinguishing between the self and other.

In a conventional counselling relationship that does not place the body or the non-verbal as central in communication, this realm of expression that is separate from language is usually viewed as secondary (Feltham, 2008). The advances in developmental psychology that involve the conceptualisation of the infant as primarily relationship-seeking have occurred alongside the theoretical shift in



psychological therapy away from the inner processes of the individual to a 'relational turn' (Beebe & Lachman, 2003). As the infant's relationship with its caregivers is viewed as central to emotional development (Fonagy & Target, 1997), the counsellor has become more accountable in the therapeutic relationship as their personal and emotional involvement in the process is viewed as increasingly important (Beebe & Lachman, 2003). On recognising the essential communication that occurs between mother and infant, much psychological research has highlighted the link between this early developmental relationship and the encounter between the counsellor and client (e.g. Fonagy & Target, 1997 and Beebe & Lachman, 2003) which can be seen as similar ways of 'hearing'. For Bion (1962, as cited in Mondrzak, 2004), the mother-baby model, in terms of the relationship of container-contained is the basis of therapy. This firstly relates to the initial stages in the therapeutic relationship in which there is an objective for the counsellor to create a 'facilitating environment' (Winnicott, 1965) and to be consistently emotionally available (Mahler, 1975, as cited in Jacobs, 2006), both of which match the caregiver's aims to create a secure base for the infant, who does not consequently require the caregiver to be in view to achieve a 'felt security' (Sroufe & Waters, 1977). According to Winnicott (1960), this 'holding' phase occurs pre-verbally, which indicates the importance of the counsellor empathising with the non-verbal and bodily experience of their clients. This emotional 'holding' could perhaps be viewed as a non-verbal way of 'hearing' as the mutuality and empathy are frequently non-verbal and non-conscious processes (Rubin & Niemeier, 1992). This has been described as:

*'...a sense of being 'on the same wavelength', a sense of mutual transparency – of being fully heard by, and fully hearing, the other person.'*

(Orlinksy & Howard, 1992, as cited in Rubin & Niemeier, 1992, p. 344).

As pre-verbal experiences developmentally antedate the emergence of language, non-verbal communication can be viewed as extremely important in adults and therefore deemed to have great significance for therapeutic work (Mitchell, 1988). Not only in the early stages, but throughout the therapeutic relationship, the interactions consisting of non-verbal communication have also been suggested to closely resemble the exchanges that occur between mother and baby (Lemma, 2003). The emotional mirroring achieved through affect-reflective gestures is viewed in much literature as central to the counselling process (Gergely & Watson, 1996) and this continual empathy, expressed primarily non-verbally, appears to have similarities to 'primary maternal preoccupation' (Winnicott, 1965). Following from this, Stern (1998) describes special moments of attunement in therapy, which have been connected to the 'moments' experienced between a mother and her child, and are described as when something of importance is happening which bears on the future, and the relationship is consequently altered. Such therapeutic change has been found to occur in the domain of unconscious 'implicit relational knowing' and this is where development necessarily occurs in non-verbal infants (Stern, 1998).

The literature that emphasises the link between the infant-caregiver relationship and the therapeutic encounter suggests there is much within counselling that bypasses language and illustrates other forms of communication that perhaps need to be 'heard'. Within the field of psychological therapy, the framework of psychoanalysis lends itself to non-verbal communication due to the various 'silent' qualities such as the consistent environment, fixed hours, transference and countertransference

(Leira, 1995). As well as the clear link to infant development, other powerful non-verbal communication within counselling has been described, such as regulation of postural and facial exchanges together with greeting and parting rituals (Lachmann & Beebe, 1996), and therapeutic change may occur at a procedural level as a consequence of the client being responded to differently (Lemma, 2003). The meaning a client gains from a therapeutic encounter may also be implicit in the relational dialogue and does not require verbalisation to be in some sense known, which challenges the traditional view that it is the spoken word that is the mediator of psychic change (Lyons-Ruth & Jacobovitz, 1999). This recognition of non-verbal communication follows a current interest within psychological literature for 'something more than interpretation' (Stern, 1998), whereby other features of the therapeutic process are viewed as being able to determine or contribute to change. Associated with this is an overall encouragement for a greater focus on the qualitative processes underpinning therapy, and less on the content of verbal exchanges (Lemma, 2003). This all suggests the important role of non-verbal communication in the process of 'hearing' in the counselling relationship, which can be seen as similar to early ways of being 'heard' in life. This does not negate the necessity of language as a key factor of therapeutic change in conventional counselling, but is viewed as an essential integration.

### **'Hearing' the Other**

As has been proposed in the earlier infant development research, the self emerges through relationship (Nanda, 2006), which suggests the importance of the 'other' in this process. This study has illustrated some of the parallels between infant development and the therapeutic encounter, and this continues with the theme of

otherness. The previous wealth of literature concerning the hard of hearing client, disability, attempts to 'hear' the other in all relationships and particularly within the counselling relationship, has adopted the position of determining the best interests of the other. This has been especially evident in literature documenting the specialist needs of certain client groups and debating the most suitable counsellor for particular clients. In contrast to the prevailing tone of this study, is literature that introduces the importance of difference and 'otherness' and explores the ethical aspects of human relationships and within the therapeutic encounter. This is another important aspect of 'hearing' to consider as a critique of the prior literature and it provides the conclusion to this chapter.

In beginning to describe this notion of 'otherness', there will be a consideration of Buber's (1937) theory, which centres on a philosophy of the self in terms of relationships. He refers to the 'I-It' relationship, which is based on logical empiricism, positivism and determinism (Watson, 2006), which can be related to the medical model as discussed in this study. The 'I-It' relationship places the client as an invention of the counsellor's thinking (Ventimiglia, 2008) as they are objectified and positioned according to a variety of categories, resulting in inevitable alienation from the counsellor. This relates to the theoretical frameworks that aim to establish boundaries of pathology and health (Walsh, 2005) and the categories and themes attached to individuals that are frequently accepted and their limits ignored. In contrast is the 'I-Thou' relationship, which has been described as a deep personal engagement and intimacy with the other (Buber, 1937). Within this philosophy, the therapeutic encounter is viewed as a quest for 'human wholeness' as the counsellor avoids a rational and methodological approach to clients (Watson, 2006). 'Hearing'

within Buber's philosophy would be part of a 'dialogical therapy' in which what happens *between* client and counsellor is prioritised, and therefore healing through meeting (Friedman, 2008). 'Hearing' in this way can be viewed as 'confirming' the client, which can only truly be achieved through recognising their uniqueness, and not through empathy or identification (Friedman, 2008). In this way, the client is 'heard' through being brought into full realisation of the self by the other (Friedman, 1993; Moore, 1996; Kramer, 2003, as cited in Ventimiglia, 2008).

As part of this description of counselling, is the idea of meeting others and holding one's ground (Boszormenyi-Nagy & Krasner, 1986, as cited in Friedman, 1989) which has implications for a counsellor 'hearing' a client without abandoning their own position. In this way, the individual's point of view is confirmed through coming into dialogue with the opposing view of others (Friedman, 1989) and the relationship is one that is direct, mutual, present and open (Friedman, 2003, as cited in Nanda, 2006). Although the counsellor can attempt to experience the other side of the relationship, separateness and distance is maintained (Friedman, 2003, as cited in Nanda, 2006) and when each individual in the therapeutic dyad recognises their affect on the other, there is the suggestion that greater self-awareness emerges for the client (Nanda, 2006). As the client is moved to respond more fully to the other, they become more in tune with their own self (Friedman, 1999, as cited in Nanda, 2006). The literature describes such an authentic relationship as not necessarily involving comfort, because conflict and difference are likely to be provoked, but a deep respect for the other is maintained (Nanda, 2006). Therefore 'hearing' in the counselling relationship is explained to require:

*'Wrestling with the patient, for the patient, and against the patient'.*

(Buber, 1990, as cited in Nanda, 2006, p. 355).

From this perspective, 'hearing' is possible through understanding that the client can only be 'heard' through relationship. There is a holistic view of the human being in such a therapeutic encounter, with no split between the body and mind as the other is responded to (Nanda, 2006).

'Hearing' through recognising otherness and holding one's ground relates to any counselling relationship, but its relevance to working with clients with disabilities can be highlighted. This study's review of literature that relates to disability and the counselling relationship has been engaged with a debate around how best to 'hear' such clients. The literature generated conclusions as to the benefits of involving a specialist counsellor, who is either someone with a disability themselves, or with competency in working with such clients, alongside a continual awareness of any potential practical difficulties and how to make adaptations to them. This would be met with challenge and criticism when the concept of otherness is involved. The clear commitment to the wellbeing of disabled clients has been suggested to result in a silencing of differences (Chantler & Smailes, 2004). By reducing any difference in the therapeutic dyad, there are objections to the notion of a client being 'heard' as a result, which consequently challenges what it means to 'hear' in the counselling relationship. A failure to attend to difference has been suggested to prevent any fruitful exploration for counsellor and client as a key aspect of the therapeutic relationship is described as being able to attend to what is unspoken in a sensitive way (Chantler & Smailes, 2004). This suggests that when a client's disability

becomes a factor in the relationship, whether through practical reasons or a counsellor misunderstanding an experience, the opportunity to explore such difference would have therapeutic benefits. The desire to eliminate any potential difficulties in the counselling experience for the disabled client could be explained as attempts to avoid any difference due to the counsellor's deep fear of a sense of otherness (Spencer, 2000).

Recognising the importance of otherness in the counselling relationship is evident in literature that encourages counsellors to be transparent about difference, with the suggestion that work with any minority client is aided as a consequence and in fact reduces any potential power relations (Chantler & Smailes, 2004). The level of empathic understanding of a counsellor has been described as being much deeper than having shared experiences with a client (Spencer, 2000) and research has claimed that the need for a cultural match is not always desired (Burman et al, 1998; Shafi, 1998; Netto et al., 2001, as cited in Chantler & Smailes). Instead, some literature supports a greater acceptance of otherness together with individual responsibility, which has been shown to result in greater self-awareness, authenticity and sensitivity to the other (Spencer, 2000). This relates to the hard of hearing client whereby the counsellor would acknowledge the hearing loss, whilst aiding the client's understanding of the impact or meaning of the disability for themselves and for the other. By altering the therapeutic conditions so any obvious difference is excluded, the opportunity for the hard of hearing client to be more fully aware of themselves would be bypassed and this could be viewed as not 'hearing' them therapeutically.

It has been suggested that all counselling is or should be intercultural in some way (Gordon, 1996, as cited in Spencer, 2000) and Rogers (1950) has claimed that for some, the whole process of counselling can be described in terms of differentiation. When there is enough space for otherness to be experienced, there is the suggestion of enhanced therapeutic change (Spencer, 2000) and therefore the possibility of being 'heard' in this way. The subjectivity of the therapist as 'other' is said to be a fundamental dimension of the developmental process in therapy and essential to engender the unique otherness of the client (Jacobs, 2009). This important recognition of difference creates a paradox in which to gain greater closeness in a meeting, more space needs to be available (Spencer, 2000).

Following Buber's propositions about the relationship in counselling, the philosopher Levinas agrees that it is the relationship between people that holds the key to human nature (Sampson, 2000), but also challenges Buber. Levinas (1967) objects to the notion of the 'I' creating and confirming the existence of the 'Thou' and encourages a conception of otherness as separate from the consciously reflecting 'I' (Greenwood, 2007). This criticism highlights how the 'Thou' position of the client has the potential to be transformed into an 'It' as soon as any sense of understanding is imposed by the counsellor. At the core of Levinas' philosophy is the argument that ethics must precede ontology and therefore 'being for others' has priority over 'being for self' (Loewenthal, 2005). Levinas distinguishes between 'non-intentional' and 'intentional' thought as part of his critique of Buber's work. The former refers to instantaneous moments prior to any need to rationalise and explain what is experienced which is associated with the internal reflective process of the latter (Greenwood, 2007). Levinas (1984, as cited in Greenwood, 2007) suggests that any intentional thought



prevents the opportunity for real and spontaneous contact, whereas the non-intentional confirms the separateness of the other.

Although Buber has attempted to highlight the dangers of adopting an 'I-It' relationship, intention appears to remain when determining 'Thou' in relation to 'I'. In contrast, any ideological frameworks that provide the power relationship involved in counselling are challenged when adopting the philosophy of Levinas (Walsh, 2005) and such accounts of human life become contextless and disconnected (Clegg & Slife, 2005). Through concerning the self with the other beyond our own being, all ideological themes can ultimately be broken apart (Levinas, 1969, as cited in Clegg & Slife, 2005). Levinas introduces ethical responsibility into a relationship, in which the counsellor as 'I' responds to the client as 'Thou' spontaneously and separately from any reflective process (Greenwood, 2007). Responding in this way therefore precedes any attempts to comprehend the client. This form of 'hearing' does not involve an aim to understand another through particular expertise, but openness to immediate contact and a recognition that clients are 'other', and any glimpse of this would be prior to any theories about them which are developed within mental health care (Greenwood, 2007).

*'The hope resides not in the wisdom and cleverness of the therapist, but in the fact that we are all in the presence of someone who may dispossess us of our understanding, our comprehension, and call us to hear and speak'.*

(Halling, 1975, as cited in Loewenthal, 2005, p. 3).

Connected to this is the client's relationship with others outside of the counselling room. Sayre (2005) describes how the counselling venture has developed as being one that is client-centred, which appears to sit in contrast to the medical model's 'I-It' relationship, but does not adhere with the philosophy of Levinas. As Levinas sees the call to respond to the needs of the other as at the centre of human existence, counselling would consequently be depicted as a fundamentally unethical practice (Sayre, 2005). If the well-being of the client is the focus of therapeutic work and viewed as ultimately healing, this contradicts the ethical purpose of living that Levinas describes (Sayre, 2005) and throws the whole process of individualistic therapy into disarray. Others in the client's life often emerge as 'issues' and this is said to limit the client in the healing process as there is no recognition of their ethical responsibility to others (Sayre, 2005). The counsellor is also described as being limited if there is continual monitoring of the therapeutic relationship to ensure their needs do not impinge on those of their client as they are unable to be completely present while only in the role of healer (Sayre, 2005). Adopting an ethical vision would reject the current individualistic process of counselling and encourage a decentering for both counsellor and client (Sayre, 2005) in which uncertainty would be viewed as a positive condition (Clegg & Slife, 2005). Therefore, being 'heard' as an individual separate from the other would be viewed as unethical according to Levinas' philosophy. Alternatively, being 'heard' would involve the client being recognised as a unique other and being healed through being open to otherness. Therefore, the client would be encouraged to recognise their ethical responsibility to others in their life, but attempt to 'hear' them preceding any sort of comprehension. True otherness will consistently be sabotaged within the counselling process, and in every human encounter, but maintaining an awareness of the meaning of otherness

is suggested to provide the opportunity for non-intentional authentic responses to emerge (Greenwood, 2007).

Again, with relevance to disability in the counselling relationship, Walsh (2005), referring to the writings of Levinas, suggests that healing only occurs through a therapeutic interaction with a genuine other who remains other and if the otherness is destroyed the therapist affirms their identity as being the one in charge. Therefore, it is only on their unique and separate plains that the counsellor and client can converse (Loewenthal, 2005) and the identity of the therapist disappears (Walsh, 2005). What is left is 'me' speaking with 'you' (Walsh, 2005). There would be no 'I' as the non-disabled counsellor with 'Thou', the disabled client, only an openness to respond to the other and encourage the other to do the same. The discovery of another person is said to be prevented when client labels are involved (Greenwood, 2007), which relates to the hard of hearing client, as well as any mental health categories. The external world is often viewed as safer if it is processed, which can be achieved through the adoption of categories, and this prevents it being as threatening as a relationship with an unknown other (Greenwood, 2007). This relates to the power of language and its continual labelling and dividing that is often left unchallenged. With a move away from the 'I-It' relationship in counselling people with disabilities, there would also be a distancing from seeing the 'I' as forming any construction of the other at all, with an aim to relate to the client with a disability spontaneously in an ethical way of 'hearing'.

This chapter has contained a variety of areas of literature, some relating to the hard of hearing client, some relevant to any individual in the counselling relationship, but

all conceptualising the notion of 'hearing'. It began by illustrating the importance of 'hearing' the hard of hearing individual as part of a distinct client group between the Deaf and hearing worlds, followed by literature highlighting the various ways disability is 'heard' within the counselling relationship. This led to developmental psychology literature describing how 'hearing' another develops, followed by descriptions of the powerful role of language. This sat alongside the philosophical debate as to whether any true reality of a person can be 'heard' or whether reality is a construction. At the conclusion of this wealth of literature has been a critique involving the suggested therapeutic benefits of acknowledging and encouraging otherness and difference in the counselling relationship and therefore an ethical way of 'hearing' in which every client is 'other'. In conclusion, the context for this study is now evident, including the reasons for the choice of subject and the literature that makes clear the complexity of the notion of 'hearing'. This research aims to provide another way of addressing this notion, using the hard of hearing client group as an important example.

## Chapter 3

### METHODOLOGY

This study will now develop through a separate line of discussion, which also has clear links to the previous contextual literature. This chapter is necessary to document the methodological journey that resulted in a choice of method which was judged as most appropriate to investigate 'hearing' in the counselling relationship. Of great importance to this decision was the researcher's epistemological view of the world. Beginning with positivist science, then considering phenomenological approaches and moving to discourse analysis, a critique of these methods will be illustrated before a final choice is reached. There will be an in depth account as to how this chosen method relates to the relevant subject matter and how the various elements to be addressed will be incorporated in the research process. Any piece of research can be viewed as a way of 'hearing' something and a study that places 'hearing' another as its central concern appears to require especially thorough deliberation over what different research methods claim in relation to 'hearing' data. Considering the most appropriate method of studying being 'heard' in the counselling relationship has led the researcher to attempt to determine how best to generate and analyse data in order for the participants to be 'heard' and also challenging the suggestion that 'hearing' any truths of their experience is actually a possibility.

In traditional scientific research, the underlying assumption is that all phenomena can be explained by a single set of natural laws (McLeod, 1994) and discovering these is achieved by adhering to an approach that believes knowledge and truth are contained within the object of enquiry, which can be discovered by observing and

exploring the external world (Greenwood, 2009). This position of positivism suggests that objects still have meaning, regardless of any human consciousness of them (Crotty, 1998). With this scientific method in mind, the quest to determine whether a counsellor is able to 'hear' their client would be investigated through proving or disproving this hypothesis by taking the views of the relevant participants as fact, and truths about being 'heard' and 'hearing' another would potentially be discovered. As the hard of hearing client is the focus of this study, the associated medical and clearly defined physical impairment might appear to lend itself to a similarly structured and efficient method of researching, suggesting a potential revelation of truth, but this can be firmly challenged.

The empirical tradition favours the realist view that increasingly sophisticated research consists of better approximations to the truth (Tolman, 1980). This sits in stark contrast to the claims of idealists who describe any reality as only emerging from constructs (Tolman, 1980). The traditional and modernist methodological approaches have been uprooted by developments in methodology (Davison, 2006) and qualitative research has emerged as a critique of the modern quest for objective knowledge (Rennie et al., 2002). This originated in the development of phenomenological methods where lived experience is the focus of study. Ways of studying how clients are 'heard' based on the classical empiricist model could be rejected in favour of such methods, which are grounded in the philosophical works of Husserl (1900, as cited in Bell, 1990). The ideas of Husserl challenge traditional science in its claim that the world exists independently from a person's perception, but encourage the idea of 'knowledge' and 'truth' being constructions generated as a result of the internal processes of human beings (Greenwood, 2009).

Phenomenological research moves away from any scrutiny of an object in the external world to the examination of the observer's view of that object and is therefore referred to as a 'pure' science of consciousness and one that is stripped of all empirical content (Greenwood, 2009). Husserl believed all knowledge stems from conscious awareness and the mind is directed towards objects, which he referred to as 'intentionality' (McConnell-Henry et al., 2009). Researching the hard of hearing clients based on Husserl's phenomenological philosophy would result in studying their individual lived experiences relating to the concept of 'hearing' in the counselling relationship. No preconceptions about being 'heard' would be involved when faced with participant data, only a concern with what might be directly given, as Husserl insisted any preconceived ideas must be put aside in order to reach the essence of experience (McConnell-Henry et al., 2009).

This type of method could appear to have potential benefits towards 'hearing' the participants through attempting to reach their individual lived experiences through an investigation of their conscious thoughts, seeing this as a source of a real picture of their views on being 'heard' (Moran, 2000), with no interference on the part of the researcher. Although Husserl aimed to explore human experience, he has been criticised for a continual motivation to offer objective data (McConnell-Henry et al., 2009) as his phenomenology is seen as a sustained search for truth. Methods based on this philosophy have been described as looking for 'unities of sense' that emerge when there are repeated experiences in consciousness (Husserl, 1948; 1973, as cited in Churchill, p. 11) and these attempts to reach an essence can be seen as a way of grasping stability and a return to natural science, which phenomenology originally aimed to challenge.

As part of these criticisms of Husserl, phenomenological ideas have expanded to include those of Heidegger (1927) who criticised the notion of transcendental intentionality and argued that a person's way of thinking must be influenced by their experience and their positioning within the existing culture (McConnell-Henry et al., 2009). Heidegger shared Husserl's phenomenological goal of exploring lived experience but was interested in moving from description to interpretation and saw the researcher as a legitimate and important element of the research process (McConnell & Henry, 2009). Heidegger's hermeneutic approach to phenomenology has generated methods in which there is a back and forth movement of questioning and re-examining the text under analysis, with the acknowledgment of the researcher's subjectivity in the generation of any results (McConnell & Henry, 2009). One such method is Interpretive Phenomenological Analysis (IPA) (McLeod, 1994), which involves a process of phenomenological reduction that analyses the essential conscious act (Jennings, 1986). This is in stark contrast to Husserl's conception of phenomenological reduction in which the researcher is not thought to have any involvement in the end result. For the purpose of this research, IPA would give rise to various perspectives and meanings of 'hearing' in the counselling relationship (McLeod, 1994), with the acknowledged interpretation of the researcher. If this research could attempt to understand the changing meanings of the hard of hearing clients by investigating their lived experience connected to various contexts and the researcher's own positioning, this could be a way of 'hearing' them that is distanced from any positivist stance.



Connected to phenomenological research, with its interest in subjective experience, is Grounded Theory, which was also a method established in reaction to extreme positivism (Glaser & Strauss, 1967). As a challenge against any 'grand theories' about 'hearing' another within the counselling relationship, Grounded Theory would allow for an investigation of being 'heard' by analysing the production of meanings and concepts used by the individual hard of hearing participants (Suddaby, 2006). In contrast to a phenomenological approach, the experiences analysed would be abstracted into theoretical statements about being 'heard' based on how well data fit the organically emerging categories (McLeod, 1994). Reaching a new theory using this approach could be viewed as potentially empowering for the hard of hearing client as their specific experiences around being 'heard' would be generated, perhaps indicating more effective ways of 'hearing' another in the counselling relationship. Using Grounded Theory would result in theories generated in relation to this, creating some stability to the notion of being 'heard'.

A method such as Grounded Theory can be criticised for its desire to 'sort' and 'bind' knowledge of the world (Tierney, 1994, as cited in Davison, 2006), when developed from a philosophy that claims to challenge the goals of traditional scientific enquiry. Any theories that emerge from Grounded Theory can be viewed as limiting as there is the assumption that experiences of participants are understood unproblematically and the complexities of social interaction are left unexamined (Davison, 2006). In response to such criticism, a Constructivist Grounded Theory approach developed as an off-shoot of Grounded Theory and recognises the mutual creation of knowledge by the researcher and participant and aims for an interpretive understanding of meanings (Charmaz, 2000, as cited in Glaser, 2002). Whilst an

adoption of the Constructivist Grounded Theory approach would appear to successfully reject any stability to the notion of being 'heard' in the counselling relationship, it has been criticised as a complete remodelling of the original goals of Grounded Theory (Glaser, 2002). The basic aim of Grounded Theory is described as ultimately objectifying data and therefore any interpretations of the researcher would be deemed an unwarranted intrusion (Glaser, 2002).

Although there have been developments in phenomenology, such as Heidegger's hermeneutics, and models such as Constructivist Grounded Theory, there is the argument that it never escapes attempts to reach truth as it finds a way of 'knowing' through active engagement, with the basis for truth in the life-world (Ladkin, 2005). Despite questioning the ability of a researcher to provide a definitive view of the external world and therefore acknowledging the interpretation involved in research, the observation of the researcher is still consistently privileged and the methods are based on an unwavering acceptance of language. This study has explored literature relating to language in the context of 'hearing' and recognising the insecurity of language has strong implications for the subsequent choice of method. This invites a return to the theories of Wittgenstein (1953, as cited in Heaton & Groves, 1994) who challenges the frequent implicit suggestion that language is used to communicate from one head into another. In all the aforementioned methods, ways of 'hearing' participants have been debated without any consideration that language is possibly all that is being researched.

Language is prioritised over experience in postmodern research (Churchill, 2005) and this is in stark contrast to the phenomenological philosophy. Postmodern

thinkers also prefer to speak of differences or 'disunities' in place of the continued search for unities (Churchill, 2005). In such research, there is no concern with 'getting it right' or 'telling it like it is' (Davison, 2006) and the venture should expose any structures that make versions of reality a historical fiction (Denzin, 1997). This relates to investigating the counselling relationship, as this study challenges the therapeutic claims of potentially 'hearing' the true experience of another due to language being the problematic mediator. Although the realm of non-verbal communication has been recognised as also involved in the 'hearing' process, the challenge remains against any reality of another being accessed. Therefore, a research method that overlooks language or claims to create any certainty or reveal any hidden truths would seemingly contradict the basis of the study. As this research engages with other interpretations of 'hearing' in the counselling relationship, it must also maintain an awareness of the limits of 'hearing' in its own venture into the experiences of the participants.

### **Discourse Analysis**

Discourse analysis is a form of researching that places language as the focus of study and recognises how words do not reflect, but constitute our external reality and our knowledge about it (Georgakopoulou & Goutsos, 1997). Discourse analysis generally rejects realist and positivist approaches whereby objects exist independently of thought (Parker, 1998), with the awareness that language produces and constrains multiple and shifting meanings (Burman & Parker, 1993). Therefore, it is not the sequence of sentences which represents coherent discourse, but the reader or listener who assumes connected events and interprets linguistic cues (Potter & Wetherell, 1987). Here is the recognition that language is not a transparent

medium of truth telling and so using discourse analysis in this research would produce no stability about the participants' experiences of being 'heard'. Any meaning that might be generated would be assumptions on the part of the researcher. Using discourse analysis in this study would allow for a critical re-reading of the taken for granted processes that occur in counselling practice and also other forms of research that claim to establish facts or theory (Cowan & McLeod, 2004). A parallel would be generated between counselling and research through placing discourse at the centre of the method of analysis, which acknowledges that any truths of clients cannot be 'heard', and challenges the desire of researchers to make discoveries about their participants.

A distinction can be made between discourse analysts who are concerned with discourse practices or performative qualities of discourse and those who are interested in the role of discourses in the context of subjectivity and power relations (Willig, 2000). The former is a discursive psychology that aims to identify how people construct their way of speaking and to understand the 'action orientation of talk' (Potter and Wetherell, 1987). This could be beneficial for this particular study in potentially recognising the hard of hearing individuals' constructions of their disability and being clients in the counselling relationship and what might be produced through the interaction with the researcher in the creation of meaning connected to 'hearing'. The other strand of discourse analysis has been inspired by Foucault and post-structuralism and holds a wider view of social, institutional and historical frameworks within which discursive constructions are produced, and observes the power relations involved in this (Willig, 2000). It is this macro-level Foucauldian discourse analysis that may connect more inherently to this study due to the expert dominant

discourses that have been explored relating to disability, mental health and counselling, and this will now be explored in greater depth.

### **Foucault**

Cheek & Porter (1997, as cited in Mackey, 2007) describe Foucault's work in three phases – the 'archaeological' phase, involving the analysis of knowledge, the 'genealogical' period, with a focus on power and its relationship to discourse and knowledge, and 'technologies of the self' focusing on how people constitute themselves. All of this work centres on the forms of:

*'objectification which transforms human beings into subjects.'* (Foucault, 1983, as cited in Markula, 2004, p. 304).

Within his vast array of work, Foucault highlights certain knowledges that have developed over time and various practices that have established particular social actions and institutions (Ball, 1990, as cited in Morgan, 2005). He identifies two types of power, labelled 'sovereign' and 'disciplinary' (Foucault, 1977). The former is described as hierarchical and visible whereas the latter is subtle and all-encompassing (Morgan, 2005). This disciplinary power that infiltrates the lives of every person is evident through the discourses they use. Foucault (1972) sees discourses as social practices that systematically form the individuals and experiences of which they speak and he recognises how humans are made subjects within their culture in this process. The discourse analysis inspired from his writings makes the political visible in tacit truths and the social and historical conditions of the actual existence of statements emerge (Diaz-Bone et al., 2007).

Foucault's work contains many different aspects, therefore it is important to identify which areas have most relevance for this particular study (Garrity, 2010). Firstly, in *Discipline and Punish* (Foucault, 1977), Foucault's description of disciplinary power enlightens us as to how professionals and specialists within the human and social sciences have come to act as judges of normality and certain regimes of truth have developed (Rose, 89, 98; Kenway, 90, as cited in Morgan, 2005). This work gives an explanation for the ideas that guide professional practices and how they have developed such power (Mackey, 2007), which can be applied to the counselling profession. More specifically, *Madness and Civilisation* (Foucault, 1973) documents how mental illness has been viewed as the reverse of Reason which has great relevance to a study that aims to research how clients are 'heard'. Secondly, the importance of analysing discourse is evident in *Archaeology of Knowledge* (Foucault, 1972), as Foucault views the individual as a 'function of discourse' (Deleuze, 1988, as cited in Garrity, 2010) and refuses to examine statements outside of their historical context. He seeks the discursive and practical considerations for the existence of any truth and meaning.

Using this as a framework, the participants in this study would be conceptualised as 'being talked' by the language they use as they would be understood to only have certain discourses available to them (Willig, 2000). They would be viewed as having been made subjects and also turned themselves into subjects of particular truth claims through various discourses (Willig, 2000). The 'truths' would therefore be viewed as creations dependent on particular contexts and only certain subject positions for the hard of hearing clients would be viewed as possible. This type of

analysis would observe the multivoicedness of language instead of searching for underlying processes or themes, which would be the aims of other contrasting research methods (Parker, 2005). Therefore, the language used would be viewed as creating alternative meanings, in contrast to any true meanings being communicated by participants. Research such as this would offer an alternative version of counselling practice as dominant discourses would be highlighted and any assumptions deconstructed (Morgan, 2005).

Foucault describes the processes of normalisation and classification in which comparison and differentiation takes place, such as binary divisions of physical/mental and strong/weak (Webb & Macdonald, 2007). In this study, the literature around disability has described the types of oppressive discourse consistently constructed and subsequent literature on disability in the counselling relationship illustrates how the field of counselling is frequently tangled up in the power dynamic that operates in the rest of society. The social world in which counselling has developed is predominantly characterised by segregation and marginalisation of people who are different to the 'norm' (Barnes, 1991, as cited in Swain et al., 2003). Therefore, the aims of the counselling profession to be separate from the expert-patient dynamic is in conflict with how disability is predominantly considered within society. This suggests hard of hearing clients are often 'heard' from the point of view of a specific social attitude and against the constructed marker of 'normality'. What is highlighted is the impact of discourse on the creation of various 'truths' that are rarely viewed as constructions through language, for example, the notion of a 'psychology of the deaf'.

Foucault would view the dominant discourses that operate in society as prevailing, whether or not the client is disabled. Society consistently judges all individuals in terms of what is 'normal', which has particular relevance for mental health as labels of illness are created and generally accepted as truths. Foucault's analysis of practices of discipline and confession in modern Western society give some explanation for how the realm of the 'psychological' is understood (Foucault, 1977). He would not see a 'psychology' as such, only changing historically-constituted psychologies which are culturally specific and certain types are prioritised (Burman & Parker, 2005). Currently in the field of psychology, individuals are often seen as isolated and competitive individuals which connects with discourses around Western individualism (Parker, 1992). The normalising process is also greatly evident in the field of psychology which has been described as a reaction to the threat of populations becoming destabilised (Wilbraham, 2009). This relates to the Western 'psy-complex', which refers to the various technologies of the self that fabricate normal and preferred people, their conducts and relationships (Rose, 1998, as cited in Wilbraham, 2009). As part of this, the concept of 'mental health' is used as part of a complete medicalisation of distress (Foucault, 1973) and internal mental states are attributed to human beings which are believed to direct their behaviour (Costall & Still, 1987, as cited in Parker, 1992). Our culture is said to be increasingly psychological (Burman & Parker, 2005) and it has been suggested that the more psychology is institutionalised, the greater its power (Parker, 1992).

As part of this powerful psychological discourse is the field of counselling, and such therapeutic practice is criticised by Foucault for claiming deeper truths are reached in the process, instead of recognising a variety of discourses in action (1981, as cited in



Parker, 1992). The therapist is described as being only able to adopt culturally available discourses that are relevant to particular aspects of client experience (White & Epston, 1989, as cited in Parker, 1992) and Foucault cautioned against regarding certain phenomena as existing outside the discourses about them as he explored this subjection to language (Allan, 1996). Therapeutic discourses are explained to capture people as different subjects, which have become accepted as accurate models of the individual (Parker, 1992). Counsellors can therefore be seen as part of a power dynamic that exists in the rest of society, and has become a regime of truth in which 'hearing' clients is believed to occur, when in fact they can only be 'heard' through various discourses and subject positions.

This Foucauldian analysis of discourse is effective in showing how powerful images of the self and the world circulate in society and in the field of therapy (Parker, 2005), such as the position of counsellors as 'experts' and of certain individuals being 'disabled' or 'mentally ill'. Using this method would enable dominant discourses to be reflected (Willig, 2000) in what the hard of hearing participants say about being 'heard' in the counselling relationship and enable a mirroring of the conventional counselling relationship where language is often the prioritised form of communication. By recognising that language is a construction of reality and part of a power dynamic, the voices of the participants could be 'heard' in this way. This suggests the emergence of an alternative definition of 'hearing'. The hard of hearing participants could then be thought of as being 'heard' partly by acknowledging that 'hearing' their true experience is unachievable. Additionally, would be an awareness of the power relations that also operate in the context of a research interview and through the subsequent analysis, as the requirements of the researcher will influence

the organisation of the producer's discourse (Potter & Wetherell, 1987). Any apparent contradictions between discourses would also be viewed as contradictions between the researcher and the participants (Burman & Parker, 1993) as the researcher's individual epistemological construction determines what is elaborated on and how it is understood (Harvey, 1989).

### **Resistance**

The work of Foucault has been criticised for ignoring the concept of freedom within the wealth of discourses and power relations (Vighi & Feldner, 2007) and the possible resistance to change that emerges in relation to social entities (Chiapello & Fairclough, 2002). Foucault often portrays individuals as passive in the power dynamic discourse creates, and any agency is left undocumented (Finch-Lees et al., 2005). Newton (1998, as cited in Finch-Lees et al., 2005) describes the limits of Foucauldian approaches in refusing to show how people 'agentically play with discursive practices' (p. 1191). As part of this critique, social life is described as reflexive, as people not only relate within networks of social practices, they also interpret and represent to themselves and one another how they act and interact (Chiapello & Fairclough, 2002). Willig (2000) also suggests a need to observe the relationship between discourse, subjectivity and experience. However, this connects with the later writings of Foucault in which he became more concerned with the individual and the interaction between the self and others (Fox, 1997) and introduced the concepts of resistance and freedom (Butin, 2001). This emerged in Foucault's work through his descriptions of 'relations of power', which implies power is not some omnipresent concept, but is embedded in relationships (Butin, 2001).

*'I've insisted too much on the technology of domination and power. I am more and more interested in the interaction between oneself and others in the technologies of individual domination, the history of how an individual acts upon himself, in the technology of the self.'* (Foucault, 1988, as cited in Willig, 2000, p. 553).

Therefore, resistance can be conceptualised as an action within the relations of power and invites the possibility of alternative subject positions which can be created by the individual (Willig, 2000).

There is the common suggestion within the field of Foucauldian discourse analysis that the analysed speakers may be innocent of what the discourse is doing whilst dominant forms of cultural identity are being kept in place and they are active participants in the process (Parker, 2005), but choosing to focus on hard of hearing clients in this research does not imply their passivity (Willig, 2000). Tensions and contradictions may emerge from coexisting multiple meanings in the various interviews, suggesting the presence of expert discourses that are also being challenged (Willig, 2000). The hard of hearing clients would therefore not be deemed to have necessarily constructed themselves in accordance with expert discourses, but positioned themselves in relation to them (Willig, 2000). As Foucauldian discourse analysis has been criticised for neglecting the ways discourses can be acknowledged and transformed by the lay population (Lupton, 1997), placing the hard of hearing clients as central allows for an illustration of such a process. Therefore, this research could ultimately be viewed as empowering for the hard of hearing client, due to a potential repositioning of the subject (Willig,

2000). The clients could be seen as being subject to the oppressive discourses of society that are mirrored in the counselling relationship, but also involved in the creation of discourses of resistance.

In conclusion, Foucauldian discourse analysis was decided to be the most appropriate method for this piece of research. It is a method that enables the discipline of counselling to be deconstructed (Burman & Parker, 2005) and allows the many boundaries, such as normal and pathological, to be challenged, which has been described as the task of radical qualitative research (Parker, 2008a). Through seeing the hard of hearing participants within a social framework (Parker, 1992), they will be 'heard' in this way, with no claims to reach any truths of their experience. Using Foucauldian discourse analysis will observe how the hard of hearing client illustrates any dominant discourses in action in the counselling relationship, together with any resistant discourses or alternative ways of being 'heard'. This will initially relate to the hard of hearing client, but will expand through the analysis to encompass any client being 'heard' in the counselling relationship. Foucault encouraged an:

*'evacuation of our own culture in order to open a free space for innovation and creativity'* (Foucault, 1988 as cited in Mackey, 2007, p.96).

This will be applied to the culture of counselling and the way clients are 'heard' within it.

## Chapter 4

### METHOD

#### Participants

Hard of hearing clients were chosen to be the participants for this research as an attempt at beginning to fill the gap into studies of counselling with hard of hearing clients and viewing them as a separate group to Deaf clients as there is currently a deficit of attention in this area. Discourse analysis provides little guidance as to whether any discourses should be supported and which marginal voices should be allowed to speak (Burr, 1998), but the 'hard of hearing' group were highlighted as distinct from the hearing and Deaf worlds in the hope that their production of discourses in action and possible alternative discourses could be observed.

The selection criteria for participants was of great importance for this study as there are a wide range of people who may describe themselves as hearing impaired and the research focuses on a specific client group. The hard of hearing client group were chosen as opposed to people who describe themselves as Deaf, as Deaf people identify themselves as a separate group to others who have a hearing loss and the majority rely on British Sign Language (BSL). Deaf people may therefore require a counsellor who uses BSL or would need an interpreter. The main factor in this study was that the client group was positioned between the Deaf and hearing worlds.

Participants were recruited through advertising via lipreading teachers. Students of lipreading would commonly define themselves as hard of hearing as they are

requesting skills to lipread others due to still living in the hearing world whilst experiencing a hearing impairment. The researcher contacted lipreading teachers directly from a teacher database and the literature was supplied to them to show to their students, and an advert was also placed on the lipreading teachers' online network asking them to do the same. There were nine responses in total. Five participants self-selected as a result of this advertising, and Participants 4 and 9 became involved through word of mouth. These participants did not take part in lipreading classes, but defined themselves as hard of hearing and matched the criteria for the study. Participant 4 then invited her hard of hearing relative to take part, who became Participant 6. Participant 5 lives in Canada and is a lipreading teacher and self-selected as a result of seeing the research advert on the online lipreading teacher network and it was agreed that she could take part in the study through an email interview as she is unable to use the telephone as a result of her hearing loss. As this participant was hard of hearing and had experience of counselling, she met the research criteria and therefore her input was deemed important and the adaptations of method allowed for her experience to be included in the data analysis.

Nine participants were interviewed. It was decided that this number was adequate for a qualitative study of this type where the development of norms or generalisation is not the aim (Bicknell & Liefoghe, 2006). Eight to ten participants gives enough data for a thorough study, whilst allowing for in depth analysis of the transcriptions (e.g. Walsh et al., 1999). Interviews were selected as the best method of gathering data as the researcher was able to clarify points, or explore certain topics in greater depth (McLeod, 1998). Interviews also allowed for a focus, as the context could be

prevented from becoming too broad, and there was standardization, whereby the same themes were addressed in each interview (Potter, 2003). Cohen (2003) found her deaf and hard of hearing clients preferred structure in their interviews and when carrying out interviews for a discourse analysis, Parker (1992) also suggests a semi-structure is preferable, so this was adhered to in this study. There were main questions, with prompt questions adapted to the particular participant responses, if certain areas appeared important to develop. The main questions were as follows:

*Tell me about your experience of counselling?*

*In what ways did you feel 'heard' in the counselling relationship?*

*Tell me about any times when you didn't feel 'heard' within the relationship?*

*To what extent were practical issues important in the counselling relationship?*

Each interview was carried out in a place most convenient for the participant, whether this was at their home or a neutral location. Using a room at Roehampton University was suggested as a possibility in the recruitment literature, but no participants decided to do this. Participants 1, 2, 6, 8 and 9 undertook interviews in their homes, and Participants 3, 4, and 7 were met in cafes on their request. In adhering to ethical guidelines, the safety of the researcher was taken into account in all these situations, with an arranged call made prior to each interview and one after, with a procedure understood should these calls not be received.

Excluding the email interview, each interview was audio-recorded, and was stated to last for 50 minutes to reflect the therapeutic hour, as the main element of the interview was the experience of therapy. For Participants 2 and 3 the interview

length was significantly shorter due to their specific experiences of counselling and the amount they felt they could offer the research. Although not in the initial expectations for the practical undertaking of the study, this data is still believed to be of equal relevance for analysis. It can also be viewed as fitting with the overall nature of this study in which homogeneity does not have to generate more accurate material. There are no claims that certain conditions will assist in any conclusions being made about the data. This also relates to Participant 5, whose data did not come in the form of a recorded verbal interview, but from interview style email communication.

### **Ethics**

The ethical implications of this study were seriously considered, especially due to the research being about past counselling experiences and interviewing participants who have a disability. The research proposal was accepted by the School Ethics Committee and the University Ethics Board.

The researcher was skilled and comfortable in communicating with people who are hard of hearing and who lipread as her mother has an acquired hearing loss and is profoundly hard of hearing. Any required adaptation included speaking very clearly, repeating words, and sometimes using finger spelling for the first letter of words which were hard to lipread. It was also recognised that each participant would have a different severity of hearing loss and individual ways of understanding speech and there was therefore a consistent openness about being educated by the participants in order to be able to adapt to their individual needs. It was made clear in the recruitment literature that the participants must be able to lipread if their hearing loss



was severe enough to not be able to hear speech. This was believed to be in the best interests of the participants to prevent the researcher working outside her capabilities in communication.

Prior to each interview, the participants were provided with a Briefing Document explaining the research, along with a Consent Form. Following the interviews, participants were given a Debriefing Document which included information on how they could anonymously withdraw from the research should they wish to do so and they were given the option of speaking with the researcher following the interview as emotional material may have been talked about. None of the participants chose to do this. Copies of all of these documents can be found in the Appendices section.

## **Analysis**

Researchers in discourse analysis often warn against systemising their approach as it is concerned with a sensitivity to language rather than as a method (e.g. Wetherell & Potter, 1992; Willig, 1999, as cited in Parker, 2004), but it is possible to indicate stages in the process (Potter, 2004). In discourse analysis, analysts can adopt their own methodological procedures, providing the researcher explains their detailed and thorough process with justification of their choices (Taylor, 2001, as cited in Morgan, 2010). Therefore, a Foucauldian discourse analysis was carried out with some guidance from Parker's criteria (1992, 2005), and incorporating the ideas of Willig (2000) in her recognition of the lay population potentially positioning themselves in relation to expert discourses and producing alternative constructions.

Each participant interview was transcribed and within each transcription, every point was noted in which an assumption could not be accepted and objects, subjects and pictures of the world were observed and highlighted, alongside the type of power in play (Parker, 2005). Any contradictions within the original transcriptions were then determined in which participants created alternative subject positions for themselves (Willig, 2000). All of this criteria was used to organise the material into discourses, and within these discourses, categories were established which then framed the text (Parker, 2005). Parker (2005) stated that the categories may refer to ideological images, so this was adhered to with the dominant discourses. The discourses created by the participants in any discourses of resistance were not categorised in ideological terms as if all discourses are viewed as ideological, the term becomes redundant (Parker, 1992). The categories within the discourses of resistance were simply referred to as 'images'. Ideological images and other images will be explained in greater depth in the following Analysis chapter. As discourses and ideological images are historically located, a discourse analysis needs to locate its objects in time, therefore explanations were generated as to how the various dominant ideological images arose, how they have changed and how they have told a story (Parker, 1992). The analysis had origins with the hard of hearing client, and developed to relate to any client being 'heard' within the counselling relationship.

## Chapter 5

### ANALYSIS

This chapter will document the analysis of being 'heard' in the counselling relationship, using a form of Foucauldian discourse analysis and originating with the experiences of hard of hearing clients. The analysis was guided by Parker (1992, 2005), and incorporated the ideas of Willig (2000), as outlined in the Methodology and Method chapters. The analysis process will be illustrated, beginning with a reflexive account of the research process. This will be followed by a description of how certain discourses and then categories were generated from the participant data. When categorising the dominant discourses, ideological images were used, as suggested by Parker (2005). Ideologies have been described as:

*'significations/constructions of reality (the physical world, social relations, social identities), which are built into various dimensions of the forms/meanings of discursive practices, and which contribute to the production, reproduction or transformation of relations of domination.'*  
(Fairclough, 1992, as cited in Finch-Lees et al., 2005, p. 1191).

Ideologies have political connotations due to their association with dominance and power (Geertz, 1985; Fairclough, 1992, as cited in Finch-Lees et al., 2005) and are said to be most effective when they become discursively embedded and therefore accepted as common sense (Fairclough, 1992, as cited in Finch-Lees et al., 2005). In addition to these definitions, Parker (1992) states that ideology should be seen as a description of relationships and effects of a particular place and historical period, and later adds that it can relate to a certain practice in which there is organisation of

theoretical frameworks of knowledge (Parker, 2004), which relates to the practice of counselling. Therefore, ideology will be used in the study in relation to the images of being 'heard' which have developed in the practice of counselling, involving the relationship between counsellor and client and the power involved in this. Although Foucault (1980, as cited in Parker, 1992) criticised the term 'ideology' as he associated it with 'truth', it will be used in this study under the guidance of Parker (1992, 2005), with a continual awareness that any such ideological 'truths' can be deconstructed.

This will be followed by a narrative relating to the various ideological images associated with the dominant discourses, interpreting the history and development of each, and a description of the other images connected to the discourses of resistance. Throughout the narrative around the ideological images and other images, the uniqueness of how each participant made sense of their counselling experiences was viewed as important, alongside the broader experience of being 'heard' that cut across their narratives (Pringle & Markula, 2005). The concept of being 'heard' as a hard of hearing client will evolve into an exploration around being 'heard' as any client in a counselling relationship and this will thread through the analysis of the ideological images and other images. The validity and quality of a discourse analysis is based upon the reasoning and arguments provided within the narrative (Fejes, 2008).

### **Reflexivity**

Reflexivity and discourse have been described as culturally bound due to the importance of reflexivity being specific to our time and place within Western culture

(Parker, 1992). It is a necessary component of discourse analysis, but should not be seen as dissolving any discourse as a consequence (Parker, 1992). Therefore, any reflexivity in this study should not be viewed as attempting to remove the researcher's involvement in the research process as this has been deemed impossible.

Central to the debate around 'hearing' the participants is the position of the researcher, which involves particular knowledge, motivation and interest (Holloway, 1989, as cited in Parker, 1992). As referred to in the introduction to this study, the researcher's mother is profoundly hard of hearing and therefore has a certain relationship to hearing disability. This may have affected the way particular aspects of the research have been highlighted and others made less important (Parker, 2005). As a result of the various difficulties the researcher's mother has faced in connection to her hearing loss, the drive for this study originated with a desire to explore the experiences of others in a similar situation and encourage change within the field of counselling in which awareness of this particular client group seemed small. Therefore, championing this client group is likely to have influenced the 'hearing' of their interview material, with various preconceptions about their needs and the counselling process. The organisation of the participant discourse will have been affected by particular requirements (Potter & Wetherell, 1987). The participants were also aware of the researcher's mother's disability and therefore an element of 'being in it together' may have seeped into the interviews, as well as in the subsequent analysis, or both parties wanting to please the other and avoid challenges to the perceived ideas of the research.

The researcher is also a counselling psychologist in training as well as a client and therefore sits on both sides of the 'hearing' process under analysis. The researcher has individual ways of attempting to 'hear' clients and individual desires as to how to be 'heard' by her counsellor. In addition, the researcher has no hearing loss. The participants were aware of all of this which, once again, is likely to have affected their responses. They may have been more likely to adopt discourses that had therapeutic or medical origins, depending on their conceptualisation of the researcher's role. The researcher's clear interest in issues around hearing impairment might have also been met with discomfort due to the researcher not sharing their experience of disability. The analysis itself has been recognised as a working of power as things are classified (Webb & Macdonald, 2007) and the way various discourses and ideological images are described can be reflected upon in terms of individual moral and political choices (Parker, 2002). Therefore, the entanglement between the researcher's personal thoughts, images and history can be spoken of, but not separated due to this awareness, which highlights the mutual constructions that emerge in any human relationship. From these reflexive considerations, the practical account of the analysis undertaken in this study will now follow.

## **Stages of analysis**

### **Step 1**

Each interview was firstly transcribed. An example of a transcript can be found in the Appendices section. All of the transcripts were then carefully read and any parts where there was evidence of a possible dominant discourse in action were copied and pasted onto a new document. Parker (1992) describes a discourse as being

about objects, subjects and pictures of the world, which may appear to involve assumptions, therefore, this was used to guide the decisions. An annotation was made against each selection of text explaining the particular interpretation of the discourse and the relevant type of power being used. Parker (2005) defined these as 'axes of power'.

The following are examples of this initial stage:

Example 1:

**Participant:** 'Because I have this experience of um not...not being 'heard' for who I am as a deaf person. And this was I think around my parents' choice to send me to a normal school where it...I was told 'Don't tell anyone you can't hear' and so um that part he didn't really...get.'

**Annotation:** The subject position of the 'deaf person'. Connected to dominant medical model discourse of disability, but wanting this label to be recognised as part of identity. Being deaf in comparison to what is 'normal' – the counsellor did not understand this as he thought she was 'normal'. The power of the medical model.

Example 2:

**Participant:** 'I wasn't...I wasn't being 'heard' and I think – this is one of the notes I've made here - I think it is because I...I personally have managed to deal with it in my way, that when I go to see people they think 'Well she's asking advice on how to deal with the relationship but she's fine, because she's handling it.'

**Annotation:** ‘Dealing with it’ and ‘handling it’ - part of the Western therapeutic discourse of independence and individualism. To manage individually is positive and therapeutic support is unnecessary. The power of individualistic ideology.

## **Step 2**

The transcriptions were read again to identify any discourses that challenged the dominant discourses, or where the participants were creating alternative subject positions for themselves. This was a similar process to Step 1, in which careful and critical reading was required, but instead of searching for evidence of power in play, any text that provided tension or contradiction was looked for. This process was inspired by Willig (2000) and her suggestion that individuals can position themselves in relation to expert discourses or create alternative constructions. As there are often conflicting discourses within cultural practices, room for resistance is allowed (Parker, 1992). Once again, an annotation was made against each discourse, and these pieces of text were added to the new document alongside the dominant discourses.

An example is as follows:

**Participant:** ‘...so he wasn’t saying ‘Oh what a pity, what a shame, how you must have felt’, this that and the other, he was just talking um.... ‘This is a great gift’ um and it was almost as if he could see the gift and, ‘cause I always sensed that it was a gift um and he was going ‘You have a great gift, let’s develop it here and lets really bring it to light’ and...and anything that’s that kind of a gift is always light...’



**Annotation:** An alternative discourse to viewing disability as a loss – seeing it as a ‘gift’. A reaction to the dominant discourse of the medical model of disability. The hearing impairment becomes objectified as a gift.

### **Step 3**

The document that now contained a variety of possible discourses was filtered into more clearly defined discourses to create discourse headings. As explained in Step 1, Parker (1992, 2005) guides the process of distinguishing discourses due to the objects, subjects, pictures of the world and axes of power, but does not suggest ways of labelling the discourses found. Therefore, the discourse headings were established through an intuitive process resulting in terms that were judged to appropriately summarise the pieces of text they were assigned to. The full document can be found in the Appendices section, but following are some examples of this process:

Example 1:

**Participant:** ‘...with respect to talking to the counsellors um it’s only now I think that my deafness is really becoming the issue because everything else, although I haven’t achieved what I’ve wanted in life, and maybe I’ve just got to come to terms with that properly and recognise that I have achieved everything even though I’ve been lonely, whatever all my life, so that’s for me to deal with, but...but it’s um...it is now being recognised, my deafness and um...and...and I think I’m understanding for the first time that my deafness is an issue here.’

**Annotation:** 'Coming to terms' in relation to her disability and deafness as an 'issue'. The subject position of the 'deaf person' which had been avoided. The power of recognising an identity.

Here, the subject position had been identified in the annotation, as well as the power associated with identity. This extract was one of many that were selected as part of the 'Self/Identity' discourse. The idea of deafness being incorporated into the self and used to describe difficulties in life indicates a powerful discourse in which there are changing subject positions of the self. There is also evidence of other discourses in action, such as the normalising discourse of 'coming to terms' with something that is different and the discourse of individual achievement, which is clearly something this participant sought. This illustrates the complexity of discourses and their interrelationship (Parker, 1992). 'Self/Identity' heading was selected as the predominant discourse and therefore the extract from Example 1 was copied under that discourse heading.

Example 2:

**Participant:** 'I said to him 'I had this peculiar thought' and I told him about it and I said 'Why?' I said 'That wasn't normal'. And he – it was the first time I saw him smile - he said 'I think its anxiety making you be like this', in other words he was...what he was testing me for was to see if I was suffering from a simple human condition like anxiety or whether I really was mentally imbalanced.'

**Annotation:** The medical model discourse about 'normality' and objectifying 'mental illness'. 'Anxiety' and 'mental imbalance' are constructed realities. The power of the medical model.

This extract is seeped with language that can be associated with the medical model. 'Normal', 'anxiety', 'simple human condition' and 'mentally imbalanced' are all concepts that rest on descriptions of individuals in terms of expert judgements, and each take on their own reality for the participant, as identified in the annotation. This was seen to be clear evidence of the medical model as part of the counselling relationship and the discourse heading 'Medical' was chosen to 'fit' with many other extracts where such a powerful process was evident.

Example 3:

**Participant:** '...it's my ears that are here (*makes her hands into ear shapes over her heart*), everywhere (*makes ear shapes all over body*), uh I've got ears all over...'

**Annotation:** Communicating the limits of words for her. Constructing meaning through her hands and recognising how she hears with her whole body.

The piece of text stood out in the particular transcription as there was not only a pause in speech whilst the body took over as a communicative tool, but the participant spoke in a way that contrasted with the previous content. Having 'ears all over' did not appear to resonate with any dominant discourses that had been imposed upon this participant, but illustrated a subversive practice (Willig, 2000). This involved incorporating a new discourse in reaction to the dominant discourses

that described hearing in limited ways and had deemed this participant as different to the 'norm'. Therefore, such extracts came under the heading 'The body/Non-verbal' as evidence of resistance to dominant and powerful discourses.

The relevant sections of text were copied and pasted beneath each discourse heading, forming a second document. The established discourses were divided into dominant discourses and discourses of resistance. The separate headings were created due to the clear difference between the dominant discourses predominantly searched for in conventional Foucauldian discourse analysis and the discourses involving alternative subject positions of the speakers, developed from the ideas of Willig (2000). The word 'resistance' is used in Willig's (2000) literature and was judged as an appropriate term to reflect the type of discourses under its heading in which participants were viewed as resisting the powerful structures that frequently defined them.

### **Dominant discourses**

*Psychological/Therapeutic*

*Self/Identity*

*Medical*

### **Discourses of resistance**

*The body/Non-verbal*

*Personal*

**Step 4**

With the transcriptions now organised by the identification of these various discourses, categories were generated within each discourse by returning to and examining the text under each discourse heading. Parker (2005) encouraged fast choices to be made when deciding upon categories, and suggested ideological images as a useful template to frame the text when analysing dominant discourses. Ideological images were therefore used to categorise the dominant discourses, but the discourses of resistance were only referred to as 'images'. As explained in the opening to this Analysis chapter, the ideas of those who resist power relations cannot be viewed as ideological as the term is made redundant when ideology is described as evident everywhere (Parker, 1992).

**Dominant Discourse:**      **Psychological/Therapeutic**

**Ideological image:**      *'Hearing' the loss*

**Dominant Discourse:**      **Self/identity**

**Ideological images:**      *Being 'heard' as an independent individual*

*Being 'heard' in parts*

**Dominant Discourse:**      **Medical**

**Ideological image:**      *Being 'heard' as being cured*

**Discourse of resistance:** **The body/Non-verbal**

**Image:**      *'Hearing' at another level*

**Discourse of resistance: Personal****Image:** *'Hearing' something else***Step 5**

The ideological images within the dominant discourses and images within the discourses of resistance will now be described in detail. The ideological images will be located historically as a discourse analysis cannot take place without identifying its object in time (Parker, 1992). There needs to be evidence that is beyond the specific extracts of transcriptions to avoid the pitfall of circularity in which the texts are simply used to show evidence of the ideological image in that text (Antaki et al., 2002). The ideological images will document the development of discourses and identify other instances of the discourses (Parker, 1992), therefore showing how wider patterns of talk are mobilised by the participants (Antaki et al., 2002). Because the analysis in this study particularly relates to power, ideology and an institution (counselling), providing a history of discourses and ideological images is described as being of great importance in suggesting how dominant groups provide their justification and prevent other discourses making history (Parker, 1992). The ideological force of language will be explored from the generated images of being 'heard' by observing how 'realities' in ourselves, the world and our relationships are constructions (Parker, 2004).

Foucault did not provide any methodological guidelines about how to carry out the practice of historical location and did not claim that a totalising theory develops as a result of the process, only attempts to grasp the conditions which hold at any moment for stating the truth (Dean, 1994). Therefore, as there do not appear to be

restrictions on how a historical location of discourses or ideological images needs to take place, this will be carried out by relating what has been found in the participant data with other examples in wider literature and there will sometimes be a return to the literature generated in the Theory chapter as part of the process where appropriate. It was decided that linking the Analysis and Theory chapters would illustrate how the various ideological images are replicated in other pieces of literature. There will also be an identification of possible relationships between the different discourses under analysis (Parker, 1992). A good discourse analysis has been described as moving convincingly back and forth between the general and the specific (Antaki et al., 2002) so there will be a focus on the participants and the patterns of talk being used alongside evidence of the existence and development of discourses and ideological images on a larger scale. In addition to this, the relationship between the hard of hearing client and any client being 'heard' in the counselling relationship will be consistently provided.

## **Dominant Discourses**

**Dominant discourse:** Psychological/Therapeutic

**Ideological image:** 'Hearing' the loss

Some participants referred to their hearing impairment as a 'loss', which can be viewed in relation to both the Medical and Psychological/Therapeutic dominant discourses. The Medical discourse will be considered firstly as the label of 'physical disability', which forms an important element of this study, requires the recognition of the 'loss of a bodily function' and the difference to the structured 'norm'. This is very relevant for the hard of hearing individual, whose hearing impairment is often acquired and therefore the loss is highlighted in comparison to when they could hear.

Viewing hearing impairment in terms of a physical loss has developed as a culturally accepted definition, structured within the discourses of the able-bodied. During the interview process, the term 'hearing loss' was consistently used by both researcher and participant, indicating how ingrained it has become in everyday speech. In the Theory chapter, literature from the Royal National Institute for the Deaf described hard of hearing people as having 'a mild to severe hearing loss' ([www.rnid.org.uk](http://www.rnid.org.uk)), showing how the term has been adopted by both hearing and hearing impaired individuals.

Having acknowledged the presence of the medical model in "hearing' the loss', the Psychological/Therapeutic dominant discourse will now become the focus of describing the historical development of the ideological image due to the concept extending beyond the definition of a bodily absence. The following extracts illustrate how loss is integrated in the therapeutic encounter:

Extract 1:

**Participant:** '...it also happened that just before we adopted the kids my dad had died, um, and so one of the big themes that came out of all of this, as we sort of worked through this, was the whole question of loss, and things being taken away from me, and so obviously the hearing came into that because it was just one more thing.'

Extract 2:

**Participant:** '...you know there was quite a large element of...of that experience of counselling helping me to actually um have insights into the impact of my hearing loss, because I think up until that time I hadn't really



**thought about it, um, and I...and it was through the counselling, and obviously the wide ranging discussions, because you know when we started it was kind of looking at every aspect of my life and thinking about how all the different things interact and I think, you know, it actually gave me a different awareness of...of how, you know, how much I had been struggling even though I hadn't recognised it.'**

In both extracts, the counselling process is described as increasing the clients' awareness of their loss. In Extract 1, the loss is associated with another type of loss and the idea of things being taken away, whereas Extract 2 focuses on recognising the feelings associated with loss. In these extracts, conceptualising being hard of hearing as a loss is expressed positively, as the clients' 'difference' is acknowledged within the hearing world which somehow validates their experience. Although being 'heard' within the image of loss could be viewed as restrictive as part of a discourse that makes it appear a reality, understanding hearing impairment in terms of loss can be viewed here as a hopeful predicament for the hard of hearing clients as they relate to the universal concept of loss when they were otherwise experiencing isolation. Ideological images involve a power dynamic, but Foucault was clear to explain that power does not always have to be associated with oppression, but can enable individuals to be positive and creative (Foucault, 1977), which relates to these extracts under analysis.

As the idea of loss has been identified as present within the counselling relationship, the analysis develops from a focus on the hard of hearing client to any client being 'heard' within this framework of loss. Loss has been described in many forms in psychological and sociological literature, initially relating to bereavement or

separation, but also in more hidden ways. Loss of tradition connected to social structures and relations is described (Beck & Beck-Gernsheim, 1995, as cited in Russell, 1999), loss of predictability concerning others in control (Giddens, 1992, as cited in Russell, 1999), loss of codes of morality (MacIntyre, 1981, as cited in Russell, 1999), loss of boundary to self or to role (Sennett, 1977, as cited in Russell, 1999), or loss of order, meaning and purpose (Taylor, 1991, as cited in Russell, 1999). This multitude of losses can be seen to contain other images relating to more discourses, such as the concept of a self and the notion of tradition, each pervading Western culture and at some stage becoming naturalised and accepted.

In contrast to being faced with this array of possible losses, Western culture has not always been so eager to place issues of loss at the forefront and in the early 20<sup>th</sup> century, it has been suggested that issues associated with death and bereavement were denied, with both established as taboo subjects (Clewell, 2004). Freud has been identified as overcoming this cultural situation through his literature on two responses to loss, labelled 'mourning' and 'melancholia' (1917, as cited in Clewell, 2004). He can therefore be viewed as bringing the subject of death, loss and bereavement into the public domain. He describes the processes as being:

*'...in reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as one's country, liberty, and ideal, and so on.'* (Freud, 1917, as cited in Clewell, 2004, p. 43).

These losses are associated with the notion of mourning, suggesting a process of grief should be embarked upon. Within this theory, emotional ties to the lost object

are relinquished, whether through literal or symbolic death and become re-attached to a new object (Clewell, 2004). According to this discourse of loss, the first loss we experience is the mother (Clewell, 2004) and Abraham & Tork (1980, as cited in Clewell, 2004) conceptualise an empty space as a result of this primary loss of the maternal breast. From this, the void of the mouth is filled with words in the infant's process of mourning (Abraham & Tork, 1980, as cited in Clewell, 2004), which describes the process of language acquisition due to this essential loss. This suggestion that language is a necessary replacement for the loss of the mother is a theory that introduces new 'realities' relating to human development.

The influence of Freud has helped pave the way for the therapeutic enterprise and impacted on the Western cultural understanding of grief in which the individual is encouraged to go through a process of stages in the counselling process. In more contemporary dominant discourse, Kubler-Ross & Kessler (2005) have identified these stages of grief as denial, anger, bargaining, depression and acceptance, which have regularly been applied to the actual loss of a person, but also other less obvious 'losses'. Extract 2 perhaps illustrates the hard of hearing client having been subject to a period of denial within the framework of loss as part of the dominant discourse. More specifically, Freud provided the basis for the psychodynamic and psychoanalytic strands of therapy and their development of 'loss language'. Although counselling incorporates many approaches which have relevance to this theme, psychodynamic theory refers to loss in abundance and the concept is seemingly prioritised in the therapeutic encounter. Psychodynamic theory can be seen as owning specific ideas and constructions relating to the theme of loss which

have developed as 'truths' in the therapeutic world and examples of this will now be considered.

As part of psychodynamic theory and practice, a 'relational turn' occurred (Beebe & Lachman, 2003), with a greater interest in the importance of the social world as opposed to only internal processes. This encouraged the integration of attachment theory, in which human beings are viewed as making strong bonds to others and produce a variety of reactions as a result of separation and loss (Bowlby, 1979, as cited in Spurling, 2004). Spurling (2004) describes how loss is conceptualised within this theory:

*'The interplay of attachment, separation and loss runs like a thread through the whole life cycle, but will manifest itself in different forms or through different crises at each different stage.'* (p. 52).

The way loss is viewed infiltrates all aspects of the counselling relationship, including the way time-limited work is managed, with the idea that knowledge of an ending will have a powerful impact on the client and is likely to bring up feelings to do with loss and death (Spurling, 2004). Psychodynamic counselling practice continuously evolves, with client experiences often framed and given meaning by various notions of loss (Spurling, 2004). Clients are therefore being 'heard' from a certain perspective, which can be seen as a created 'reality'.

Returning to the participant data, is the following extract:

Extract 3:

**Participant:** ‘...the whole thing for me is around loss. Um because I think we’ve all kind of got this sense that we’re...we’ve lost a bit of something you know um - not many people I know who feel completely full um and...and not only do they feel full but they don’t even have to be conscious of the fact they feel full they just are full and they can just walk into life as that...’

Extract 3 illustrates the relevance of loss for hard of hearing clients and for any client. This particular client shows how meaning is applied to a particular experience by placing it in a loss framework. The ‘fullness’ described suggests a perceived reality of objects within, that may leave the individual and create a void. Overall, the medical model discourse that views hearing impairment as a loss, is incorporated into the Psychological/Therapeutic discourse of loss in which theories about acceptance, processes and ‘working through’ come to the fore. This suggests being ‘heard’ as a hard of hearing client involves the counsellor recognising a loss, and for any client, importance is placed on ‘hearing’ in terms of loss, in whatever shape it may appear in the individual’s life.

**Dominant discourse:** Self/Identity

**Ideological image:** Being ‘heard’ as an independent individual

Within the discourse of Self/Identity, two ideological images have been suggested in this analysis, concerning individualism and the self. Both are interrelated, but there are subtle differences that will be highlighted and will develop with greater clarity once a history of their development is provided. What appears to emerge is that as a result of the field of counselling gaining awareness and distance from a dominant

discourse such as the medical model, this may just be substituted with another dominant discourse.

'Being 'heard' as an independent individual is the first image to be explored and the following extract depicts how individualism is a key factor in the counselling relationship:

Extract 1:

**Participant: 'Because they don't give you advice, they try and make you correct yourself, you see you have to do it all yourself, that's what counselling's about as far as I can understand yeh, they don't advise you do they, oh no, they get inside you and bring it out.'**

This extract is packed with the language of individualism, focusing on self-correction and doing it 'all yourself'. Perhaps most striking is the final image of counsellors who 'get inside you and bring it out', firstly suggesting a counsellor's perceived ability to bring an objectified 'problem' to the surface, but also assuming this problem is completely contained within the individual. As well as the client appearing detached from any others in their life, the relationship between counsellor and client does not seem to be involved in the process, indicating a passive individual able to be 'corrected' by a counsellor. Whilst elements of medical discourse are evident here with the counsellor as 'expert', the image of the counselling process could also be seen as having traces of the language of business or industry; the client as machine.

The dominant culture has been described as heavily infiltrating mental health care and the counselling process, with the suggestion that there is a covert objective to

make people conform to society's dominant values (Peavy, 1996). For example, the cognitive-behavioural approach has been linked with the smooth-running factory as a life-model, alongside mental health being described in terms of rationality, materialistic values and individualism (Peavy, 1996). The concept of a smooth-running factory is evident in the following participant extract:

Extract 2:

**Participant:** 'But with all counselling I'm frightened of the fact that the counselling process is hindered by deafness and your thought train is messed up once too often and the...it means that you don't get the smoothness that other people probably get through perfect communication, whatever disability they might have, if they can talk and listen, then the counselling shouldn't be so much of a problem...'

Here, the client has a 'thought train' and when words can be heard the ride is 'smooth', and there is 'perfect communication'. The idea of difficulties within the counselling relationship, or ruptures that need repair, are not deemed therapeutic as part of this ideological image of the independent individual. Being hard of hearing is therefore objectified as something separate from the client and something that 'messes up' the counselling as opposed to providing any therapeutic material. Extract 3 builds on this idea, and illustrates how the deafness is conceptualised as separate to the client in the counselling process:

Extract 3:

**Participant:** '...cause they're trying to understand all the emotional stuff from the [mental] illness and I'm trying to help with that, but not thinking that maybe

**the hearing loss was something that's a consideration, that's even causing a problem at the meeting um, you know.'**

This participant suggests an awareness of the dominant discourse in action in the counselling process (Willig, 2000). The hard of hearing individual suffers in a social context due their inability to hear others and the exclusion this brings about, however, this clashes with the individualistic ideology of counselling in which the problems are viewed as rooted in the individual. In this extract, the 'meeting' referred to is the counselling session, therefore the relationship between client and counsellor is also part of the absence of a social context for the 'mental illness'. This can be linked back to the Theory chapter of this study in which a fundamental tension was described in literature comparing the social model of disability with the individualism of the counselling practice. When the client is viewed separately to their social context, the oppression of people with disabilities is disavowed (Swain et al., 2003). The social context for the hard of hearing individual is predominantly the hearing world and therefore the difficulties they face are likely to be associated with this external environment.

This individualism has implications for any client in the counselling relationship. The ideological image of the independent individual has been described as a product of Western culture, in contrast to the presumed collectivism of the East (Sampson, 2000). This results in the individual being abstracted from any situation they are involved with and a person-other relationship of independency (Markus & Kitayama, 1991). Ji et al. (2000) suggest the industrialisation in the West established this predicament, whereas the East's predominant agriculture demanded more



interpersonal skills. There are also theories which explain how institutions such as the church and the family have become less stable, meaning individuals have come to increasingly rely on themselves (Russell, 1999). In contrast to these depictions of the development of Western individualism, is a theory from a religious perspective. This theory acknowledges the secular and scientific domination of the modern Western world, but argues that Christianity has played a key role in modern civilisation (Sampson, 2000). The individual's personal relationship with God is emphasised in Protestant Christianity, together with individual responsibility for salvation and an encouragement of autonomy (Sampson, 2000). From this, the self-sufficient individual is said to have emerged (Dumont, 1985, as cited in Sampson, 2000).

Caplan & Nelson (1973, as cited in Sampson, 2000) describe how the ethic of individualism plays a role in psychology's approach to understanding social problems, which have become more about the individuals than the situations they are in. For example, psychodynamic theory traditionally interprets distress as the result of internal dynamics originating in childhood (Spurling, 2004), although there have been vast developments to this theory and the emergence of the 'relational' approach, as has been previously described in this study. Where originally there was the psychodynamic belief that theorists could not combine an interest in the external and internal world of an individual, new emphasis on the role of mothers emerged, and the communication system they develop with their child from birth (Gergerly & Watson, 1996). From this, greater importance has been placed on the individual in relation to others in the therapeutic process.

Humanistic counselling could be suggested to reflect individualism in a more obvious way. A metaphor associated with this approach is the view of human existence like an acorn, with the individual requiring a nurturing and facilitative environment to successfully grow (Peavy, 1996). This conceptualises a unique individual that has the opportunity to develop without influence of the community they may be a part of. Rogers (1957, as cited in Russell, 1999) speaks of a person's 'locus of evaluation' as internal, individual and personal. This can be challenged from an ethical perspective as the individual does not appear to have any responsibility for the other (Russell, 1999). Within the humanistic philosophy is a primacy of individual ethics which necessarily excludes external morality, and counsellors can be seen as part of this individualistic process (Russell, 1999).

Referring to the counselling venture in a more general sense, individualism is also evident with the notion of someone being provided with a service, which involves an instrumental relationship between person and other (Sampson, 2000). Counselling practice could therefore be seen as part of the consumer industry in which clients are aided in disengagement from difficult relationships with others (Sampson, 2000). The influence of consumerism is evident in these participant extracts:

Extract 4:

**Participant:** '...these are the services that are available', you know either through the NHS or other bodies you know and just so...so you can see it as a package or as a menu, that you can say 'Well I don't really need that right now but I know it's there if I need it later.'

Extract 5:

**Participant: 'I think it...I think it's...it's about how you present things to people in a way that they can then see it as being both available and accessible.'**

In both these extracts the subject position alters from one of client, to one of consumer. This could be viewed as empowering for the hard of hearing individual, or any individual, as it appears the client is in control in contrast to the 'expert' counsellor, although this can be challenged. Terms such as 'empowerment' have become commonplace in counselling as it adopts new discourses from business culture (Russell, 1999) and the language of 'service', 'package', 'menu', 'present', 'available and accessible' all connect with the ideological image of the independent individual who is being 'heard' in a consumer society. This can be criticised on ethical grounds through considering the incompatibility of business and counselling values (Russell, 1999).

The hard of hearing clients have illustrated the individualistic discourse in action, which has been associated with viewing hearing loss as disrupting the 'smooth' counselling process, ignoring the social context of their possible difficulties and encouraging a consumer perspective on the therapeutic encounter. For any client, being 'heard' as an independent individual may incorporate similar factors, with the acknowledgement that 'perfect communication', as suggested in Extract 2, can only be another construction of 'truth'. It may be that the field of counselling emphasises its individualistic elements in the hope of gaining distance from the medical model. This was referred to in the Theory chapter where the literature described counselling as appreciating the personal, the subjective, the individual and the agentic (Allen,

1980; American Psychological Association, 1952; Howard, 1985, 1986; Meara, 1989, 1990; Thompson & Super, 1964, as cited in Howard, 1992). However, another ethically questionable dominant discourse may often become its replacement.

**Dominant discourse:** Self/Identity

**Ideological image:** Being 'heard' in parts

Linked to the ideological image of 'being 'heard' as an independent individual', is the image of 'being 'heard' in parts'. The notion of 'parts' has emerged from the concept of a 'self' that has been objectified and can therefore be divided up. 'Parts' of a self especially relates to the hard of hearing individual, who can be seen to have changing subject positions between the Deaf and hearing worlds. As the description and historical location of this ideological image progresses, the tensions and contradictions involved in this will be apparent.

Extract 1:

**Participant:** 'So what this third therapist did was to really say 'In this room here it's just you the deaf child, you the deaf person, you the deaf adult, you the deaf human being', and so it was just fantastic because he really 'heard' that part of me that had never been quite heard before.'

Extract 2:

**Participant:** 'Through her I have learned that my hearing loss has played a pivotal role in defining how I see myself.'

In these extracts, being identified as someone with a hearing loss is depicted in a positive way as there is relief associated with having a deaf identity 'heard' by the counsellor. Once again, there is evidence of Foucault's (1977) conceptualisation of

power that does not have to be associated with oppression. Although these participants have to identify themselves as either deaf or hearing due to how society is structured, they are somehow validated through adopting the disability label that had previously been ignored due to not being part of the Deaf world. These hard of hearing clients could not hear in a hearing world, and the counsellors 'hearing' their deafness enables an acceptance of their experience.

Whilst also objectifying a 'deaf identity', Extract 3 places it in a negative light as the participant speaks of the counsellor's point of view:

Extract 3:

**Participant: '...they're seeing a deaf person and thinking 'How do we deal with this deaf person?' and I know the person that's on the other side of that deaf issue...deafness issue so um...so it...so I think then I had the best...they dealt with me the best way they could...'**

Here, there is a clear separation of parts of the self – the 'deaf person' and 'the person on the other side'. The hearing counsellor does not include this client as part of the hearing world, but the subject position of 'deaf person' is rejected by this individual.

Similarly, Extract 4 describes the participant not wanting a 'deaf identity' in this situation, and additional dominant discourses are in action when referring to the counselling process:

Extract 4:

**Participant:** ‘...at that time I think I was being ‘heard’ because they were recognising that this was a typical, almost a wom...a female, not a deafness issue but a female issue...’

This interplay of discourses illustrates how this participant is ‘being talked’ by the discourses available to her (Willig, 2000). The ‘deafness issue’ can only be replaced with an alternative dominant discourse, in this case relating to gender, with the ‘female issue’ connected to dominant discourses around women. For example, femininity has been historically associated with emotion, which has been linked to madness and ‘hysteria’, a common ‘affliction’ affecting women in the Victoria Age (Jones, 1953, as cited in Elkins, 2009). However, showing emotions has gradually come to be viewed as positive and healthy alongside the development of therapeutic discourse (Parker, 2008a). Therefore, femininity is now perceived as an asset instead of a threat (Burman, 2006, as cited in Parker, 2008a) and men have become more of a ‘problem’ within mental health discourse as they are associated with a lack of emotional expression (Parker, 2008a). This gendered conceptualisation of emotions is evident in Extracts 5 and 6 in which a male participant speaks of his experience of couple counselling:

Extract 5:

**Participant:** ‘...it was very much a sort of more adversarial, emotionally charged environment where it’s more difficult to...to...to try and...it’s like you’re trying to derail the conversation and the moment by saying ‘Oh I didn’t hear that’, rather than keep...you know.’

Extract 6:

**Participant:** ‘...you think ‘Oh’ yeh, and...and ‘is’ and ‘isn’t’ and ‘can’ and ‘can’t’ is (**Interviewer:** Is huge!) just a huge and...and in an environment like that it’s...it’s difficult to have a proper conversation where you resolve things because you...you it’s so, so easy to pick up the wrong message. Say something and that’s it...it’s just woوو because you’ve heard... (**Interviewer:** The speed of it.) Doesn’t take long, to go from this to this (*mimes something small becoming something big, laughing*).’

The idea of ‘gendered selves’ is evident in these extracts, with the counselling associated with a feminine, ‘emotionally charged’ environment that challenges the masculine discourse of wanting to ‘resolve things’ through ‘proper conversation’. As a hard of hearing client, the misunderstanding of speech is suggested to interfere with the emotional process. The participant could be seen here as fearing his interruption of ‘Oh I didn’t hear that’ would be faced with attacks against his perceived male emotional immaturity as opposed to being as a result of his hearing impairment.

Another participant again objectifies the ‘deaf person’ as a separate part of the self, but this deaf part takes on the qualities associated with discourses around disability, therefore an interplay of discourses evident once again:

Extract 7:

**Participant:** ‘I think that maybe that’s where I feel she’s not quite ‘hearing’, that this is the deaf...now the deaf person in me maybe, appealing for you hearing people to sort it out for me, I can’t do anymore. I think...I think so yes,

**maybe...so yes, all...all my young life maybe my youth has helped me to overcome the deafness and...and maybe I have come over to other people as coping. Now I'm tired and I want other people...but...but I think she's listening...'**

This participant associates her deafness with the part of her that is in need. She therefore positions herself within the dominant discourses of the hearing world in order to be 'heard'. Her language fits with the 'tragedy' version of disability, which would describe having a hearing impairment as a sorrowful situation (Clapton, 2003). Such a discourse connects disability with suffering, dependency, unhappiness and loss (Clapton, 2003). This emphasises the tensions for the hard of hearing client in rejecting and adopting various subject positions in order to be 'heard'. These apparent dilemmas for hard of hearing individuals were reflected in the Theory chapter of this study in which their relationship with disability was described as a subtle one (Corker, 1995). There was also the suggestion of acknowledging the difference of disability in the counselling relationship whilst not allowing it to define the whole person (Westwood & Nayman, 1981), which relates to the image of parts of the self and a changeable identity.

This ideological image of 'being 'heard' in parts' rests on the belief in a 'self' or an 'identity' that can be divided and this relates to any client in the counselling relationship. An individual's identity has been culturally objectified, which is reflected in the growing number of words pre-fixed by 'self' in the last 500 years, such as self-development, self-responsibility, self-expression, self-esteem, self-awareness and self-respect (Gibbons, 1996, as cited in Russell, 1999). People were seen as having a single rational identity in the Enlightenment, whereas a more complex modern 'self'



has emerged and an individual's identities are now viewed as malleable (Russell, 1999). This has been associated with a 'crisis of self' due to the rapid social changes of modernity resulting in the loss of traditional frameworks (Beck & Beck-Gernsheim, 1995; Giddens, 1991, 1992; Heelas, 1992; Lasch, 1984; Taylor, 1991, as cited in Russell, 1999) and this loss of social identity has had implications for the individual. This connects with the earlier ideological image of 'hearing' the loss', as the self is viewed as unstable due to the absence of these frameworks. Concepts of loss and the self are therefore interrelated in their connection to the changing social world.

This 'crisis of self' can be viewed as central to the counselling venture, which is often described as helping individuals in their adjustment to change and providing the possibility of altering their 'identities' (Russell, 1999). The ways of forming identity have become endless and depend on the particular type of client involved (Kelly, 1955). Counselling has been linked with the modernist notions of self and described as constructing its own notions of self which it helps the client create or reinvent (Foucault, 1981, as cited in Russell, 1999). Some counselling models claim to help clients liberate their 'true selves' (Freud, 1922, 1961; Rogers, 1951, 1961, as cited in Russell, 1999). Moreover, both the psychodynamic and humanistic traditions celebrate the notion of the authentic self emerging through a reflexive process (Russell, 1999). In psychodynamic theory, the 'real' self only emerges through the successful negotiation of developmental stages, with each stage referred to as a 'crisis' (Erikson 1963). Whilst in the person-centred approach, as part of a humanistic philosophy, the notion of a 'real' self is central and the client is encouraged to discover the self they 'truly are' (Russell, 1999).

This attention on the 'self' can also be linked with the historical preoccupation with the idea of an internal regulation of self, in which the individual is described as a carrier of the 'self-consciousness of the West' (Elias, 1930, 1978, as cited in Russell, 1999, p. 342). In this way, counselling can be seen as having a role in preventing behaviours associated with criminality or mental illness, which represent diversions from the 'norm' (Russell, 1999). The following participant extract illustrates this in action:

Extract 8:

**Participant:** 'Now the problem was I had been in prison in 2003 after a conviction 2002 when I was inside for 10 months. And I knew which counselling I needed and I pleaded with the authorities, 'Please may I have this counselling, it's to show that I want to better myself'. 'Sir we've got no money', was the response, all the time, 'We've got no money', 'But it's not fair, all these other people who've done things worse than me or not so bad as me they're on the course now, why can't I?' 'Because you're deaf, we can't afford to bring anybody in to help you.'

Here, the participant describes wanting counselling to 'better' himself, therefore it seems to be conceptualised as part of the self-regulation process. The extract also illustrates how the hard of hearing individual is discriminated against due to their disability. Counselling is deemed necessary in this situation due to the notion of self-regulation and yet it is withheld because of the power of the dominant hearing discourse that judges a person with a disability as requiring unaffordable help.

Therefore, in this situation the 'self' needs changing, but the 'deaf self' is not permitted to do this.

Being 'heard' as a 'self' appears to be integral to the counselling relationship, which gives rise to the image of 'being 'heard' in parts'. Whilst the hard of hearing client's altering subject position suggest their identity needs to change in order to be 'heard' in different moments in time, any client may be 'heard' through the framework of the self and identity, whether this relates to their gender or another label attached to them. The counselling process, involving self-fulfilment and self-actualisation as an end in itself can be clearly linked to the previous ideological image of 'being 'heard' as an independent individual' and the ethical dilemmas which emerge as a result.

**Dominant discourse:** Medical

**Ideological image:** Being 'heard' as being cured

The medical model is based on an 'expert' 'diagnosing' a 'patient' and then providing 'treatment' to 'cure' an 'illness' (Elkins, 2009). Being hard of hearing is something that is associated with the medical model as it is a physical disability that has been diagnosed by an expert, therefore a medically defined 'condition' had already been attached to each participant prior to their counselling experience.

This created tensions when the participants talked about the therapeutic process because medical and interpersonal frameworks merged and the similarities in language between mental and physical health became apparent.

Extract 1:

**Participant:** ‘Because they were treating the depressive illness with um medication, but there was nothing really being done about the hearing loss, so when I had the meetings it was mainly focused on how the medication was helping the...you know rather than ‘Well ok we’ve dealt with that piece but we still have to remember that you’ve got a hearing loss that we can’t cure.’”

In this extract there is language from the medical model as the counsellor was ‘treating’ a ‘depressive illness’. This participant talks about his hearing loss as something ‘we can’t cure’ as he must adopt the dominant medical discourse in order to communicate what he experiences as lacking. The counselling process appeared to involve him being ‘heard’ by an expert and because hearing loss could not be ‘cured’, the associated difficulties he faced were not involved in the therapeutic process. The concept of the ‘depressive illness’ being removed through the administering of medication is an example of mental health issues becoming objects that take on separate realities to the clients concerned. The ideological image of being cured is therefore inherently part of the medical model.

Extract 2:

**Participant:** ‘...getting counselling for my...whatever I have. That’s what...I wanted that because maybe that would make me feel more...more better in myself to cope with the everyday life...’

In Extract 2, the participant again adopts medical discourse as she associates counselling with being for something that she ‘has’ and something which requires a label. The fact she refers to this as ‘whatever’ might suggest the confusion over

medical discourse being linked with a therapeutic experience, in which a diagnosis appears necessary although not readily understood. In the Theory chapter of this study, there was literature that described counselling for people with disabilities as often being based on what professionals think the client wants (Dixon, 1977, as cited in Rosenberg, 1997) and pre-understandings associated with a certain diagnosis are often imposed on the therapy (Greenwood, 2008), which provides similar evidence of the medical discourse infiltrating the therapeutic encounter.

The origins of the medical model within the field of counselling are with Freud and his work as a physician (Elkins, 2009). Freud was searching for a cure for hysteria (Elkins, 2009), the female affliction referred to within the Self/Identity discourse, which illustrates the interplay of the gendered and medical discourses. From this, psychoanalysis developed and was the product of the medical community therefore medical terminology emerged alongside (Elkins, 2009). As medical and physical conditions have a bodily reality, 'mental illnesses' too have come to be taken as literal. Alternatives to medically based therapy arose with the introduction of behaviourism to the Western world in the 1920s, which involved new explanations for 'mental illness' that were distanced from the medical model (Elkins, 2009). However, since this development, behaviourism has become strongly connected to the medical establishment, with approaches such as cognitive-behavioural therapy being the empirically supported treatments (Elkins, 2009).

In contrast, humanistic psychology encouraged notions of personal growth, self-awareness, improved relationships and more effective interpersonal skills (Rogers, 1971, as cited in Elkins, 2009), which carried little evidence of medical model

discourse. Rogers (1951, as cited in Elkins, 2009), the founder of the person-centred approach, altered therapeutic terminology from 'patients' to 'clients', refused the use of labelling, and developed the core conditions of empathy, congruence and unconditional positive regard. This is an example of a rejection of the dominant medical discourse in favour of a unique therapeutic discourse created to distance the venture from the associated medical model. Such efforts have been successful in their aims to some extent, but the practice of counselling remains to be heavily influenced by medical discourse (Elkins, 2009), and the alternative therapeutic discourses face other criticisms that were evident earlier in this analysis.

The continual power of medical discourse and the ideological image of 'being 'heard' as being cured' have been suggested to remain due to political and economic reasons, as well as the perceived respect gained from a therapeutic practice having medical foundations. Mainstream psychology has been described as rife with politics and often more connected to money and power than professional or ethical values (Elkins, 2010). Consequently, any therapeutic discourse that distances itself from the medical model is likely to be rejected or ignored in a process that originates with political and economic considerations. Related to this is the current drive towards short-term, technique-dominated, cost-effective counselling, which illustrates the political power over psychological practice (Elkins, 2010). It has also been suggested that there is a type of status and respect given to the field of counselling when it becomes associated with medicine and science (Elkins, 2009). Both have been continually held as important in Western culture, therefore there is a natural tendency to adopt medical model language with the promise of medical and scientific connotations in counselling (Wampold, 2001 et al., 2001).

Many counselling approaches have attempted to gain scientific validation (Peavy, 1996), and the Theory chapter of this study cited evidence of the medical model in the diagnosis of disorders in counselling and the focus on specific techniques which have efficacy connected to positive outcomes (Jensen, 2006). However, it can be argued that experiments and mathematics are incompatible with the therapeutic process and any claims or results cannot therefore be supported (Fancher, 1995, as cited in Peavy, 1996). Applying medical criteria to a nonmedical process can be viewed as very problematic, with the typical therapeutic experience having very little in common with a medical approach (Elkins, 2009). Conversely, contemporary research has actually shown that apparent 'empirically supported' techniques have little to do with therapeutic outcomes and the personal and interpersonal dimensions of therapy are the most influential factors, alongside the context of the therapy under study (Wampold, 2001).

Returning to the hard of hearing participants, the extent of the power of science and medicine is evident in the following extract:

Extract 3:

**Participant:** 'I was terrified that they wouldn't recognise that what I might say was related to being deaf rather than having a mental instability, and I was terrified they'd take my children away from me. As terrifying as that. And I remember the first thing I...and I wasn't well, I mean I knew I wasn't well, it was...it was very bizarre, I knew that my brain wasn't functioning well, and there was this normal side of [participant's name] and this deaf side of [participant's name], the...the...the side of [name] that was affected by the

**deafness, not being able to hear, not being able to get the information, the paranoia that developed from incomplete communication, right?’**

There is evidence of the ideological image of ‘being ‘heard’ in parts’ as the participant describes her ‘deaf side’ and another side or herself, but what is also prominent is the blurring of boundaries between mental and physical health. She describes fearing a consequence of her ‘paranoia’ that would be interpreted as a ‘mental instability’ and not related to her being deaf. She adopts medical discourse to describe her experience which also suggests she is only being ‘heard’ within this framework. This participant is limited to the subject positions of ‘mentally unstable’ or ‘deaf’, illustrating a merging of the medical model with the therapeutic discourse. Willig (2000) suggests that experiencing the body as ‘sick’, ‘healthy’ or ‘disabled’ can become internalised, and this appears evident in the extract, as the participant is defined by the dominant discourses.

It has been claimed that the medical model will continue to dominate mainstream psychology and therapeutic practice in spite of a wealth of criticism (Jesen, 2009; Laungani, 2002; Linley & Joseph, 2004; Joseph & Linley, 2006; Wampold, Ahn & Coleman, 2001, as cited in Wong, 2010). This is due to the credibility of medicine and science which govern Western culture with little threat from any viable alternatives (Wong, 2010). The hard of hearing client has been shown to be ‘heard’ within this medical framework and alongside receiving a disability diagnosis, their ‘mental illness’ is often ‘heard’ in a similar way, with the potential to be ‘cured’. This relates to any client, impacted by the medical discourse that prevails in the counselling relationship.



## **Discourses of Resistance**

As described in the Methodology chapter and the opening to this Analysis section, the analysis will now develop to incorporate the ideas of Willig (2000) and develop a narrative focusing on the images that have emerged relating to discourses of resistance and the alternative subject positions created by the participants. Acknowledging any resistance forms part of a wider critique of Foucault's work involving his frequent denial of the concept of freedom (Vighi & Feldner, 2007) and the possible resistance to change that emerges in relation to social entities (Chiapello & Fairclough, 2002). Therefore, as well as the participants being viewed as subject to the discourses and ideological images previously explored, they are also seen as involved in the creation of discourses and images of resistance. This narrative will relate to each image in turn, with suggestions as to how the images, as part of discourses of resistance, have been formed in reaction to ideological images and dominant discourses. Once again, the descriptions of the various discourses and images are suggestions that have emerged from a particular perspective and an alternative narrative could have been provided by another researcher.

**Discourse of resistance:** The body/Non-verbal

**Image:** 'Hearing' at another level

Some participants spoke of subversive ways of 'hearing' in which they adopted unique subject positions that challenged the dominant discourses. Several of these related to communication as separate from language and therefore they were grouped together under the heading 'The body/Non-verbal' discourse. Within this the image of "'hearing' at another level' was deemed appropriate as the participants suggested the inadequacy of 'hearing' through language alone. Extracts 1 and 2 are

from the same participant interview and introduce the idea of an individual adopting a discourse that is unique to her:

Extract 1:

**Participant:** 'I have a huge number of esoteric interests which are entirely about my deaf person, because I see things at another level.'

Extract 2:

**Participant:** 'I think that he um he really 'heard' my (*pause*) he witnessed what I...the levels at which I 'hear' so um I've often, my sisters and I think well you know, the trouble with the frigging hearing world is they think they can hear but in fact they're not listening to anything, (*laughs*) um that's when we get, you know, pissed off, but there is a level in which we've forgotten how to really listen deeply and there's all sorts of levels of communication, so what this therapist did was he really confirmed for me that yeh I am indeed 'hearing' at other levels...'

'Esoteric' refers to something that is 'designed for, or appropriate to, an inner circle of advanced or privileged disciplines; communicated to, or intelligible by, the initiated exclusively' (Oxford English Dictionary, 1989). This participant adopts the discourses of self and identity and also the medical discourse that would conventionally limit her through the label of 'deaf person'. But she uses these discourses to create a subversive practice by altering the subject position of 'deaf person' as she describes being able to do things others do not and to 'hear' in alternative ways, which completely transforms the medical discourse around people with disabilities. She uses the identity of 'deaf person' as something that resists the

dominant discourses and ideological images that usually define her in narrow ways. The participant has placed the notion of 'hearing' in an alternative framework in which language is not prioritised. She can be seen as reacting to the hearing world and their dominant discourses that divide people into who can hear and who cannot and she subverts the meaning of this. Instead, as a hearing impaired individual, she describes 'hearing' in ways which are not accessible to others.

This has implications for any client in the counselling relationship who could be 'heard' in this broader way. Esoteric interests can be connected to cultural evolution and adaptations in the thinking of the Western world (Carpenter, 1977) which has been incorporated into some counselling approaches and described as liberating (Carpenter, 1977). As part of this are practices such as meditation, which has become a component of some therapies through guidance from the Buddhist faith which claims that our intellect and reason is not strong enough to solve our problems (Kondo, 1952, as cited in Carpenter, 1977). As part of this meditative practice is the teaching to turn attention inwards, achieve insight beyond intellect, broaden and deepen this insight in daily life with others, and ultimately find release from painful situations (Kondo, 1952, as cited in Carpenter, 1977).

The participant continues to express the importance of being 'heard' in alternative ways:

Extract 3:

**Participant:** '...but you know we do have lots of forms of non-local communication and I...I, you know, deaf people tend to do that but as soon as

you get into a school situation you are told ‘No, no, no that’s not what we do’ and so a huge part of me (Interviewer: ‘It’s all squashed down’) yes, a huge part of me was just said ‘That doesn’t count’, and yet for me it was very powerful, so that was the kind of thing, trying to get that back..’

The participant uses the terminology ‘non-local’ in her description in this extract suggesting the communication is different and far-reaching. She describes ‘trying to get that back’, therefore altering her subject position as the disabled person who will always be missing something, to an individual who has had something taken away from her by the hearing world. Counselling involves her attempts to be ‘heard’ through returning to her old way of being and a prioritising of communication that does not rest on language.

These other participants continued with image of “‘hearing’ at another level”:

Extract 4:

**Participant**: ‘...what I was doing with my last therapist was getting beyond the spoken word yeh, and getting into non spoken communication and what wants to be said, what wants to be ‘heard’...’

Extract 5:

**Participant**: ‘I did lots of drawings and I was...that’s what, she’s a visualisation sort of expert you know, and I think in pictures a lot.’

In Extract 4 the participant objectifies her non-verbal communication and gives it life and identity through indicating ‘something’ wants to be ‘heard’. This invites the

image of an entity apart from the client that needs to be allowed to emerge in the counselling relationship. Extract 5 introduces the concept of ‘thinking in pictures’, therefore subverting the dominant ‘thinking’ process and the notion of counselling being a language-based practice. Both these participants want to be ‘heard’ from their own frameworks, which includes non-verbal aspects, in place of the dominant language-based frameworks which take priority in the field of Western conventional counselling.

As a final example of the image of ‘‘hearing’ at another level’ is a participant who explicitly describes the limits of language in communicating her experience:

Extract 6:

**Participant:** ‘I can’t explain, I can’t explain it. My ears and noise in my head...now it’s like the wave and the sea coming in my head (*makes noise*).’

**Interviewer:** ‘Mmm, and because it’s something that’s invisible other people...’

**Participant:** ‘Can’t explain it.’

**Interviewer:** ‘Yes.’

**Participant:** ‘Can’t explain it.’

This participant suffers from tinnitus as well as being hard of hearing. Tinnitus is a condition in which continual sounds can be heard, often in the form of buzzing or ringing (The Royal National Institute for the Deaf, [www.rnid.org.uk](http://www.rnid.org.uk)). Her experiences involving her hearing impairment could not be portrayed through words and her repetition of ‘Can’t explain it’ illustrates how fixed this belief might be. In this case, the participant provides no suggestion as to alternative ways to ‘hear’ or be ‘heard’,

but there appears to be a definitive halt to the possibility of language allowing any communication of her experience.

This data from the hard of hearing participants can be applied to any client in the counselling relationship through recognising that there are broader ways to 'hear' and be 'heard'. These individuals with a hearing impairment are perhaps more able to highlight the limits of communication through language as a result of the greater reliance on other forms of 'hearing' which have been suggested. Within the dominant discourses, the ideological images of "hearing' the loss', 'being 'heard' as an independent individual', 'being 'heard' in parts' and 'being 'heard' as being cured', do not clearly involve 'hearing' the body in the counselling process. Realms of communication relating to the body and what is non-verbal are not described as important elements in these ways of being 'heard'. The participants have resisted this and created subject positions which indicate their abilities to 'hear' and be 'heard' in alternative ways.

**Discourse of resistance: Personal**

**Image: 'Hearing' something else**

Participants also illustrated resistance to dominant discourses in their incorporation of being 'heard' in ways that were completely unique to them, therefore the discourse was entitled 'Personal'. The image of "hearing' something else' could also apply to the previous ideas around embodied communication, but here it has been linked with very individual participant creations which emerged within how they talked about being 'heard'.

Extract 1:

**Participant:** ‘But in other respects the relationship was extremely warm and with a lot of um....a very positive um...um holding – and love if you like. Um and um of course he interpreted it all as being well he was the father figure and I said ‘No, you’re my missing hearing.’’

This extract is complex and full of images, resistance, subversion and individuality. The participant creates the image of the counselling relationship as ‘warm’ and ‘holding’, which is language associated with love and safety and possibly parent and child. This could be seen as resistance to the medical model’s depiction of the expert counsellor who is clinical and distanced. In contrast to the suggestion of ‘father figure’, this participant speaks of ‘hearing’ in the counselling relationship enabling the missing part of herself to emerge through the counsellor. Therefore, the counsellor ‘hearing’ her allows her hearing to return as the participant has created her own symbolism with the counsellor described as her ‘missing hearing’. Her hearing is therefore depicted as something she had lost, which relates to the dominant therapeutic and medical discourses around loss, but she progresses to explain it has been found through her counsellor. Therefore, the subject position of disadvantaged and disabled person is adopted and then transformed into one of an individual finding and gaining. This suggests that she conceptualises the counsellor as being solely for her and she is literally facing something of herself that was missing. It also indicates her taking control in the relationship through correcting the counsellor’s understanding of what he represents which subverts the expert role within the medical model to a greater extent. The extract could also be linked to ‘hearing’ the body as there is the image of the counsellor actually becoming part of

the client's body as he represents her hearing returning. Further resistance to dominant discourses are evident:

Extract 2:

**Participant:** '...there was a huge amount of humour and laughter in the relationship and that actually um that really made me feel 'heard' because there was no sense of heaviness about it, that sort of shame of you know and...and 'Oh this is such a problem', you know that weight, so it was the lightness um the lightness and the laughter and the humour um that really helped.'

This participant reacts against the medical model of disability in which hearing impairment would necessarily be viewed as 'such a problem' and she therefore illustrates her awareness of this discourse and positions herself in relation to it. Her language of 'lightness', 'laughter' and 'humour' is starkly different from any medical discourse as well as being distanced from the ideological image of loss within the dominant therapeutic discourse. The participant therefore provides a new framework for her to gain meaning for her experience and something else is being 'heard'. This is also evident in Extract 3:

Extract 3:

**Participant:** 'I spent my time with animals and climbing trees, kind of...kind of quite a wild child actually and that child had got totally and utterly lost and then went to school and it was kind of oomph you know, 'You've got to do it this way, you've got to fit in with these people' and so I had forgotten that child really and it was like I was trying to bring that one back into being and so I



**couldn't really remember who she was either and the fact he didn't provide a space for it, yeh, so there was a struggle there.'**

This participant wants the child to be 'heard' and associates the dominant culture with a repression of this part of her. Within this are traces of the discourse of self and identity which would provide a framework for the 'child part' of her 'self', but this participant uses the discourse to create an alternative image that is unique to her. The concept of the child being 'heard' resists counselling's individualistic discourse in which the client develops in isolation, as notions of dependency, immaturity and development through others are associated with a child.

Once again, a participant creates a unique image:

Extract 4:

**Participant: '..you know the snakes and ladders board? And you've got a snake that...just as you get to the last square but one and you're almost home and then there's a snake and you go all the way back to the beginning again and you know I've experienced that and that's what my sisters will say and my daughter will say, it's just never quite being able to get into mainstream society, um and so there's always that disappointment, so I can't say it was – did I consciously feel disappointed with either of these two therapists? Because it was just so part of my whole life experience and I just kind of thought 'Well that's what happens.'**

This participant has adopted a metaphor in order to illustrate her experience of the world. The snakes and ladders board gives the image of life as a cruel game, with

counselling as part of this and not being 'heard' as an element of this game. In place of 'being talked' by the dominant discourses, the participant shows her awareness of the oppressive practices of society and positions herself in this predicament by relating it to a game. A contrasting subversive practice is shown in the following extract:

Extract 5:

**Participant:** 'I'm the partially hearing client and you're the counsellor with normal hearing, it's kind of back to front in a way isn't it, because I would worry I can't hear you, why would I think that you would worry you're not 'hearing' me? I just kind of assume you can 'hear' me. So it's odd isn't it? I know what we're looking at; we're looking at something deeper. From the face of it, as a partially hearing person I can say 'Oh well this person's got normal hearing, that's fine, she will hear everything I say, she will 'hear' me.'

This participant plays with the idea of 'hearing', reflecting this study's use of the term. She allows the notion of 'hearing' to have malleable meaning, as she recognises that it is an assumption that someone who can hear is 'hearing'. This participant suggests the 'hearing problem' can be universally applied and therefore any individual can be placed in a hard of 'hearing' subject position. Whilst the dominant discourses in counselling might classify this client within a framework of loss and illness, she makes explicit the assumptions involved in this and instead questions the 'hearing' of the hearing counsellor.

Each of these images within the discourses of resistance, namely The body/Non-verbal and Personal, illustrate how the participants were able to show their

awareness of the dominant discourses in action and position themselves accordingly. What was expressed is relevant to any client as the participants showed how a variety of images can be created which enable the selection of alternative subject positions, highlighting how individuals do not have to be viewed as passive victims within a world of dominant discourses. The discourses of resistance provide examples of the importance of integrating other realms of communication into ways of 'hearing' another in the counselling relationship, whether this be through imagery that reaches beyond the words being spoken, or allowing the body and non-verbal communication to have greater importance.

## Chapter 6

### DISCUSSION

This concluding chapter will firstly summarise and develop the previous analysis of the participant data, with reference to the dominant discourses and the discourses of resistance. Following this, the discussion will show recognition of what might have been absent from the analysis that could have allowed for a more creative process through the participants being 'heard' with greater depth. Although the study's benefits will be acknowledged, there will be an evolution of these ideas which came to the fore at the completion of the study. This was initially as a result of the literature review and the references to infant development and early ways of being 'heard', but also due to the content of some of the hard of hearing participant interviews and the importance they placed on embodied communication. Therefore, this chapter will broaden ideas relating to embodied therapy and to further possible research that could potentially increase the creativity of discourse analysis. This will involve an in-depth account of how the non-verbal aspect of communication is a much overlooked and important aspect of 'hearing'.

From this will be a return to the concept of 'otherness', firstly as a critique of the discourse analysis that took place and also to the suggestion of embodied communication aiding 'hearing'. The theory of 'otherness' challenges any attempts to 'hear' greater truths of participants or clients, but a defence is provided through conceptualising embodied 'hearing' in an alternative way. This will be explained more fully as the chapter progresses. As well as the development of a discussion around embodied therapeutic practice and suggestions for further research, this

chapter will acknowledge the limitations of the study, and describe its contribution to the field of counselling psychology.

### **Summary and implications of data analysis**

This study has focused on the counselling relationship and how clients might experience being 'heard'. Using traditional Foucauldian discourse analysis and incorporating the ideas of Willig (2000) to analyse discourses of resistance, there has been the illustration of dominant discourses evident in the practice of counselling, together with the active involvement of individuals in altering their subject positions. The analysis was based on the researcher's interpretation and could have been created very differently by someone else. For example, a focus on the ideology of the therapeutic language of loss, is likely to connect with the researcher's own experience of loss and its 'working through' in counselling, her specific training as a counselling psychologist which has involved 'loss work' and her awareness of client issues that predominantly revolve around loss. The researcher's mother refers to her hearing as a loss, as does her audiologist and Doctor, and the literature which has been read relating to her diagnosis uses the same language.

This discussion of the data will firstly focus on the dominant discourses that emerged within the study and consider the implications for counselling practice. As part of the dominant discourses, named 'Psychological/Therapeutic', 'Self/Identity' and 'Medical' were the ideological images of "hearing' the loss', 'being 'heard' as an independent individual', 'being 'heard' in parts' and 'being 'heard' as being cured.' Relating to each were suggestions as to the historical developments which allowed for their places in the counselling relationship. What has been identified within this analysis

of the dominant discourses is the integration of politics into the therapeutic field which was especially evident in relation to the medical model and the goal of individualism, both illustrating how other practices in society are mapped onto the therapeutic venture. Psychological therapists have been described as always having a political view of their work, illustrated by a quote from Totton (2003):

*'...every practitioner operates, consciously or not, from some idea of what people should be like' (p.382).*

The medical model was evident in striking ways, with some participants only able to define themselves from this framework. Returning to an example from the Analysis highlights this:

**Participant: 'I was terrified that they wouldn't recognise that what I might say was related to being deaf rather than having a mental instability...'**

Both the disability and the mental health are objectified by this participant, indicating the divisive practices of society resulting in clients only being 'heard' in a specific way, based on the markers of normality. The medical model integrated into the counselling process has been frequently criticised with the argument that there is no empirical support to validate this (Wampold et al., 2001). As an alternative to counselling being submerged in medical discourses could be conceptualising it more as a cultural healing practice, with greater links to religious and indigenous practices than to medical treatments (Frank & Frank, 1991, as cited in Wampold, 2007). Counselling viewed in this way would recognise the importance of a cultural context,

the interaction between counsellor and client and a particular interpretation of events and their meaning (Wampold, 2007). This type of debate over the definition of counselling recognises 'psychology's dual heritage' (Messer, 2004, as cited in Wampold, 2007, p.869) of the scientific and humanistic traditions which frequently divide the profession. The humanistic aspects involve the interpersonal relationship and the process of therapy, which have been shown to be robust predictors of outcome (Norcross, 2002; Wampold, 2001b, as cited in Wampold, 2007). There is the suggestion that science and psychological therapies do not have to be in opposition, but science needs to be applied to the humanistic aspects of counselling to understand the therapeutic process more fully (Wampold, 2007). If counselling is based on a model with distance from a medical basis there is the possibility of unique values enabling clear differentiation from other professions and therefore its continued respect and growth.

Similarly, individualism in counselling has been shown to involve the conflicting values of other ventures. For example, one participant expressed wanting to know in relation to her counselling that:

**Participant: '...these are the services that are available...'**

This resonates with the language of business, as do terms such as 'empowerment', often evident when counselling is described, which carries the assumption that counselling and business values are compatible (Russell, 1999). This has been suggested to ignore other values a particular client may hold and that a goal of individualism in fact creates a standardisation of people (Russell, 1999). Therefore,

the self-determination counselling has been criticised for may never actually be achieved, with every client being encouraged to develop in a similar way. It has also been suggested that counselling perpetuates a cycle of despair for the individuals involved. The absence of community and tradition may have resulted in the experience of low self-esteem, confusion over values, anxiety and depression (Cushman, 1990, as cited in Tredinnick & Flowers, 1999) and if counselling continues to foster individualism, these difficulties will continue. Returning again to the data, one participant described the counselling process:

**Participant: ‘...they try and make you correct yourself, you see you have to do it all yourself, that’s what counselling’s about...’**

This participant is clearly ‘being talked’ by the dominant discourse of individualism in which the therapist and others in the client’s life are not seen as relevant.

From the examples of the medical and individualistic elements within the counselling relationship, this type of qualitative research encourages a critical distance from such ideology and the attempts to define how people should be (Parker, 2008b). This analysis of the dominant discourses has illustrated how clients are ‘heard’ in limiting ways that depend on how the rest of society is structured, and the difficulties and tensions within this process have been described. From these observations of the rigid frameworks within which counselling can be seen to operate, are alternative ideas on ways of being ‘heard’, which developed through an analysis of discourses of resistance.



The second part of the analysis identified the discourses of resistance as being 'The body/Non-verbal' and 'Personal' and developed various images within these. These images were grouped under the headings 'hearing' at another level' and 'hearing' something else', but within these were further images that will be summarised here. The participants suggested 'hearing' esoterically, 'hearing' the body, the counsellor's 'hearing' representing the client's hearing, being 'heard' through humour and laughter, 'hearing' the child and 'hearing' symbolism. This development of analysis illustrated the participants' awareness of dominant discourses and their decisions to create alternative constructions for themselves. The images were explored from the particular point of view of the researcher and could have been conceptualised in other ways, but the aim of analysing resistance was not to create fixed alternative ways of 'hearing' but as encouragement of creativity in the counselling relationship and the suggestion of infinite ways individuals can be 'heard'. The examples highlight how frameworks can be dissolved in the 'hearing' process and the importance of recognising the individual and unique ways clients can be 'heard'.

Overall, the analysis has illustrated how 'hearing' is a complex concept and using a method such as Foucauldian discourse analysis reveals how what is predominantly recognised as truth is culturally formed. Therefore, conventional notions of 'hearing' in the counselling relationship can be deconstructed. It can also be suggested that to fully 'hear' another is an impossibility and instead, what can be 'heard' are various constructions by speaker and listener which are dependent on a wealth of different factors. Alongside this, the incorporation of possible discourses of resistance indicates further scope for 'hearing' in the counselling relationship. A key element of

this resistance focused on bodily and non-verbal communication and this idea will now be developed.

### **Embodiment**

As part of the discourses of resistance, the participant data referred to non-verbal communication several times, such as:

**Participant:** ‘..there’s all sorts of levels of communication, so what this therapist did was he really confirmed for me that yeh I am indeed hearing at other levels...’

**Participant:** ‘...what I was doing with my last therapist was getting beyond the spoken word...’

This was in addition to the non-verbal communication that was described in the developmental literature in the Theory chapter whereby the importance of integrating such ways of ‘hearing’ into communication in the counselling relationship was suggested. The Theory chapter included a summary of literature that related to the non-verbal qualities evident in the conventional counselling relationship. As previously suggested, these bodily or non-verbal ways of communicating or being ‘heard’ could be seen as especially relevant to the hard of hearing client whose reliance on communication through words is limited.

Whilst a distance from social ideology might involve viewing counselling in a more humanistic, interpersonal way, or encouraging focus on the client’s family or community as well as the individual, ‘hearing’ someone in an embodied way, and

therefore integrating the body and mind in the process, may result in a greater distance from the individualistic and medical foundations of counselling which were suggested through the identification of dominant discourses. For example, the traditional healing methods that incorporate the body have been described as focusing on disharmony between the individual and their environment (Crawford & Lipsedge, 2004) which encourages a therapy that views individual distress in terms of the relationship to external factors which will then dictate the subsequent therapeutic process. Therefore, conceptualising the therapeutic process in this embodied way could encourage greater reflection on the value-orientation of the work and 'hearing' in an alternative way.

This has given rise to the following discussion of how 'hearing' predominantly occurs in the counselling relationship and the development of ideas relating to embodied therapies. Whilst non-verbal communication is deemed to be an important aspect of the therapeutic relationship, it is often overlooked by counsellors and within counselling training (Rubin & Niemeier, 1992). In conventional counselling, the weight is usually placed on verbal interventions, which then overshadows the importance of the quality and nature of the therapeutic relationship which can be viewed as separate from the language used (Lemma, 2003). In fact, human communication in its totality is often thought about in terms of language, and acknowledging the existence of a functional communication system without a reliance on words can prove challenging (Bullowa, 1976).

The interest in the non-verbal or bodily realm of communication within counselling appears to be in its infancy, and in traditional psychology there is a suggested

reluctance to speak of bodies talking, but usually of ‘talking heads’ (Feltham, 2008). Although the idea of an integration of the mind and body in health care has been historically documented, the modern scientific approach to healing appears to have reduced the likelihood of a person being viewed as a whole (Latorre, 2000). Although perceived differently in some other cultures, there seems to be minimal attention to the body in Western theory of counselling (Feltham, 2008) with its emphasis on reason and thinking, and an increasing movement towards personal understanding through a cognitive process and away from a trust in feelings (Feltham, 2008). It is perhaps the case that rational thought is deemed to be a more reliable source of therapeutic improvement (Feltham, 2008) and therefore ‘hearing’ within the counselling relationship could be viewed as moving further away from the body, the non-verbal and sometimes feelings, and resting on the cognitive descriptions from the client, with similarly intellectual interventions used by the counsellor. As expressed by Whitehouse (1958):

*We are a verbal culture. We understand through words. We depend on words for contact with each other. We think in words. We can even talk without listening to ourselves and listen to others without hearing.’* (p. 34).

If mainstream psychological therapy remains to conceptualise the mind as the focus of therapeutic treatment, only one aspect of a client appears to be aligned with through the prioritised ‘talking’ (Latorre, 2000). The mind and body have been shown to be connected chemically, there can be greater emphasis on consequently treating them as a system (Latorre, 2000) and there is even neurological evidence for an ‘emotional brain’ and for sensory and feeling level channels having greater

importance than the channels of reason and logic (Damassio, 1994). It has been suggested that in order for some achievement of viewing the mind and body in conjunction, there needs to be a connection between counsellor and client at levels that lay beyond the scope of words (Hoffman, 2009), and this is achieved within Body and Dance Movement Therapies, in which therapists actively work with the body/mind, non-verbal/verbal interconnections as part of the therapeutic process. Such therapists working with the body describe the client's physical condition as inextricably linked to the psychological one (e.g. Whitehouse, 1958; Totton, 2003; Meekums, 2002).

Although this study has illustrated the importance of non-verbal communication in conventional therapy, there remains to be a stark difference to the practices in which non-verbal expression is prioritised or completely integrated with the verbal, which therefore encourages alternative ways of 'hearing'. A variety of therapies are emerging within the therapeutic world which sit in contrast to the dominant verbal practice of mainstream counselling and interrogate the Cartesian mind-body split (Moodley et al., 2008). There is a growing interests amongst counsellors and psychotherapists in the therapist's embodied subjectivities as a source of wisdom (Corrigall, Payne & Wilkinson, 2006; Etherington, 2003; Shaw, 2003, as cited in Meekums, 2008a) and movement metaphors have been described to offer the opportunity to express feelings when language is inadequate (Meekums, 2008b). Observing the literature around these types of therapy provides the possibility for clients' alternative constructions of personal experience to be 'heard'. Embodied therapies embrace the body and may focus on dance and movement, which are seen as a kind of non-verbal language (Whitehouse, 1956) and can perhaps be

viewed as other methods of being 'heard'. A theory within this therapeutic realm is that through having movements witnessed by another person, an individual is able to see themselves with greater clarity (Adler, 1994). In such therapy, the body is sometimes considered to be the unconscious and therefore disregarding spontaneous movements could result in a separation from unconscious experience (Whitehouse, 1958). An acceptance of the bodily communication of a client does not necessarily have to negate the importance of verbal interaction, but the client is able to be enlightened as to the different ways of talking and listening (Latorre, 2000), which might broaden the ways of being 'heard' by another.

The ideas of embodied therapies have been incorporated in some types of more conventional counselling through the distinction between embodied knowing and language based knowing (Shotter, 1996), which suggests an alternative focus to 'hearing' than reliance on the language used. Knowing through language has been connected to theory and skill whereas knowing through embodiment involves the anticipations brought into the therapeutic space and forms a dialogical communication as part of a relational therapy (Shotter, 1996). This embodied knowing encourages counselling in a move away from the Western Cartesian tradition together with the counsellor being viewed as 'expert', as the meeting between counsellor and client is what becomes of importance (Shotter, 1996). In place of being tied to the limits of language, counsellors have been suggested to have the opportunity to feel liberated by moving to a sublingual vocabulary which brings them closer to being alongside their clients and recognising what needs to be addressed (Hoffman, 2009).

Embodiment within counselling can involve 'witness practices', which are ways of relating that operate on the feeling level (Hoffman, 2009). 'Witness thinking' has been described as,

*'a dynamic form of reflective interaction that involves coming into contact with another's living being, with their utterances, with their bodily expressions, with their words, their works.'* (Shotter, 1996, p. 285).

Bodily communication is stated as essential in such therapeutic work and there is attention to breathing, posture, inner and outer voices, alongside an awareness of the therapist's own body (Hoffman, 2009). Recognising what cannot be spoken of within an interpersonal therapy is said to allow for a move away from an understanding of the inner life of the client to a concern with the threads that link together all individuals (Hoffman, 2009). Attempts to manage meaning are perhaps normal in current Western societies and many psychotherapy models are built on this (Shotter, 1996), but communicating via channels that include the non-verbal and the body seems to allow for an acceptance of the shared vulnerability of people who no longer have to find explanations for their distress in the process of talking, but can possibly be 'heard' through their expression of what is seemingly impossible to speak of.

Continuing with the theme of integrating body and mind as other ways of 'hearing' in the counselling relationship is literature on the predominant attitudes in traditional Western mental health care in which illness is seen as located in the individual (Moodley et al., 2008). This is reflected in the medical models of mental health,

disability and counselling. Therapies that do not rely solely on verbal interventions have been suggested to incorporate a wider understanding of the relevant problem (Moodley et al., 2008). The traditional healing methods that recognise illness as disharmony between a client and their external environment (Crawford & Lipsedge, 2004) connects with the social model of disability and has implications for the hard of hearing client whose limbo state between the Deaf and hearing worlds would be the key environmental factor. In such a healing process, a development towards coping with the hearing loss in terms of the imbalance with the environment would be encouraged in contrast to an elimination of symptoms (Waldram, 2000). This type of therapeutic intervention seems to be increasingly popular within Western culture as increasing numbers of people are seeking alternative, complementary and traditional healing, which is perhaps in reaction to the predominant message in psychological therapies that it is only the mind that needs to be treated (Moodley & West, 2005).

Other cultures that are more accustomed to bodily and non-verbal healing processes argue that the talking therapies misunderstand illness presentations (e.g. Bhugra & Bhui, 1998) and many clients depend on traditional healing practices alongside a mainstream mental health professional (Novins et al., 2004). This type of combined therapy that is shown to be requested by clients, and which has been observed in the discourses of resistance in this study's analysis, suggests an integration of bodily communication in conventional counselling could aid an experience of being 'heard'. Returning specifically to the hard of hearing client, it is likely they may experience difficulty hearing the spoken word which suggests there will be a greater reliance on non-verbal communication than their hearing counterparts and a weighting on verbal expression by the counsellor could be viewed as increasing any power dynamic.



Trikakis et al. (2003) suggest more meaningful treatment could occur by accessing the other senses and advocates Sensory Movement Interventions (SMI) in which therapy does not rest on verbal communication. But similar studies that acknowledge therapeutic intervention that integrates the body for such clients are difficult to find.

### **Embodied research**

As a result of this previous consideration and exploration of broader ways of 'hearing' in the counselling relationship, the way the participants were 'heard' in this research has also been reflected upon. Discourse analysis was carried out with a sole focus on the language being used by the participants. Following the suggestion that 'hearing' can be developed in the counselling relationship by integrating the body to a greater extent, using the body in the research process could expand the creativity in 'hearing' data. The discussion so far has focussed on how integrating the body can help avoid the power dynamic as embodied 'hearing' can challenge the individualistic and medical models of counselling. What follows is a consideration of how the body can be conceptualised as another vehicle for the communication of power, which invites a return to the ideas of Foucault.

Foucault had much to say about the body, which encourages the possibility of expanding the reliance on words in the analytic process. Foucault (1977) viewed the body as the critical site for the workings of power and the focus for the practice of discursive formations (Malacrida, 2005). He saw power as being within the body and transmitted by it, and the individual being produced in this process and not formed of some inner essence (Malacrida, 2005). Foucault described how the:

*'...societal values and knowledge, administered through discursive practices such as institutional routines, are written on the surfaces of individual bodies* (1988, 1990, as cited in Malacrida, 2005, p.530).

This suggests the integration of non-verbal communication in a discourse analysis could enable the dominant discourses to be evident in non-verbal ways, therefore providing an additional method to 'hear' how the participants are 'being talked' through their bodies. In addition to this, the body could also be used in an analysis to observe any discourses of resistance and not just as a recipient of inscription (Meekums, 2008a). In the same way this study has justified recognising any alternative subject positions potentially created through language (Willig, 2000), a similar process of resistance could be evident through analysing what is non-verbal. The incorporation of bodily communication in analysis also connects with the context of disability in which the body is the focus of the labelling. In Foucault's model, the body that is different or 'less-than' has been responded to in different ways across time and space (Malacrida, 2005), therefore future research involving people with disabilities could use an embodied analysis to observe the bodily expression of oppression and resistance. Research which is based on a social constructionist perspective has been criticised for ignoring the notion of embodiment and Willig (2000) has encouraged concern with what it means to 'be a body' rather than to 'have a body', which is something that could be more involved in future research. This would involve viewing the body in terms of its experiential and expressive qualities as opposed to only its involvement in communication and symbolism (Willig,

2000). Moreover, the body is involved in its own creation of meanings and not a blank to which meaning is attached (Willig, 2000).

From the literature in this study describing non-verbal communication, data from the hard of hearing participants, Foucault's prioritising of the body, and Willig's (2000) ideas of embodied analysis, there is the suggestion that bodily and non-verbal communication between the participants and researcher could be incorporated in a future discourse analysis. This could be achieved through video-recording the participant interviews and creating a commentary on the non-verbal communication that is witnessed by the researcher. Georgakopoulou & Goutsos (1997) have suggested that new technology could help with the interaction of linguistic and non-linguistic expression in research. It seems that methods could be advanced to allow for a more thorough study of embodiment which would provide integration between the study of language and the study of the body, both illustrating potential discourses in action, therefore language would be analysed in conjunction with what can be seen. This has been achieved in some other research methods, especially relating to Dance Movement Psychotherapy (e.g. Allegranti, 2009; Moore & Yamamoto, 1988). As has been previously suggested, the hard of hearing participants may communicate in a more embodied way due to their necessary reliance on information as separate from the language used. Whilst this might be unique to people with a hearing impairment, it could also provide information as to broader ways of 'hearing' any participant.

Following the suggestion of incorporating the body in discourse analysis, critical discourse analysis (Fairclough, 1992, 2001; Fairclough & Hardy, 1997, as cited in

Finch-Lees et al., 2005) involves the analysis of language, but has also been used to include body language and visual images in the process (Chiapello & Fairclough, 2002). Using this method would also incorporate this study's interest in viewing the individual as agent and not a passive recipient of the power of discourse, therefore recognising the limitation of Foucault's ideas. Critical discourse analysis and critical discursive psychology (Edley, 2001, as cited in Finch-Lees et al., 2005) both draw from Foucauldian discourse analysis but focus on the reactions of lay people and their resistance to dominant discourses. Alongside observing discourse at the macro level, these methods involve closer textual analysis to describe how discourses can be changed or reinterpreted in a process of individual resistance (Alvesson & Willmott, 2002, as cited in Finch-Lees et al., 2005). If used in future research, this method would allow the resistance of participants to take a more prominent position, which could be seen as a way of 'hearing' them with greater success, and also broaden 'hearing' through incorporating the non-verbal.

### **A return to the Other**

As a challenge against the previous suggestion of greater integration of the body in counselling and research, and a potential critique for the discourses and images which emerged in the Analysis that was actually carried out, the concept of 'otherness' will be returned to, which was initially explored in the Theory chapter of this study. The critique of both rests on the premise that the more someone attempts to understand another, the more the other becomes a construction of that person's thinking. Levinas' philosophy challenges any ways of attempting to 'hear' due to a prioritising of the 'I' in establishing ways of developing the framework. This could apply to a counsellor constructing their clients and also researchers

constructing their participants. Foucault provided the foundations for the discourse analysis which was carried out in this study and Foucault's conceptualisation of ethics can be viewed as fundamentally opposed to that of Levinas. Whilst Foucault desired the replacement of a historic meta-narrative with discourse and therefore an ethic that maximises freedom, Levinas prioritised ethics over any concern with being and focused on responsibility for the other (Loewenthal & Abrams, 2005). Whilst both were keen to overcome what is institutionalised, the basis for this is starkly contrasting.

Research focusing on hard of hearing clients could be seen as falling into an unethical practice of labelling a client group in order to generate some authority over the best ways to work in the counselling relationship. It could be viewed as an 'intentional' process, therefore excluding the notion of otherness. Considering the analysis within this study, it may have been more ethical to have identified a real image of otherness by investing in greater creativity and spontaneity in response to the data. An example of this will be attempted here to illustrate the point. On returning to the participant interview transcripts, some images have been generated as a suggestion as to how this spontaneity could have been achieved. Referring to a practical requirement, this participant spoke of the counsellor needing to have 'light on her face':

**Participant: '...we made sure that the room was set up in a in a certain way so that we were sitting by the window with the light on her face um so that I could see her as well as um hear clearly.'**

Putting aside any interpretations of this participant's meaning or experience, a variety of images could be allowed to emerge using the researcher's imagination in a stream of consciousness, as follows:

***'Light on her face'***

*A light being turned on, a light bulb, the counsellor as light bulb, ideas, potential, intelligence, 'hearing' from perspective of logic and cognition, a guiding light, the counsellor as guiding light, light as something angelic, godly and pure, 'hearing' transpersonally, 'hearing' by guiding and encouraging goodness, light in contrast to dark, a fear of darkness*

Continuing from this example is a possible link with the image of darkness which was evident in the following participant extracts, and a similar spontaneous and creative process follows:

**Participant:** '..there was some way in which he hadn't got who I was, and some way in which I couldn't say who I was and so there was this whole shadow area that was not brought into the relationship.'

**Participant:** 'And so that for me is then about myself fully accepting who I am and my gifts and my strengths and what not being able to hear does bring, but because that person was still in the shadows how can you respect and...and fully know who you are if that person is not quite back with you, so I needed to really, really find her.'

***‘Shadow area/person in the shadows’***

*What cannot be ‘heard’, fear of something being ‘heard’, shame, sorrow, exclusion, shadow permanently attached to self, no escape, shadow invisible in darkness, needs light to be seen, the counsellor as lightness allowing the shadows, ‘hearing’ is bringing into the light*

In addition to the critique of this study from the framework of ‘otherness’, there are also challenges against the suggestion of possible future research involving ‘hearing’ participants in an embodied way and the consideration of increased bodily ‘hearing’ in the counselling relationship. The suggestion that non-verbal or bodily communication can aid the process of ‘hearing’ another could be seen as contradicting the notion of otherness and the ethics of Levinas with the insinuation that the other can be understood to a greater extent in this way. This critique could also incorporate the methodological argument that finding additional ways to ‘hear’ suggests a more accurate truth is reached, which would be inconsistent with the post-modern position of this study and be more aligned with a positivist approach.

As a way of combating these critiques, ‘hearing’ in an embodied way, whether in the counselling relationship or the research process, does not have to suggest any greater understanding or truth of the other is reached, but an increased depth to the ‘hearing’ venture is enabled. This allows ‘hearing’ to be conceptualised as a creative undertaking that does not have to occur in a bounded or consistent way. Willig (2000) explains how the body can be viewed as involved in the construction of meanings, which respects the creativity of the body but confirms that no greater reality of the client would be reached as a consequence of ‘hearing’ this. The body

can be integrated with this alternative definition of 'hearing' that never results in an understanding of the reality of another person, but a variety of constructions can be witnessed and 'heard'. Therefore, a development to discourse analysis involving embodied data could allow for a liberated 'hearing' of the participants with no suggestion that this enables any experience to be more accurately understood as the individuals are recognised as other. In a similar way, if the counselling venture becomes more embodied, the parameters of 'hearing' can potentially be widened, with the client and counsellor enabled to embark on a more creative, intuitive and expressive process, with the continued acceptance that 'hearing' any truths of the other is an impossibility.

### **Limitations**

This discussion will now critically reflect on the research that was carried out in greater detail, but the previous development of ideas will continue to be integrated. As documented in the Methodology chapter, discourse analysis became the chosen method after thorough deliberation. It was an effective method in achieving a critical stance towards the field of counselling and allowed for an alternative construction of participant data, with the continued awareness that no truths would be generated. This post-modern perspective acknowledged the inadequacy in claiming definitive answers in research can be found, as other methods of analysis frequently do. Although discourse analysis enables the material basis for oppression to become evident, focusing on language can also be criticised for encouraging the politicising of everyday life (Parker, 1992). When there is a heightened awareness of what language and discourse is doing, an alternative type of oppression may emerge as a consequence and no forms of escaping this are provided. Therefore, whilst the



popular view in psychology that internal cognitions allow people to use discourse needs to be challenged (Parker, 1992), the post-modern view that nothing is more important than language can be viewed as so extreme it is unhelpful.

In defence of this challenge has been this study's incorporation of the analysis of potential resistance of participants and their positioning in relation to dominant discourses. This has indicated how escape from oppressive social practice is possible. It could be suggested that instead of placing language as the focus of study, this research could have prioritised the individual meanings of the participants as another way of 'hearing' them and therefore considered phenomenological methods. But the basis for the methodological journey was the researcher's epistemology, which consistently adhered to a post-modern perspective which encouraged a method choice that would not result in any participant realities being 'heard'. Therefore, whilst it has been acknowledged that a focus on language can suggest an endless preoccupation with an unchangeable dimension of human communication, there has also been the scope for the creativity in this study through recognising that having no truths to be 'heard' can enable greater freedom in the 'hearing' process. This creativity has expanded through considering the potential of embodied 'hearing' and recognising a true other.

With regard to the more practical aspects of the method of data collection, using interviews for a discourse analysis could be criticised as they have been described as distinct speech events with particular conventions that differ from other types of communication (Georgakopoulou & Goutsos, 1997). The incorporation of an analysis of literature relating to counselling, or recordings of a counselling session in

action could have been helpful additional sources. This may have allowed for different discourses to have been identified and further creativity in recognising any discourses of resistance. However, the interview process does have factors in its favour, including the opportunity to expand on certain areas that emerge (McLeod, 1994). This study could also be criticised for analysing one-off interviews in isolation, which has been suggested to weaken any understanding of the participants' discursive practice (Willig, 2000). Willig (2000) suggests a longitudinal design of study in which a history of individual participants can be obtained. This could be another possibility for further research, but would require a thorough methodological discussion as to how greater knowledge of participant history could be incorporated in a post-modern perspective, in which any attempts to gain greater validity of results are rendered meaningless.

A final point as part of the critique of this study relates to the choice of terminology in the analytic process. Following the suggestion of Parker (2005), ideological images within the dominant discourses were selected to frame the interview text and this can be criticised. Vighi & Feldner (2007) argue that Foucault did not claim ideology was necessarily involved in the process of people being made subjects as they could be 'seized' through various disciplinary procedures inscribing themselves on their bodies. Therefore, the data could have been framed in alternative ways, perhaps involving subject positions connected to micro-power (Vighi & Feldner, 2007) that did not have to relate to any ideology. This could also be linked with the previous suggestion of embodied research in which what can be seen when interviewing participants would be analysed in conjunction to what is heard. This could allow for bodies to be 'heard' without the suggestion of ideology whereby what the body

communicates could enable an observation of how individuals are 'seized' without their awareness and language would not be required to communicate this. Although some of the limitations of this study suggest it could have been carried out in alternative and perhaps more effective ways, the study itself, alongside the subsequent development of ideas can be seen as contributing to the field of counselling and this will be the focus of the final section of this chapter.

### **Contribution to counselling psychology**

How this study has made a contribution will firstly relate to how the hard of hearing individual has been highlighted as part of a distinct client group. Also considered is how the dominant discourses in counselling have been observed, therefore increasing awareness of the potential for the therapeutic relationship to be part of an oppressive power dynamic. In addition is the acknowledgement of the diverse resistance of clients and alternative ways of being 'heard', of which the hard of hearing clients have offered unique insight. Connected to this is the suggested contribution to both counselling research and counselling practice regarding embodiment alongside the concept of 'otherness' and 'hearing' as part of an ethical process.

At the focus of this research has been the clear labelling of a disability which creates tension with a philosophical and political stance of challenging the oppressive nature of categories. Categories have been viewed as constructions through language with no 'realities' of their own. Foucault warned against the dangers of 'totalising discourses', and claimed that speaking on behalf of others limits them, which could be applied to this study, but he was also criticised for refusing to commit to positive

recommendations for action (Burr, 1998). The unwillingness to label has been suggested to deny the difficulties people with disabilities may face (Allan, 1996) and they may consequently be disadvantaged when any necessary requirements are left unrecognised (Abberley, 1993, as cited in Allan, 1996). Whilst avoiding making any 'truth' claims throughout the research process, it has been an important task to 'hear' the hard of hearing client group in as much as is possible and this has required an acceptance of the disabled and non-disabled distinction (Liggett, 1998). The analysis can be viewed as a construction on the part of the researcher, with no suggestion of any revelation of reality from the participant interviews. However, highlighting the hard of hearing group as separate from people who define themselves as Deaf or hearing was important to this research with the recognition that their particular needs are often overlooked. This study has highlighted the hard of hearing individual as separate from the Deaf individual and the hearing individual and therefore increased awareness of this client group.

Although this research gradually departed from championing the hard of hearing client group and embarked on a deconstruction of the notion of metaphorical 'hearing', the hard of hearing individual is not to be lost through the rejection of any 'truths' or stability within a post-modern epistemology. It has been of great importance to recognise how hard of hearing clients are enveloped between the dominant hearing and Deaf discourses when there may be alternative ways for them to be 'heard'. Through this research, the hard of hearing individuals have subverted some of the commonplace discourses attached to hard of hearing people and the researcher has attempted to 'hear' their individual data with regards to the 'hearing' venture.

It has been a personal challenge to 'hear' the hard of hearing clients when attempting to explore the universal concept of 'hearing' and being faced with a social constructionist method, but it is important to reflect upon the initial drive to identify and highlight this client group. The decision to focus on the discourses of resistance, in addition to the traditional dominant discourses within Foucauldian discourse analysis, reflected a personal desire to support hard of hearing individuals. Through documenting their contributions to the notion of 'hearing' and potential ways for any client to be 'heard', they can be viewed as subverting the image of a vulnerable client group who are discriminated against and encouraging a broader conceptualisation of the notion of 'hearing'. Therefore, whilst this research reflects a drive to deconstruct the counselling profession, the hard of hearing participants are the voices through which this has been achieved, highlighting the researcher's strong desire for this client group not to be marginalised.

Although this study has labelled the hard of hearing individual, this has been associated with what data this client group could provide in terms of the wider issue of 'hearing' in the counselling relationship. The disability has not been associated with something missing, but with what these individuals could offer that would shed light on the therapeutic venture. They firstly illustrated the dominant discourses in action that could be applied to any client. Whilst there is a wealth of other research relating to the counselling venture, this study argues that the data collection process and the theories which are subsequently suggested do not recognise the important role of discourse in the creation of perceived 'realities' and the whole research process being subject to this. In contrast, this study has enabled the hard of hearing

clients to highlight how counselling adopts a variety of dominant discourses through which the clients are 'heard' and has enabled the psychological institution of counselling to be viewed in an historical and political context.

Secondly, the hard of hearing clients encouraged 'hearing' to be considered in new ways. This research has repositioned the subject as any challenges and reactions to dominant discourses have been explored (Willig, 2000) and the process of deconstructing existing conceptualisations has allowed the construction of new discourses which can encourage change (Marshall & Raabe, 1993). Therefore, as well as observing counselling as an institutionalised practice, there has been the identification of alternative frameworks from which to be 'heard'. As part of this, is the hard of hearing clients' discourse around the body and non-verbal communication. This study has incorporated ideas relating to an embodied way of 'hearing' and being 'heard' within the research process and the therapeutic encounter. From this, has been the recognition that the notion of otherness greatly challenges the counselling and research process and views them as potentially resting on intentionality and so attempts to 'hear' another in this way can be viewed as unethical. There has been reflection on this critique and suggestions as to ways of 'hearing' that could be viewed as non-intentional as part of a creative and spontaneous process. In defence of the challenges provided by Levinas' ethics, which would view embodiment as simply additional ways to construct the other, the individual could perhaps be appreciated non-verbally prior to the dominance of intentionality. This would be a possible way of combining ways of 'hearing' with the ethics of Levinas.

Firstly, this is important for future discourse analytic research in which the integration of the body into the analysis could allow for a new dimension to 'hearing' data, which could be an interesting contribution to the counselling research field. Secondly, there are implications for the therapeutic relationship. There is the hope that the counselling profession can gain awareness of dominant discourses, discourses of resistance and the potential integration of embodied 'hearing'. Alongside this is awareness of the ideas of otherness and the suggestion that counselling needs to undertake a process of reflection and evolve as an ethical venture. If counselling is to be viewed as a moral practice, with an interest in the ethical development of the clients involved, counsellors need to 'hear' their clients as others as well as encouraging them to view themselves in relation to others and engage in moral reflection (Russell, 1999). In this way, counselling could be seen as aiding clients develop a sense of purpose and ethical behaviour (Russell, 1999). Russell (1999) suggests that:

*'...the moral duty of counsellors and counselling discourse is both to self-consciously declare their affinities to systems of morality, and to re-examine the concepts of self which they wish to propagate.'* (Russell, 1999, p. 349).

This could be seen as an ethical way of 'hearing'.

## CONCLUSION

This study in its entirety has moved from considering research and literature relating to hard of hearing clients, disability in the counselling relationship and the ambiguous

term of 'hearing', to documenting the methodological process in choosing Foucauldian discourse analysis, and an additional form of analysis. Research was then provided into 'hearing' in the counselling relationship which illustrated dominant and resistant discourses, and a reflective discussion emerged as to further possible research and a creative and ethical 'hearing' process in the counselling relationship. Throughout the study has been the balance between 'hearing' the hard of hearing client group and 'hearing' the uniqueness of the other.

This has provided a new context for considering the wealth of literature that was generated in the Theory chapter. Much of the literature that related to the hard of hearing client suggested certain requirements might be needed in order for successful 'hearing' to occur. Similarly, there was literature which suggested ways of 'hearing' disability from the perspective of the social model as opposed to the medical model. This study has developed to conceptualise 'hearing' in alternative ways. Although there has been the consistent importance of 'hearing' the client group of hard of hearing individuals, this has not generated a set of rules and parameters as to how this should be done. Likewise, any observed frameworks from which these clients have been 'heard' have not been rejected in favour of new ones. The participants have shown unique and individual ways to be 'heard', including a greater incorporation of the body and creativity. This study also argues for ultimately 'hearing' otherness.

The analysis of the specific client group of hard of hearing individuals has illustrated how being hard of 'hearing' can apply to everyone. This initially relates to the post-modern perspective that there are no truths to be discovered, therefore a variety of



constructions are what can be 'heard'. But it also connects to the notion of something else that needs to be 'heard' and an encouragement for definitions of 'hearing' to expand. This study has not attempted to pin down and define the concept of 'hearing' in the counselling relationship, therefore no conclusions can be made as to the findings or any stable answers to the research question. Instead, this study aims to broaden and liberate thinking about 'hearing', which relates to both research and the practice of counselling. Consequently, this study is relevant for researchers 'hearing' their participants and counsellors 'hearing' their clients.

---

## References

Adler, J. (1994). The Collective Body. In P. Pallaro (Ed.) *Authentic Movement: Essays by Mary Starks Whitehouse, Janet Adler and Joan Chodorow*, pp. 190-204. London: Jessica Kingsley Publishers.

Allan, J. (1996). Foucault and Special Educational Needs: a 'box of tools' for analysing children's experiences of mainstreaming. *Disability & Society*, 11 (2), pp. 219-233.

Allegranti, B. (2009). Embodied Performances of Sexuality and Gender: A Feminist Approach to Dance Movement Therapy and Performance Practice. *Journal of Body, Movement & Dance in Psychotherapy*, 4 (1), pp. 17-31.

Antaki, C., Billig, M., Edwards, D. & Potter, J. (2002). Discourse Analysis Means Doing Analysis: A Critique of Six Analytic Shortcomings. [submission to *Discourse Analysis* online]

Baldwin, T. (2006). Philosophy of language in the twentieth century. In B. C. Smith & E. Lepore (Eds.) *The Oxford Handbook of Philosophy of Language*, pp. 60-99. New York, US: Clarendon Press.

Beebe, B. and Lachman, F. (2003). The relational turn in psychoanalysis: A dyadic systems view from infant research. *Contemporary psychoanalysis*, 39 (3), pp. 379-409.

Bell, D. (1990). *Husserl*. New York: Routledge.

Bhugra, D. & Bhui, K. (1998). Psychotherapy for ethnic minorities: Issues, context and practice. *British Journal of Psychotherapy*, 14 (3), pp. 310-326.

Bicknell, M. & Liefoghe, A. (2006). The art of stress. *Journal of Occupational and Organisational Psychology*, 79 (3), pp. 277-394.

Breggin, P. R. (1999). Empathic Self-Transformation and Love in Individual and Family Therapy. *The Humanistic Psychologist*, 27 (3), pp. 267-282.

Breggin, P. R. (1997). Psychotherapy in Emotional Crises without Resort to Psychiatric Medications. *The Humanistic Psychologist*, 25 (1), pp. 2-14.

Brown, G. & Yule, G. (1983). *Discourse Analysis*. Cambridge: Cambridge University Press.

Buber, M. (1937). *I and Thou*. Edinburgh: T&T Clark.

Bullowa, M. (1976). From non-verbal communication to language. *International Journal of Psycholinguistics*, 5, pp. 5-14.

Burman, E. & Parker, I. (2005). Critical Discursive Practice in Psychological Culture. In W. Zongjie, F. Fan & Z. Weili (Eds.) *Cultural Diversity of Discourse: Facilitate Co-Existence & Harmony* (pp. 80-91). Hangzhou: Zhejiang University Press.

Burman, E. & Parker, I. (1993). *Discourse Analytic Research: Repertoires and Readings of Texts in Action*. London: Routledge.

Burr, V. (1998). Realism, relativism, social constructionism and discourse. In I. Parker (Ed.) *Social Constructionism, Discourse and Realism*. pp. 13-26. London: SAGE Publications Ltd.

Butin, D. W. (2001). If this is resistance I would hate to see dominant: Retrieving Foucault's notion of resistance within educational research. *Educational Studies: Journal of the American Educational Studies Association*, 32 (2), pp. 157-176.

Byre, M. R. (1998). Diversity within the deaf or hard of hearing population: Wisdom from seeing the whole. *Early Child Development and Care*, 147, pp. 55-70.

Carpenter, J. T. (1977). Meditation, Esoteric Traditions – Contributions to Psychotherapy. *American Journal of Psychotherapy*, 31 (3), pp. 394-404.

Chantler, K. & Smailes, S. (2004). Working with difference: Issues for research and counselling practice. *Counselling & Psychotherapy Research*, 4 (2), pp. 34-39.

Chiapello, E. & Fairclough, N. (2002). Understanding the new management ideology: a transdisciplinary contribution from critical discourse analysis and new sociology of capitalism. *Discourse Society*, 13 (2), pp. 185-208.

Churchill, S. D. (2005). Humanistic Research in the Wake of Postmodernism. *The Humanistic Psychologist*, 33 (4), pp. 321-334.

Clapton, J. (2003). Tragedy and catastrophe: contentious discourses of ethics and disability. *Journal of Intellectual Disability Research*, 47 (7), pp. 540-547.

Clegg, J. W. & Slife, B. D. (2005). Epistemology and the hither side: A Levinasian account of relational knowing. *European Journal of Psychotherapy, Counselling and Health*, 7 (1-2), pp. 65-76.

Clewell, T. (2004). Mourning Beyond Melancholia: Freud's Psychoanalysis of Loss. *Journal of the American Psychoanalytic Association*, 52, pp. 43-67.

Coates, J. (2004). *Women, Men and Language, 3<sup>rd</sup> Edition*. Harlow: Pearson Education Limited.

Cohen, C. B. (2003). Psychotherapy with Deaf and Hard of Hearing Individuals: Perceptions of the Consumer. In F. K. O. Yuen (Ed.), *International perspectives on disability services: The same but different*. pp. 23-46. Binghamton, NY, US: Haworth Maltreatment and Trauma Press/The Haworth Press.

Collier, A. (1998). Language, Practice and Realism. In I. Parker (Ed.) *Social Constructionism, Discourse and Realism*. pp. 47-58. London: SAGE Publications Ltd.

Cowan, S. & McLeod, J. (2004). Research methods: discourse analysis. *Counselling and Psychotherapy Research*, 4, p. 102.

Crawford, T. A. & Lipsedge, M. (2004). Seeking help for psychological distress: the interface of Zulu traditional healing and Western biomedicine. *Mental Health, Religion and Culture*, 7, pp. 131-148.

Crotty, M. (1998). *The Foundations of Social Research*. Sage: London.

Damasio, A. R. (1994). *Descartes' Error, Emotion, Reason and the Human Brain*. New York: G.P. Putnam's Sons.

Dean, M. (1994). *Critical and Effective Histories: Foucault's Methods and Historical Sociology*. London: Routledge.

De Bruin, E. & De Graaf, R. (2005). What do we know about Deaf clients after 13 years of ambulatory mental health care? An Analysis of the PsyDoN Database, 1987-1999. *American Annals of the Deaf*, 149.5, pp. 384-393.

Denzin, N. (1997). *Interpretive ethnography: Ethnographic practices for the 21st century*. Thousand Oaks, CA: Sage.

Diaz-Bone, R., Buhrmann, A. D., Rodriguez, E. G., Schneider, W., Kendall, G. & Tirado, F. (2007). The Field of Foucaultian Discourse Analysis: Structures, Developments and Perspectives. *Qualitative Social Research*, 8 (2), pp. 1-26.

Downing, D. G. & Bazargan, S. (1991). *Image and Ideology in Modern/PostModern Discourse*. New York: State University of New York Press.

Edley, N. & Wetherell, M. (2001). Jekyll and Hyde: Men's Constructions of Feminism and Feminists. *Feminism & Psychology*, 11, pp. 439-457.

Elkins, D. (2009). The Medical Model in Psychotherapy: Its Limitations and Failures. *Journal of Humanistic Psychology*, 29 (1), pp. 66-84.

Elkins, D. (2010). David Elkins Responds. *Journal of Humanistic Psychology*, 50 (2), pp. 256-263.

Erikson, E. (1963). *Childhood and Society, 2<sup>nd</sup> Edition*. New York: Norton.

Fejes, A. (2008). Governing nursing through reflection: a discourse analysis of reflective practices. *Journal of Advanced Nursing*, 64 (3), pp. 243-250.

Feldman, D., Kluwin, T. N. & McCrone, W. P. (2006). Deaf clients' perceptions of counselling expertise as a function of counsellor's signing skill, gender and therapy type. *American Annals of the Deaf*, 150 (5), pp. 167-172.

Feltham, C. (2008). Here comes everybody: Multicultural perspectives on the body in counselling, psychotherapy and mysticism. *Counselling Psychology Quarterly*, 21 (2), pp. 133-142.

Fellinger, J., Holzinger, D., Gerich, J, Goldberg, D. (2007). Mental distress and quality of life in the hard of hearing. *Acta Psychiatrica Scandinavica*, 115 (3), pp. 243-245.

Finch-Lees, T., Mabey, C. & Liefouge, A. (2005). 'In the name of capability': A critical discursive evaluation of competency-based management development. *Human Relations*, 58 (9), pp. 1185-1222.

Fonagy, P. and Target, M. (1996). Playing with reality: Theory of mind and the normal development of psychic reality. *International Journal of Psychoanalysis*, 77, pp.217-223.

Fonagy, P. and Target, M. (1997). Attachment and reflective function: Their role in self-organization. *Development and Psychopathology*, 9, pp. 679-700.

Fonagy and Target (2003). *Psychoanalytic Theories: perspectives from developmental psychopathology*. London: Whurr.

Foucault, M. (1977). *Discipline and Punish*. London: Allen Lane.

Foucault, M. (1973). *Madness and Civilisation*. New York: Vintage.

Foucault, M. (1972). *The archaeology of knowledge*. New York: Pantheon.



Fox, N. J. (1997). Is there life after Foucault? Texts, frames and differends. In A. Petersen & R. Bunton (Eds.) *Foucault, Health and Medicine*, pp. 31-50, London: Routledge.

Friedman, M. (2008). Buber and Dialogical Therapy: Healing Through Meeting. *The Humanistic Psychologist*, 36, pp. 298-315.

Friedman, M. (1989). Martin Buber and Ivan Boszormenyi-Nagy: the role of dialogue in contextual therapy. *Psychotherapy: Theory, Research, Practice, Training*, 26 (3), pp. 402-409.

Garrity, Z. (2010). Discourse Analysis, Foucault and Social Work Research: Identifying Some Methodological Complexities. *Journal of Social Work*, 10 (2), pp. 193-210.

Georgakapoulou, A. & Goutsos, D. (2004). *Discourse Analysis, An Introduction, 2<sup>nd</sup> Edition*. Edinburgh: Edinburgh University Press.

Gengerly, G. and Watson, J. S. (1996). The Social Biofeedback Theory Of Parental Affect-Mirroring: The Development Of Emotional Self-Awareness And Self-Control In Infancy. *International Journal of psycho-analysis*, 77, pp. 1181-1212.

Glaser, B. G. (2002). Constructivist Grounded Theory? *Forum of Qualitative Social Research*, 3 (3), pp. 1-10.

Glaser, B. G. & Strauss, A. L. (1967). *The discovering of grounded theory: Strategies for qualitative research*. New York: Aldine.

Glickman, N. S. (2009). Adapting Best Practices in CBT for Deaf and Hearing Persons with Language and Learning Challenges. *Journal of Psychotherapy Integration*, 19 (4), pp. 354-384.

Greenwood, D. (2009). Embracing the 'allegiance effect' as a positive quality in research into the psychological therapies – Exploring the concept of 'influence'. *European Journal of psychotherapy and Counselling*, 12 (1), March 10, pp. 41-54.

Greenwood, D. (2008). A case of counselling with a person diagnosed with dementia. *Philosophical Practice, Journal of the APPA*, 3, pp. 333-341.

Greenwood, D. (2007). Relational care: learning to look beyond intentionality to the 'non-intentional' in a caring relationship. *Nursing Philosophy*, 8, pp. 223-232.

Harvey, M. A. (1989). *Psychotherapy with deaf and hard-of-hearing persons, A systemic model*. New Jersey: Lawrence Erlbaum Associates Inc.

Heaton, J. & Groves, J. (1994). *Introducing Wittgenstein*. Cambridge: Icon Books.

Heidegger, M. (1927). *Being and Time*, as cited in Farrell Krell, D (Ed.). (1978). *Basic Writings Martin Heidegger*. London: Routledge.

Hoffman, L. (2009). The Art of Witness: A new bright edge. *Arts and Architecture*, pp. 1-19.

Howard, G. S. (1992). Behold our creation! What Counselling Psychology Has Become and Might Yet Become. *Journal of Counselling Psychology*, 39 (4), pp. 419-442.

Hui, A. & Stickley, T. (2007). Mental health policy and mental health service user perspectives on involvement: a discourse analysis. *Journal of Advanced Nursing*, 59 (4). Pp. 416-426.

Irving, K., Treacy, M., Scott, A., Hyde, A., Butler, M. & MacNeela, P. (2006). Discursive practices in the documentation of patient assessments. *Journal of Advanced Nursing*, 53 (2), pp. 151-159.

Jacobs, M. (2006). *The Presenting Past. The Core of Psychodynamic Counselling and Therapy*. Oxford: Open University Press.

Jacobs, L. (2009). Attunement and optimal responsiveness. In R. Hycner & L. Jacobs (Eds.) *Relational approaches in Gestalt therapy*. pp. 131-169. Cambridge, MA, US: Gestalt Press Book.

Jenkins, P. (1999). Client or patient? Contrasts between medical and counselling models of confidentiality. *Counselling Psychology Quarterly*, 12 (2), pp. 169-181.

Jennings, J. L. (1986). Husserl revisited: The forgotten distinction between psychology and phenomenology. *American Psychologist*, 41, pp. 1231-1240.

Jensen, D. R. (2006). Medical model influence in counselling and psychotherapy: Counselling Psychology Training Directors' Views. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 67 (4-B), pp. 2229.

Ji, L. -J., Peng, K., & Nisbett, R. E. (2000). Culture, control, and perception of relationships in the environment. *Journal of Personality and Social Psychology*, 78, pp. 943-955.

Kelly, G. (1955). *The Psychology of Personal Constructs, Volume One: a Theory of Personality*. New York: Norton.

Kubler-Ross, E. & Kessler, D. (2005). *On Grief and Grieving: Finding the Meaning of Grief Through the Five Stages of Loss*. New York: Scribner.

Ladkin, D. (2005). 'The enigma of subjectivity': How might phenomenology help action researchers negotiate the relationship between 'self', 'other' and 'truth'? *Action Research*, 3 (1), pp. 108-126.

Laszlo, C. (1995). Is there a hard of hearing identity? *Journal of Speech-Language Pathology & Audiology*, 18 (4), pp. 248-252.

Latorre, M. A. (2000). Integrative Perspectives: A Holistic View of Psychotherapy: Connecting Mind, Body and Spirit. *Perspectives in Psychiatric Care*, 36 (2), pp. 67-68.

Leira, T. (1995). Silence and communication: nonverbal dialogue and therapeutic action. *Scandinavian Psychoanalytic Review*, 18, pp. 41-65.

Lemma, A. (2003). *Introduction to the Practice of Psychoanalytic Psychotherapy*. West Sussex: John Wiley & Sons Ltd.

Loewenthal, D. & Abrams, E. (2005). Responsibility and Ethico-Moral Values in Counselling and Psychotherapy. *Existential Analysis*, 16 (1), pp. 1-23.

Loewenthal, D. & Kunz, D. (2005). Levinas and the Other in psychotherapy and counselling. *European Journal of Psychotherapy, Counselling and Health*, 7 (1-2), pp. 1-5.

Loewenthal, D. & Snell, R. (2003). *Post-modernism for psychotherapists: A critical reader*. East Sussex: Brunner-Routledge.

Luey, H. S., Glass, L. & Elliot, H. (1995). Hard of hearing or deaf: Issues of ears, language, culture and identity. *Social Work*, 40 (2), pp. 177-182.

Lupton, D. (1997). Foucault and the medicalization critique. In A. Petersen & R. Bunton (Eds.) *Foucault, Health and Medicine*, pp. 94-110, London: Routledge.

Lyons-Ruth, K., & Jacobovitz, D. (1999). Attachment disorganization: Unresolved loss, relational violence and lapses in behavioral and attentional strategies. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment theory and research*. pp. 520-554. New York: Guilford Press.

Mackey, H. (2007). Do not ask me to remain the same. Foucault and the professional identities of occupational therapists. *Australian Occupational Therapy Journal*, 54, p. 95-102.

Malacrida, C. (2005). Discipline and dehumanization in a total institution: institutional survivors' descriptions of Time-Out Rooms. *Disability and Society*, 20 (5), pp. 523-537.

Markula, P. (2004). 'Turning into One's Self': Foucault's Technologies of the Self and Mindful Fitness. *Sociology of Sport Journal*, 21, pp. 302-321.

Markus, H. & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological Review*, 98, pp. 224-253.

Marshall, H. & Raabe, B. (1993). Political discourse: talking about nationalization and privatisation. In E. Burman & I. Parker (Eds.) *Discourse Analytic Research: Repertoires and Readings of Texts in Action*. London: Routledge.

McConnell-Henry, T., Chapman, Y. & Francis, K. (2009). Husserl and Heidegger: Exploring the disparity. *International Journal of Nursing Practice*, 15, pp. 7-15.

McLeod, J. (1994). *Doing Counselling Research*. London: SAGE Publications Ltd.

Meekums, B. (2008a). Embodied narratives in becoming a counselling trainer: an autoethnographic study. *British Journal of Guidance & Counselling*, 36 (3), pp. 287-301.

Meekums, B. (2008b). Developing emotional literacy through individual Dance Movement Therapy: a pilot study. *Emotional and Behavioural Difficulties*, 13 (2), pp. 95-110.

Meekums, B. (2002). *Dance Movement Therapy: A creative psychotherapy approach*. London: Sage.

Mitchell, S. A. (1988). *Relational Concepts in Psychoanalysis: An Integration*. Cambridge, Mass.: Harvard University Press.

Mondrzak, V. (2004). Psychoanalytic process and thought: Convergence of Bion and Matte-Blanco. *International Journal of Psychoanalysis*, 85, pp. 597-614.

Moodley, R., Sutherland, P. & Oulanova, O. (2008). Traditional healing, the body and mind in psychotherapy. *Counselling Psychology Quarterly*, 21 (2), pp. 153-165.

Moodley, R. & West, W. (Eds.) (2005). *Integrating traditional healing practices into counselling and psychotherapy*. Thousand Oaks, CA: Sage.

Moore, C. L. & Yamamoto, K. (1988). *Beyond words: Movement observation and analysis*. Netherlands: Gordon & Breach.

Moran, D. (2000). *Introduction to Phenomenology*. London: Routledge.

Morgan, A. (2005). Governmentality versus choice in contemporary special education. *Critical Social Policy*, 22, pp. 325-348.

Mrdjenovich, A. J. & Moore, B. A. (2004). The professional identity of counselling psychologists in health care: a review and call for research. *Counselling Psychology Quarterly*, 17 (1), pp. 69-79.

Myers, S. (2000). Empathic Listening: Reports on the Experience of being Heard. *Journal of Humanistic Psychology*, 40, pp. 148-173.

Nanda, J. (2006). Knowing it in the body: 'I-thou' in therapeutic encounter. *Existential Analysis*, 17 (2), pp. 343-358.

Novins, D. K., Beals, J., Moore, L. A., Spicer, P., Manson, S. M. & AI-SUPERPFP Team. (2004). Use of biomedical services and traditional healing options among American Indians: Sociomographic correlates, spirituality, and ethnic identity. *Medical Care*, 42 (7), pp. 670-679.



Ong-Dean, C. (2005). Reconsidering the social location of the medical model: An examination of disability in parenting literature. *Journal of Medical Humanities*, 26, pp. 64-81.

Oxford English Dictionary (1989). 2nd ed. Oxford: Clarendon Press.

Pallaro, P. (1996). Self and body-self: Dance/movement therapy and the development of object relations. *The Arts in Psychotherapy*, 23 (2), pp. 113-119.

Parker, I. (1992). *Discourse Dynamics: Critical Analysis for Social and Individual Psychology*. London: Routledge.

Parker, I. (1998). *Social Constructionism, Discourse and Realism*. London: SAGE Publications Ltd.

Parker, I. (2004). Discursive practice: Analysis, context and action in critical research. *International Journal of Critical Psychology*, 10, pp. 150-173.

Parker, I. (2005). *Qualitative Psychology: Introducing Radical Research*. Berkshire: Open University Press.

Parker, I. (2008a). Constructions, Reconstructions and Deconstructions of Mental Health. In A. Morgan (ed.) *Being Human: Reflections on Mental Distress in Society* (pp. 40-53). Ross-on-Wye: PCCS Books.

Parker, I. (2008b). Politics versus Psychotherapy. *Psychotherapy and Politics International*, 6 (2), pp. 91-97.

Peavy, R. V. (1996). Counselling as a culture of healing. *British Journal of Guidance & Counselling*, 24 (1), pp. 141-150.

Peperzak, A. (1993). *To The Other: An Introduction to the Philosophy of Emmanuel Levinas*. Indiana: Purdue Research Foundation.

Potter, J. (2003). Discourse analysis and discursive psychology. In P. M. Carnic, J. E. Rhodes & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design*. pp. 73-94. Washington, DC, US: American Psychological Association.

Potter, J. & Wetherell, M. (1987). *Discourse and Social Psychology: Beyond attitudes and behaviour*. London: SAGE Publications Ltd.

Pringle, R. & Markula, P. (2005). No Pain is Sane After All: A Foucauldian Analysis of Masculinities and Men's Experiences in Rugby. *Sociology of Sport Journal*, 22, pp. 472-497.

Pugh, D. & Coyle, A. (2000). The Construction of Counselling Psychology in Britain: A Discourse Analysis of Counselling Psychology Texts. *Counselling Psychology Quarterly*, 13 (1), pp. 85-97.

Rennie, D. L., Watson, K. D. & Monteiro, A. M. (2002). The Rise of Qualitative Research in Psychology. *Canadian Psychology*, 43 (3), pp. 179-189.

Rubin, S. S. & Niemeier, D. L. (1992). Non-verbal affective communication as a factor in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 29 (4), pp. 596-602.

Russell, J. (1999). Counselling and the social construction of self. *British Journal of Guidance & Counselling*, 27 (3), pp. 339-352.

Saffran, J. D. & Messer, S. B. (1997). Psychotherapy Integration: A Postmodern Critique. *Clinical Psychology: Science and Practice*, 4, pp. 140-152.

Sampson, E. (2000). Reinterpreting Individualism and Collectivism, Their Religious Roots and Monologic Versus Dialogic Person-Other Relationship. *American Psychologist*, 55 (12), pp. 1425-1432.

Sarup, M. (1993). *And Introductory Guide to post-structuralism and postmodernism*. Hertfordshire: Harvester Wheatsheaf.

Saussure, F. (1966). *A course in general linguistics*. New York: The Philosophical Library Inc.

Sayre, G. (2005). Toward a therapy for the Other. *European Journal of Psychotherapy, Counselling and Health*, 7 (1-2), pp. 37-47.

Shotter, J. (1996). Talk of saying, showing, gesturing and feeling in Wittgenstein and Vygotsky. *The Communication Review*, 1 (4), pp. 271-495.

Singh, I. (2004). Language, thought and representation. In L. Thomas et al. (Eds.) *Language, Society and Power, An introduction, Second Edition*. pp. 17-34. London: Routledge.

Spencer, M. (2000). Working with issues of difference in supervision of counselling. *Psychodynamic Counselling*, 6 (4), pp. 505-519.

Spurling, L. (2004). *An Introduction to Psychodynamic Counselling*. New York: Palgrave Macmillan.

Sroufe, L. A. and Waters, E. (1977). Attachment as an Organizational Construct. *Child Development*, 48, Society for research in Child Development, pp.1184-1199.

Stubbs, M. (1983). *Discourse Analysis, The Sociolinguistic Analysis of Natural Language*. Oxford: Basil Blackwell Ltd.

Suddaby, R. (2006). From the editors: What Grounded Theory is not. *Academy of Management Journal*, 29 (4), pp. 633-642.

Swain, J., Griffiths, C. & Heyman, B. (2003). Towards a social model approach to counselling disabled clients. *British Journal of Guidance & Counselling*, 31 (1), pp. 137-152.

Teo, T. (2002). Friedrich Albert Lange on neo-Kantianism, socialist Darwinism and a psychology without a soul. *Journal of the history of the Behavioural Sciences*, 38 (3), pp. 235-301.

Thornborrow, J. (2004). Language and the media. In L. Thomas et al. (Eds.) *Language, Society and Power, An introduction, Second Edition*. pp. 55-74. London: Routledge.

Totton, N. (2003). Psychotherapy and Politics: A Crucial Link. *Psychodynamic Practice: Individuals, Groups and Organisations*, 93 (3), pp. 379 – 383.

Tredinnick, M. G, Flowers, B. J. (1999). Individualism and psychotherapy: Are psychologists leading or following individualistic trends? *Counselling Psychology Quarterly*, 12 (3), pp. 303-313.

Trikakis, D., Curci, N. D. & Storm, H. (2003). Sensory strategies for self regulation: Nonlinguistic body-based treatment for deaf psychiatric patients. In N. S. Glickman &

S. Gulati (Eds.) *Mental Health Care for Deaf People*. pp. 203-238. NJ, US: Lawrence Erlbaum Associates.

Ventimiglia, G. (2008). Martin Buber, God and Psychoanalysis. *Psychoanalytic Inquiry*, 28, pp. 612-621.

Vighi, F. & Feldner, H. (2007). Ideology Critique or Discourse Analysis? Zizek against Foucault. *European Journal of Political Theory*, 6 (2), pp. 141-159.

Waldram, J. B. (2000). The efficacy of traditional medicine: Current theoretical and methodological issues. *Medical Anthropological Quarterly*, 14 (4), pp. 603-625.

Walsh, R. D. (2005). Beyond therapy: Levinas and ethical therapeutics. *European Journal of Psychotherapy, Counselling and Health*, 7 (1-2), pp. 29-35.

Walsh, A., Parker, E. & Cushing, A. (1999). How am I gonna answer this one?: A discourse analysis of fathers' accounts of providing sexuality education for young sons. *The Canadian Journal of Human Sexuality*, 8, pp. 1-16.

Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist*, 62 (8), pp. 857-873.

Wampold, B. E., Ahn, H. & Coleman, H. L. K. (2001). Medical Model as Metaphor: Old Habits Die Hard. *Journal of Counselling Psychology*, 48 (3), pp. 268-273.

Watson, N. J. (2006). Martin Buber's I and Thou: Implications for Christian Psychotherapy. *Journal of Psychology and Christianity*, 25 (1), pp. 34-43.

Wareing, S. (2004). What is language and what does it do? In L. Thomas et al. (Eds.) *Language, Society and Power, An introduction, Second Edition*. pp. 1-16. London: Routledge.

Wax, T. & DePietro, L. J. (1984). Managing hearing loss in later life. *Gallaudet College/National Information Center on Deafness*.

Webb, L. A. & Macdonald, D. (2007). Techniques of Power in Physical Education and the Underrepresentation of Women in Leadership. *Journal of Teaching in Physical Education*, 26 (3), pp. 279-297.

Weisel, A. & Bar-Lev, H. (1992). Role taking ability, nonverbal sensitivity, language and social adjustment of deaf adolescents. *Educational Psychology*, 12 (1), pp. 3-13.

Wetherell, M., Taylor, S. & Yates, S. (2001). *Discourse as Data: a guide for analysis*. London: SAGE Publications Ltd.

Wetherell, M., Taylor, S. & Yates, S. (2001). *Discourse Theory and Practice: a reader*. London: SAGE Publications Ltd.

Whitehouse, M. S. (1956). Creative Expression in Physical Movement is Language without words. In P. Pallaro (Ed.) *Authentic Movement: Essays by Mary Starks*

Whitehouse, Janet Adler and Joan Chodorow, pp. 33-40. London: Jessica Kingsley Publishers.

Whitehouse, M. S. (1958). The Tao of the Body. In P. Pallaro (Ed.) *Authentic Movement: Essays by Mary Starks Whitehouse, Janet Adler and Joan Chodorow*, pp. 41-50. London: Jessica Kingsley Publishers.

Wilbraham, L. (2009). Manufacturing willingness: parents and young people talking about sex in an HIV&AIDS epidemic. *South African Journal of Psychology*, 39 (1), pp. 59-74.

Williams, M. (2009). Social Objects, Causality and Contingent Realism. *Journal for the theory of social behaviour*, 39 (1), pp. 1-18.

Willig, C. (2000). A Discourse-Dynamic Approach to the Study of Subjectivity in Health Psychology. *Theory & Psychology*, 10 (4), pp. 547-570.

Winnicott, D. W. (1965). *The Family and Individual Development*. London: Tavistock Publications.

Winnicott, D. W. (1960). The theory of the parent-child relationship, *International Journal of Psychoanalysis*, 41, pp. 585-595.



Wong, P. T. P. (2010). The future of humanistic/existential psychology: A commentary on David Elkins's (2009a) critique of the medical model. *Journal of Humanistic Psychology*, 50 (2), pp. 248-255.

[www.bacp.co.uk](http://www.bacp.co.uk), British Association of Counselling and Psychotherapy.

[www.rnid.org.uk](http://www.rnid.org.uk), Royal National Institute for the Deaf.

Yalom, I. D. (1980). *Existential Psychotherapy*. New York: Basis Books.

## **Appendices**

Briefing Document

Consent Form

Debriefing Document

Example Transcription

Example Analysis Stage, Dominant Discourses and Discourses of Resistance

## **ETHICS BOARD PARTICIPANT BRIEFING DOCUMENT**

**Title of Research Project:** Being 'heard' in the counselling relationship. An investigation into the experience of hard of hearing clients.

Thank you for your interest in this research. I am looking for participants to take part in a 50 minute audio-recorded one-on-one interview. Participants will describe themselves as being on the hard of hearing spectrum, will not use sign language as their main form of communication, and will have had an experience of counselling. If participants are unable to hear speech they will need to have a basic ability to lip read. The interviewer has experience in conversing with hard of hearing people.

### **Brief Description of Research Project:**

This research is an attempt to discover the individual experiences of therapy from the point of view of hard of hearing clients, with a focus on the extent to which they felt 'heard' within the therapeutic relationship. This will include the clients' account of any practical difficulties as well as the extent to which their unique experiences of being in the world were understood by the counsellor.

The hard of hearing client provides the focus of the research due to their unique position of being between the Deaf and hearing worlds and the lack of research giving them the opportunity to be 'heard'.

### **The interview**

The 50 minute audio-recorded research interview can take place in a private room at Roehampton University, or I could travel to your home if that would be more convenient. The interview may mean talking about some difficult experiences which could bring back uncomfortable memories. I will be available for 20 to 30 minutes following your interview should you wish to talk about your thoughts and feelings relating to the material we covered. Should you wish to discuss in greater depth any issue that arose for you during the course of the research, for which you may need more specialist support than I am able to offer, you will be given the relevant contact details.

All information you provide will be treated in confidence by the investigator and your identity will be protected in the publication of any findings. You would be free to

withdraw from the research at any point using an ID number you will be provided with, but aggregate data may still be used or published.

**Please contact me should you be interested in being a participant.**

**Investigator Contact Details:**

Sarah Knight  
School of Human and Life Sciences  
Roehampton University  
Whitelands College  
Holybourne Avenue  
London, SW15 4JD  
[Sarah\\_knight82@hotmail.com](mailto:Sarah_knight82@hotmail.com)  
Or [knight12@roehampton.ac.uk](mailto:knight12@roehampton.ac.uk)  
07813672788

Please note: if you have a concern about any aspect of your participation or any other queries, please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student, you can also contact the Director of Studies.)

**Director of Studies Contact Details:**

Anne-Marie Salm  
School of Human and Life Sciences  
Roehampton University  
Whitelands College  
Holybourne Avenue  
London, SW15 4JD

0208 3928618

[a.salm@roehampton.ac.uk](mailto:a.salm@roehampton.ac.uk)

**Dean of School Contact Details:**

Michael Barham  
School of Human and Life Sciences  
Roehampton University  
Whitelands College  
Holybourne Avenue  
London, SW15 4JD

0208 3923617

[m.barham@roehampton.ac.uk](mailto:m.barham@roehampton.ac.uk)

**ETHICS BOARD  
 PARTICIPANT CONSENT FORM**

**Title of Research Project:** Being 'heard' in the counselling relationship. An investigation into the experience of hard of hearing clients.

**Brief Description of Research Project:**

This is a study with hard of hearing clients who have had a past experience of counselling. It is an attempt to discover their individual experiences of therapy, with a focus on whether they felt 'heard' within the therapeutic relationship, and will include the clients' account of any practical difficulties as well as the extent to which their unique experiences of being in the world were understood by the counsellor – if at all. The study involves a 50 minute audio-recorded interview with each participant.

Following analysis of the interviews the researcher will consider the more general question of whether any client can be 'heard' in the counselling relationship, including an exploration of what it actually means to be 'heard' for a client. The hard of hearing client provides the focus of the research due to their unique position of being between the Deaf and hearing worlds and the lack of research giving them the opportunity to be 'heard'.

**Investigator Contact Details:**

Sarah Knight  
 School of Human and Life Sciences  
 Roehampton University, Whitelands College  
 Holybourne Avenue  
 London, SW15 4JD  
[Sarah\\_knight82@hotmail.com](mailto:Sarah_knight82@hotmail.com)  
 Or [knights12@roehampton.ac.uk](mailto:knights12@roehampton.ac.uk)  
 07813672788

**Consent Statement:**

I agree to take part in this research and have read the Briefing Document. I am aware that I am free to withdraw at any point using the ID number I have been given, but aggregate data may still be used or published. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings.

Name .....

Signature .....

Date .....

Please note: if you have a concern about any aspect of your participation or any other queries, please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student, you can also contact the Director of Studies.)

**Director of Studies Contact Details:**

Anne-Marie Salm  
School of Human and Life Sciences  
Roehampton University  
Whitelands College  
Holybourne Avenue  
London  
SW15 4JD

0208 3928618

[a.salm@roehampton.ac.uk](mailto:a.salm@roehampton.ac.uk)

**Dean of School Contact Details:**

Michael Barham  
School of Human and Life Sciences  
Roehampton University  
Whitelands College  
Holybourne Avenue  
London  
SW15 4JD

0208 3923617

[m.barham@roehampton.ac.uk](mailto:m.barham@roehampton.ac.uk)

## **ETHICS BOARD DEBRIEFING INFORMATION**

**Title of Research Project:** Being 'heard' in the counselling relationship. An investigation into the experience of hard of hearing clients.

### **Brief Description of Research Project:**

This research is an attempt to discover the individual experiences of therapy from the point of view of hard of hearing clients, with a focus on the extent to which they felt 'heard' within the therapeutic relationship. This will include the clients' account of any practical difficulties as well as the extent to which their unique experiences of being in the world were understood by the counsellor.

Following analysis of the interviews, the researcher will consider the more general question of whether any client can be 'heard' in the counselling relationship, including an exploration of what it actually means to be 'heard' for a client. The hard of hearing client provides the focus of the research due to their unique position of being between the Deaf and hearing worlds and the lack of research giving them the opportunity to be 'heard'.

### **Debriefing Information:**

Thank you for your time. I'm aware that we may have spoken about some difficult experiences, which may have brought back uncomfortable memories.

Do you feel that you have any further comments or questions before we end for today? I will be available for 20 to 30 minutes following your interview should you wish to talk about your thoughts and feelings relating to the material we covered.

Should you wish to discuss any issue that arose for you during the course of the research in greater depth, for which you may need more specialist support than I am able to offer, you may find the following contact details useful:

The British Association for Counselling and Psychotherapy (BACP) and United Kingdom Council for Psychotherapy (UKCP) have lists of therapists and the sites to search for, which can be found at

<http://wam.bacp.co.uk/wam/SeekTherapist.exe?NEWSEARCH> or  
[http://www.psychotherapy.org.uk/find\\_a\\_therapist.html](http://www.psychotherapy.org.uk/find_a_therapist.html).

Alternatively, you could ring 0870 443 5252 or 020 7014 9955 if you don't have access to the internet.

You are free to withdraw from this research at any point using the ID number provided below, but aggregate data may still be used or published.

Your ID number is: .....

**Investigator Contact Details:**

Sarah Knight  
School of Human and Life Sciences  
Roehampton University  
Whitelands College  
Holybourne Avenue  
London, SW15 4JD  
[Sarah\\_knight82@hotmail.com](mailto:Sarah_knight82@hotmail.com)  
Or [knights12@roehampton.ac.uk](mailto:knights12@roehampton.ac.uk)  
07813672788

Please note: if you have a concern about any aspect of your participation or any other queries, please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student, you can also contact the Director of Studies.)

**Director of Studies Contact Details:**

Anne-Marie Salm  
School of Human and Life Sciences  
Roehampton University  
Whitelands College  
Holybourne Avenue  
London, SW15 4JD

0208 3928618

[a.salm@roehampton.ac.uk](mailto:a.salm@roehampton.ac.uk)

**Dean of School Contact Details:**

Michael Barham  
School of Human and Life Sciences  
Roehampton University  
Whitelands College  
Holybourne Avenue  
London, SW15 4JD

0208 3923617

[m.barham@roehampton.ac.uk](mailto:m.barham@roehampton.ac.uk)

**Declaration:**

I confirm that the interview was conducted in an ethical and professional manner and that I am happy for the research to proceed using my material.

Name of participant:

Signature:

Date:

Researcher name

Signature:

Date:



## Example Transcription

### So can you tell me about your-your hearing um loss to start with and...

Ok, so I was born with um a severe to profound hearing loss **Mmm** and I have an older sister and a younger sister with the same hearing loss but there's no previous history in our family **Ok** So it's just popped up randomly. So...and I have a brother who has normal hearing and um (*pause*) so I was born in 1950. **Mmm-mmm**. Um and hearing aids didn't um come into being until 1951. **Right, right**. As well as which um I don't think my parents realised that there was any problem. **Mmm**. And even though when they did I...we all seemed to be coping anyway **Mmm, mmm** because we were using lots of other strategies to hear, **I see** what...one of which was automatic lipreading because that's what babies will do. **Right, right**. Um another was using um cognitive processes to say 'Well, I can...I can hear these sounds which are all vowel sounds' – what gets cut out with a with a high frequency hearing loss is the consonant sounds of speech, **Right, right** yeh? – but the vowel sounds sound very normal, the low frequency vowel sounds, **Mmm-mmm** high frequency's more complicated **Mmm-mmm**, but you have this long rumble of sound **Mmm**, um but the shape of the lips, put...put the shape of the words to it. **I see, I see**. So as a small child I would have learnt to have coped quite well. **Mm-mmm, mm-mmm**. Um as well as which my mother was a teacher **Mmm** and we all learnt to read very early **Mmm** and she was – I can hear at close distances, so if I am a child sitting on her lap, her voice is quite close to my ear **Yes, yeh** and you know, you...you, when you...you've got one sense that's totally down you find other ways to compensate so once you learn to read you then get another way of cognitively hearing things. **Mmm, mmm, mmm**. So a lot of my hearing is not actually to do with actual auditory stuff it's more thinking stuff. **I see, I see**. Yeh, it gets very tiring.

### And what would you say was the severity of...of the hearing loss?

Well I'm now registered profoundly **Right** deaf **Right** but on the best end of it **Ok**. My older sister um can't even use the telephone and she'd be fine in this situation but she can...she can she's got a real hearing problem, **Mmm** she's very profoundly deaf **Mmm, mmm** and she didn't learn to sign. And the biggest problem was that with being the 1950s um, the...there were no special services in education. **Mmm**. You either went to a school for special education **Mmm** or you went to an ordinary school and in those days special – as they were called, they were called special schools – they weren't very good at all **Right**. Both my parents were academics and teachers and they wanted us to go to ordinary schools and so the long and short of that was that I went to school being told 'don't tell anyone you can't hear' **Mmm, mmm** and I would say that most of the problem of not...of not being heard um – 'cause the main thing with counselling is 'Am I being heard by my counsellor?' **Mmm, mmm** – stemmed from this...from...from um, being in a kind of limbo situation. When you're not deaf you don't belong to deaf people **Mmm, mmm**. When you're not hearing you don't belong to hearing people **Mmm, mmm** so you're stuck in the middle and you can't really say 'I can't hear' because it appears you can, **Yes, yeh** you can't really say 'I'm deaf' because you're not actually **Mmm, mmm**, so where do you belong? And there's a whole sense of not being heard around that **Mmm, mmm** um and I certainly wasn't able to say at school 'I can't hear well enough' **Mmm**. So you develop all sorts of strategies **Mmm** which are masking that. **I see, I see**. So that's really where I um...um began.

### And...and I understand that you're both a therapist yourself....are you...do you describe yourself as a counsellor or...um, psychotherapist? Or...

Um well I, technically I only have a counsellor training in this country but I did do a psychotherapist training in abroad, in Europe **Right**, however it's not accredited in this country **I see, I see** and so I did a um a counsellor's training in this country so that I would um be able to register to the BACP. **I see, I see**. Yeh.

### And so as well as being a counsellor you're...you have of course been a client.

I have definitely.

### And have you had several experiences of being a client?

Um, do you mean by that different...in effect with different counsellors?

**Yes, yes.**

Yes I have and I have actually only ever worked with UKCP psychotherapists, **Right**, um **right** so in a sense I don't really know what it's like to be a client of a counsellor because they sometimes are different breeds. I've only done depth work, um and I have um one um, three major, major events, **Ok** yeh, I think in 1998 **Mmm-mmm**, the last twelve years three different blocks with three different **Mmm-mmm**, **mmm-mmm**, the second two - the first one was personal, **Mmm-mmm** you know, needing to sort myself out, the second two were relating to training.

**I see, I see. Is it ok for you to talk about each of those experiences separately?** Yeh sure, absolutely, if I can... **Yes, absolutely, yeh. From what you can remember. Yeh And so I'm thinking about whether um, as you put it as well, whether you felt heard Yeh in those experiences or if you didn't or just very generally whatever you feel is relevant.**

Um, you know actually one of the things that I was gonna say is that, it's really – it's an odd notion isn't it, um I...I'm the partially hearing client and you're the counsellor with normal hearing **Mmm**, it's kind of back to front in a way isn't it, because I would worry I can't hear you **Mmm, mmm**, why would I think that you would worry you're not hearing me? **Mmm** I just kind of assume you can hear me. **Mmm, mmm** So it's odd isn't it? **Yes, yeh.** I know what we're looking at; we're looking at something deeper **Mmm**. From the face of it, as a partially hearing person I can say 'Oh well this person's got normal hearing, that's fine, she will hear everything I say, she will hear me...'

**Mmm, mmm, it's the assumption, mmm.**

The assumption would be you would hear me. **Mmm.** So I'm wondering if it's different, if it really is different if you're a... because all clients feel 'Am I being heard?' **Mmm, yes.** Am I being empathically met by this counsellor? **Yes.** Is she there for me? All those questions. **Mmm, mmm.** And in that sense it makes no difference whether we've got good hearing **Mmm, mmm** or not, um... However your...I do agree with you though there's something a bit more about people with a hearing problem and additionally feeling not heard **Mmm** in another **Mmm** way and so... my first experience being in therapy was probably around that **Mmm-mmm** because it was definitely around uh - this was a male therapist and he really heard me as a person, **Mmm** but, I was frustrated by the whole experience because he never heard me as a deaf person. **Ok.** He never got it because he saw me – he says 'Well you know in a one-to-one you can hear me fine, I don't understand why you've got a problem', **Mmm, mmm** and no amount of my explaining to him that um the world is more than a one-to-one, **Mmm** with no noise around, how it's about confidence, um and it's about um uh, being able to be in groups of people **Mmm** um, he never quite got it **Mmm, mmm** and so in that sense, that I experienced as a kind of total empathic failure **Mmm** you know.

**Mmm. And how long was that counselling?**

That was quite a long period of time because in other respects what he was doing was help me out...helping me out with all the personal stuff we all have **Mmm, mmm** you know um and that was um let me think '98 to 2001, not quite three years, **Right, right** not quite three years.

**And you felt with - with the personal, sort of more specific issues he was empathic and...and Exactly understood but with the hearing he...he didn't.**

He didn't kind of – though he did at one time, I remember him saying 'Well maybe you got a double whammy' **Mmm** um – in...in what he was meaning by that is that when we come into life and our first experience of being parented is that **Mmm**, you know, parent...mother and father's not there, well that...that happens to all of us perhaps **Mmm** but um and that was, if you might call it, personal stuff, **Mmm-mmm** but for me there was another experience as well, not only 'Is mother and father really there for me?' you know, and 'Am I getting what I need and what I want and what I desire and what I demand?' all those things but equally um 'Is...is the world there for me?' **Mmm** People there for me? **Mmm** Because I have this experience of um not...not being heard for who I am as a deaf person. And this was I think around my parents' choice to send me to a normal school where it...I was told

'Don't tell anyone you can't hear' **Mmm-mmm, Mmm-mmm** and so um that part he didn't really...get...

**And is that relating then to your identity in some way?**

Absolutely. My core identity **Mmm** which is essentially not a hearing person. **Mmm-mmm, mmm-mmm**. My core identity is around um something – somebody who has had quite a different way of interpreting the world. **Mmm, mmm**. And it's something my sister and I and my daughter really feel – it's a bit like we're slightly different **Mmm, mmm** and yet we don't look it, **Mmm** we look just like everyone else. So...

**Mmm. So how did that effect then that first counselling experience?**

Um I just remember feeling very frustrated with him all the time **Mmm** and sort of um...I wasn't aware, I wasn't aware in that experience of what I was frustrated about actually. It wasn't **Ok** until the later ones looking back on it I could see how **Mmm** frustrated...**Mmm** I just knew that it...what I was...the frustration I was struggling with and the sense of trying to find my identity and who I was, was not being addressed just by looking at personal issues. **Mmm, mmm**. Um and there was...there was some way in which he hadn't got who I was **Mmm**, and some way in which I couldn't say who I was **Mmm** and so there was this whole shadow area that was not brought into the relationship. **I see, I see**. That was it really, yes.

**And do you think that...that affected the relationship between the two of you?**

Um, that's hard to answer, um (*pause*) um (*pause*) it must have done in the sense that I was always trying to get him to **Mmm** see this other part and what was happening there was in...in trying to get him to see it I was also trying to get myself to see it as well **Mmm, mmm** because I had kind of lost it, um this child from 0 to 7 – because I was 7 when I got hearing aids **Mmm** – so from 0 to 7, and we'd lived in the country and um I spent my time with animals and climbing trees **Mmm**, kind of...kind of quite a wild child actually **Mmm** and that child had got totally and utterly lost and then went to school and it was kind of oomph you know, you've got to do it this way, you've got to fit in with these people and so I had forgotten that child really **Mmm** and it was like I was trying to bring that one back into being **Mmm, mmm** and so I couldn't really remember who she was either and the fact he didn't provide a space for it, **Yes I see, yes** yeh, so there was a struggle there. **Mmm, mmm**. But in other respects the relationship was extremely warm and with a lot of um...a very positive um...um holding **Mmm** – and love if you like. **Mmm, mmm**. Um and um of course he interpreted it all as being well he was the father figure and I said 'No, you're my missing hearing', um, can I take you off into another line of... **Mmm, of course**. There...there...I've always felt as if I had a missing embryonic twin, **Mmm** that's a feeling I've had for a long time, now apparently there's been some medical work done in recent years which suggests that many of us are twin conceptions and that one...one twin dies off immediately. **Right**. Yeh, apparently it's not uncommon and that there's some evidence to suggest that it may be um be um...uh...I can't, I'm not a scientist, but that um...ok, let me put it metaphorically – kind of when that twin died a bit of my hearing went with it. **I see, Yeh I see yes, yeh, yeh** and I was really interested to read that **Mmm** bit of research that's been done because I've always felt that, **Mmm, mmm** and so...so for this first therapist I was saying 'No no it's not, you're not my father, you're my missing twin, **Mmm, mmm** you're my missing...' – it's like that alchemical male energy **Mmm** um that I felt, and if you talk to my sisters as well this is what we all feel, there's...there's something about, we're very feminine people, but there's something about, there's that masculine you know that...um...that gets out, **Mmm** that's proactive and gets out and does things, **Yes, yeh** that's missing. **I see, Yeh I see**. So that was really where I was feeling that didn't come into the relationship and that was um...**Mmm, mmm, mmm** but otherwise...

**And I'm interested yes that there...there was a...a part of you as a child that maybe you...you would have like to have felt that...came back to you in therapy - returned in some way** Yes, yeh but it didn't.

But it didn't, **Mmm** it didn't at all, **Mmm** and there was...there was a bit of me missing that um, I mean we're all...we're all sort of looking for what we've lost um but a lot of it...um, but there was a specific extra in me **Mmm** there was this deep Shamanic kind of – I have done a lot of Shamanic work **Mmm** – and some of it is just like DIY, I say DIY because it just sort of happens to me **Mmm** erm and I have

quite a strong communication with horses and dogs and...and actually horses tell me things – and...and this is another level, this is not strict counselling **Mmm** but you know we do have lots of forms of non-local communication **Mmm, mmm** and I...I, you know, deaf people tend to do that but as soon as you get into a school situation you are told 'No no no that's not what we do' **Mmm, mmm**, and so a huge part of me **It's all squashed down** yes, a huge part of me was just said 'That doesn't count', **Mmm** and yet for me it was very powerful, **Mmm, mmm** so that was the kind of thing, trying to get that back..**Mmm, mmm** so that's...

**So...so then your...was there quite a gap then after that before your next oh...er experience?**

No there wasn't because then I started to train in um – I have a previous training as a Social Worker and previous to that...uh um and then after that as a Reflexologist **Mmm-mm** – and I had three children and I was looking for a new way forward, so after that I decided to train in um in mind body psychotherapy actually, which is um Reichian work, William Reich um but much, much modified and improved and so I needed to be in therapy for that **Mmm-mm** so that was from 2002 to 2006 'cause it was a four year course **Right** um and so I was um so I uh saw someone then, another man, in fact all three of my therapists have been men, **Right, right** yeh um, interesting that, and...and then the next one came simply because he was the only person who was available because this was the European training they only had a limited number of people **Mmm-mm** in the country **Mmm-mm** who they would accept as a therapist **I see** so it had – and he happened to live in Kingston which is why I've ended up coming back here **Mmm-mm, mmm-mm**. So and...um...he was a psychosynthesist **Mmm-mm** um a UKCP therapist so...um and that again um was having to be there, I mean it was very valuable **Mmm-mm**, it part of my training, but again he never really quite found, we never found this...this, that child, never quite felt that I was really understood in every possible way **Mmm, mmm**, um because again he said 'I can't see why any...all this is a problem to you **Mmm** – in one to one you know you're very confident and...'

**And very much looking at the practical Yeh uh side of things rather than it seems yeh...you know a sense... And had that been...was that a fear you had before you saw him then, after your first experience or had it not really, you hadn't been so aware of...of what....**

It still wasn't quite fully conscious to me **Mmm-mm** what I was missing, because really, um I...I had a lot of um...uh - I'm...I'm trained as a transpersonal um therapist so...so I um I had a lot of what would be called out of body experiences and...and I, you know, some of them quite um far reaching shall we say and I always said well you have to go far to fetch something back **Mmm** you know and...and um...um it kind of told me again, it was almost more than a metaphor, that um what had got um...how did I come to be...have this deficient hearing in the first place? Did a lot of family consolation work, um...are you familiar with that?

**I know of it, yeh.**

Yeh great stuff, do it if you can. Um looking back into the generations of my family and I could really see how um generations of the family not wanting to hear things **Mmm, mmm**, um literally in the way they lived their lives that it actually got packed into the genetic code **Mmm, mmm** um...and it was very um, some of these sort of, you know out of body experiences sort of really informed me about that. So I...at that time working with second therapist I was more conscious of **Mmm** – there was something that had got lost **Mmm, mmm** um...but um...my second therapist really did...he was very present and he was very um aware that there was something I still was missing, **Mmm** um but again you know he was...he was very psychologically minded **Mmm** and he put it down to um 'Well you know it's something you didn't get when you were a child.'

**When you were open about feeling there was something Yes, missing? yeh. Right.**

It still came down to the more personal thing, 'Well your mother wasn't there for you, your father wasn't there for you' and all this stuff we do as counsellors **Mmm, mmm** you know, but it didn't feel to me like that, it felt like something a bit more. **Mmm**. Um, so I felt very much not heard **Mmm** absolutely **Mmm** by either of these um on the specific issue **Mmm** of having a hearing problem, I mean in every other respect I felt very much heard **Mmm** so I couldn't possibly discount them as...they were both very good experiences **Mmm, mmm**. Um...but I don't think it's possible for...if you've got an in between where you're neither deaf and you're neither hearing, I don't think it's

possible for the person with ordinary person to ever **Mmm** know **Mmm** what it's like **Mmm** I think all the other person can be is compassionate and empathic **Mmm, mmm**. Um and um...yeh.

### **But never fully hear – you don't think it's really ever possible?**

I'm not quite sure it's ever quite possible **Mmm**. And so that for me is then about myself fully accepting who I am **Mmm** and my gifts and my strengths **Mmm** and what not being able to hear does bring, but because that person was still in the shadows how can you respect and...and fully know who you are if that person **Mmm, mmm, mmm** is not quite back with you, so I needed to really, really find her **Mmm, mmm** and that didn't really happen until number three, um...

### **Mmm-mm, mmm-mm, and was...so...so with your second experience then Mmm do you remember a...a real disappointment in it or...Mmm with having to adapt in some way to...?**

Good question. Um actually what I – do I remember? I don't specifically remember an actual disappointment but it was a conscious ongoing feeling of like it always felt disappointing. I mean **Mmm** in many ways my life hasn't been, I've had a great life and done a lot of amazing things but there's always been this sense of um...um it...it just slightly falling short all the time, you know, get to a certain point in a career structure and then no further **Mmm**. Um so far with a lot of things and then no further **Mmm** and - you know the snakes and ladders board? **Mmm**. And you've got a snake that...just as you get to the last square but one and you're almost **Mmm, mmm** home and then there's a snake and you go all the way back to the beginning again **Yes, yes** and you know I've experienced that and that's what my sisters will say and my daughter will say, it's just never quite being able to get **Mmm** into mainstream society **Mmm**, um and so there's always that disappointment, so I can't say it was – did I consciously feel disappointed with either of these two therapists, because it was just so part of my **Mmm, mmm, mmm** whole life experience and I just kind of thought 'Well that's what happens.'

### **Yes it fit with what you knew.**

It fit yes, yeh, but still there was something in me getting very frustrated **Mmm, mmm** about it, um and of course, deaf people are classically um angry and um hearing people can't quite understand why they're so angry **Mmm**, I think frustration is a better word **Mmm**, yeh **mmm, mmm**. Um...also there's a whole business of...of being thought to be stupid **Mmm** which I still find you know, the people on the till in shops you know 'That'll be 59p' and you go 'What?' and they look at you as if you're stupid or something **Mmm, mmm**, and you still get that **Yes**, and it is interesting how people do make that... And also the other thing they can do is um when you say 'I didn't hear it' they will repeat it um in a way that 'Oh well she didn't understand it so I better rephrase it in a simpler way' **Mmm, mmm** and you know that still happens.

### **Mmm, very frustrating.**

Very frustrating yeh.

### **Mmm, mmm, and so your third experience of counselling?**

Mmm, so then I finished doing my...doing this um training in Europe and um had a gap and decided actually no, I really did want to practice in this country and decided to go and do the two year um Psychosynthesis **Mmm-mm** Post Graduate diploma up at um London Bridge and having spent four years with a Psychosynthesis um therapist I felt very comfortable with the whole model and so that meant going back into therapy again **Mmm-mm** and by this time I was very much more aware of what I wanted and er I was living in Devon at the time, not many therapists around, so um but there's a guy called [*therapist's name*], um who...he's written a couple of the major text books on psychosynthesis **Ok** and he's been around for thirty years and um somebody I have a lot of respect for and he's also a Kaballah expert **Mmm-mm** so he's got all the esoteric...because I have a huge number of esoteric interests which are entirely about my deaf person, because I see things at another level...

### **Can you explain to me what that means, I'm not sure?**

Esoteric?

**Yes.**

Mmm, that is hard. **Mmm.** Um, it's the mystical side of um life, if you like, it's the um...esoteric science, esoteric religion, esoteric spirituality, **Mmm-mm** so it's what you might usually call spiritual, **Mmm-mm** it's got rather lost in the phrase 'new age' it's not **Oh I see** new age it's very...it's very old age in fact **Right** but it's about being able to look at the world from different paradigms and often paradigms that we don't use in our daily life **Mmm-mm** but it's knowledge that's also there **Mmm-mm** um and I have a um...um...um, (*pause*) so do you know anything about the Kaballah?

**No.**

No, well, you could Google it **Mmm** and...um and I'm not a Kabbalist actually um but it's a very good model for understanding the world on a more um holistic...**Mmm-mm** you know, **Mmm-mm** we're all connected, um...I mean the Christian faith says the same thing, the Islamic faith, Hindu faith, they all say the same thing, they just wear different sets of clothes **Mmm, mmm** and when they put their sets of clothes on then they get into silly arguments **Mmm** about you know 'My set of clothes is better than yours' **Mmm, mmm** but actually at the nub of it all is that they're saying the same thing **Mmm** and esoteric um uh spirituality will...will look at that one rather than going off onto the sets of clothes **I see** um so um anyway [*therapist's name*] is...is um very similar to me in that way so I said...I said...I wrote to him and said 'I want to do these 40 hours of therapy with you' **Mmm-mm, mmm-mm** and I said 'I want you' **Mmm** and he said 'Yes', and that was the first instant of my actually saying 'I want to be heard for who I am **Mmm, mmm** and you're the man I want' and it was kind of like 'If you can't hear me, then no one can.' **Right, right.** And...so it was just going on a hunch, again, because it's my ears that are here (*makes her hands into ear shapes over her heart*), **Mmm, mmm** everywhere (*makes ear shapes all over body*), **Mmm** uh I've got ears all over, **Mmm**, that experience proved to be the one you know **Right** because he really – the first thing he did uh when I got there and I said 'First of all [*therapist's name*] I need you to know that I can't hear very well' so he said 'Well tell me about that' so he said 'Right, take your hearing aids out' **Right** and we did about the next four or five sessions without any hearing aids.

**What...and what was that like?**

Well, it was fun actually, but it was also the first time somebody was actually just taking that complaint of mine seriously **Mmm, mmm** and saying 'Ok you're saying that this is a problem, let's just go for that.' **Mmm, mmm.** Um 'And let's, let's, so let's focus on what you say is the problem.' **Mmm** Um, and um, so he you know so um I struggled to hear him to start with because I need to make what I call a new neural pathway for each person **Mmm** and he has quite a strong um Yorkshire or Northern accent **Mmm** um I don't know where but um... Um so um (*pause*) but after a while what it was about really was being...becoming confident that it didn't matter **Mmm** whether I actually heard all the words that were spoken or not, **Mmm** it was about realising that I can actually hear pretty well whether I've got the actual physical hearing or not **Mmm, mmm** and that was you know, as...as therapists we tend to...we take in a lot of other information don't we **Mmm, mmm** about what our clients are saying **Mmm, mmm** and in the world out there we take in a lot of other information **Mmm, mmm.** Um, so it was...it was learning that, even if I can't functionally hear very well **Mmm, mmm** I nonetheless have a pretty good idea of what's really going on.

**Mmm, and I think a lot of importance is always put on words Yes isn't it without acknowledging what else Exactly is communicated.**

Yes, mmm, and then having...learning again to have the confidence in what I was hearing **Mmm** in a different way **Mmm** um and um, because I'd lost that confidence as well, you know growing up in a hearing world had told me 'Don't do it the deaf way, do it our way, **Mmm, mmm** if you don't do it our way you won't survive' **Mmm** um and so with [*therapist's name*] it was about learning all over again to completely trust myself as a deaf person **Mmm, mmm** and in that sense the work I did with him brought back the um the...the bits that was lost **Mmm**, the bit that was still out in the shadow there, and the bit that ultimately my mother had been a bit ashamed of **Mmm, mmm.** It all comes down to shame in the end, **Mmm** because 'she'd produced three children who were...had a hearing problem, and in the 1950s that was um, it fitted in with her background **Mmm, mmm** you know er her father once told her 'You'll never have any children', **Mmm** you know, um I can't remember the reason – I do

know the reason, but she...she grew up with the idea that you know she wasn't going to be able to have any children **Mmm** and then when she had four three of them weren't right **Mmm** um so um, um so there was...there was a lot of shame around it **Mmm, mmm** and um and I think that is a big problem for...for people with hearing problems **Mmm, mmm** they often...there's a sense of not being fully included **Yes, yeh**, you know a bit excluded **Yes**, you don't quite belong. So what this third therapist did was to really say 'In this room here it's just you the deaf child, you the deaf person, you the deaf adult, you the deaf human being', and so it was just fantastic **Mmm, mmm** because he really heard **Mmm** that part of me that had never **Mmm, mmm** been quite heard before.

**And...and immediately put that at the...the forefront, Exactly at the centre of it.** You know within...within 5 minutes. **Mmm, mmm, in such contrast to your other Yes, yeh experiences where it seemed yeh sort of very hidden or minor or...**

Well because, understandably for them I was functioning as a hearing person **Mmm, mmm** um and so, and I think that's the crucial thing **Mmm** um there's a great – 'cause what you've done is you've chosen a hard of hearing spectrum, you haven't chosen deaf people. **Mmm-mm, mmm-mm.** So you've...you've...It's what I call being in limbo. **Mmm.** Yeh, **Mmm** and...and it's very hard to walk through life in limbo **Mmm**, very hard, **Mmm** um er and I do know that you know all of us have perhaps, um except possibly not my younger sister who became an accountant on the basis that 'That way I just do the books' so to speak, **Yes** and er 'It doesn't matter if I can't hear anything', and she's very...and she has a small business as an accountant um, but my oldest sister has definitely lost two whole careers through not being able to hear well enough **Mmm, mmm** and I...I couldn't stay in my first career as a Social Worker **Mmm** because I couldn't hear well enough.

**Mmm, mmm** Um and if I can just ask you **Mmm** as well about your...the third experience Yeh, **mmm** that you had which sounds a very positive one **Mmm, mmm.** **Um and...and clearly at the beginning him asking you to take out your hearing aids was the... Mmm a big part of being heard Yeh.** **And can you tell me any other ways um in which you felt heard in that relationship?**

Yeh (*pause*). Well do you know I'm gonna go with the first thing that's has come into my mind, but the whole thing being with that particular therapist was full of laughter **Mmm, mmm.** He was so light about it. **Mmm** Uh and there was a huge amount of humour and laughter in the relationship and that actually um that really made me feel heard because there was no sense of heaviness about it **Mmm**, that sort of shame of you know and...and 'Oh this is such a problem', you know that weight **Mmm, mmm**, so it was the lightness um the lightness and the laughter and the humour um that really helped. Now, ask me your question again, because that's just the first thing that comes to mind. Can you...**Mmm** can you remember the question as you worded it? Ask it again?

**In...in what other ways** In what other ways, yes **did he make...did you did you feel heard with him?**

**Mmm**, I think that he um he really heard my (*pause*) he witnessed what I...the levels at which I hear so um I've often, my sisters and I think well you know, the trouble with the frigging hearing world is they think they can hear but in fact they're not listening to anything, **Mmm** (*laughs*) um that's when we get you know pissed off, **Mmm-mm, mmm-mm** but there is a level in which we've forgotten how to really listen deeply **Mmm** and there's all sorts of levels of communication **Mmm**, so what this therapist did was he really confirmed for me that yeh I am indeed hearing at other levels um, voices that are not normally heard um and this was sort of, as I say, because he was very strong escoteric training himself. Um what wants to be said that society isn't quite daring to say **Mmm, mmm.** Um I'm often quite psychic, I hear things ahead of time **Mmm** and then of course my normal brain will say don't be so silly **Mmm, mmm** but in fact my deaf person knows they're real **Mmm, mmm**, now having the courage to stand up and say that **Mmm** can be quite difficult **Mmm, mmm** and what he said was 'Everything your deaf person hears, I can fully authenticate **Mmm, mmm, mmm** for you'. So that I think was the main thing um and he never...he never queried, he never doubted me ever **Mmm, mmm**, there was no doubt ever as to 'Well you say you can't hear, but you seem to me to be able to hear alright,' 'cause after four or five sessions without my hearing aids I could hear him with no problem because I'd got used to his...the way his lips moved **Mmm, mmm** and I'd got new neural pathway for him **Mmm, mmm, mmm**, my [*therapist's name*] pathway **Mmm**, and that's a very real thing as well **Mmm** for...for my kind of hearing loss um, um so yeh I think that was it.

**And...and sounds...it's interesting that...that such an important part seemed to be that the lightness and Mmm the laughter mmm but alongside him actually taking um your...your hearing loss um very, very seriously. Exactly yes. Both together.**

Yeh, yeh, yeh, so he wasn't saying 'Oh what a pity, what a shame, how you must have felt', this that and the other, he was just talking um.... 'This is a great gift' **Mmm** um and it was almost as if he could see the gift and, 'cause I always sensed that it was a gift um and he was going 'You have a great gift, let's develop it here **Mmm, mmm** and lets really bring it to light' **Mmm, mmm** and...and anything that's that kind of a gift is always light and is always um, and that was just his style and maybe I needed someone who...**Mmm** who was...who was um (*pause*) uh light and also I suppose I had had two previous experiences of therapy where I had done a lot of all the personal work **Mmm-mm, mmm-mm** which we all have and I have my share of it you know **Mmm-mm, mmm-mm** um around a divorce **Mmm-mm, mmm-mm** and all sorts of stuff like that you know, um so...so by him I felt completely, fully heard **Mmm-mm** in every respect.

**Mmm, and do you think a...a very important part of that was the fact he had had a...a special – special is not the right word – but a different type of training to maybe the...the norm in counselling and psychotherapy which is very reliant on, I mean I know in my training, on the spoken word and...?**

Very reliant on the **Mmm** spoken word. And I mean there are, if you go into this deeply, there are – um uh Jacques Lacan **Mmm-mm** is - L-A-C-A-N **Mmm-mm** - is you know one of the major people who says that um we're all transference, distinctly wrapped up in the language we use **Mmm**, and you can't get out of it **Mmm**, and you can't stand aside from the...from that language because we're in it **Mmm**, you know we're – it...it created who we are **Mmm, mmm**, from babyhood onwards we're...we're defined by our language **Mmm-mm** um and those um and western languages tend to have a...a similar structure apparently, Sanskrit has another and then the Chinese languages have a third **Right** and my deaf daughter spent three years in China teaching there and she said, it just... (*pause*) Psychologically people are totally different **Mmm**, it's like a different species of people, **Right** and she could see outside the language thing, so what I'm...what I'm trying to say is yeh we do depend very much on the spoken word **Mmm-mm, mmm-mm** um and so what I'm doing, what I was doing with my last therapist was getting beyond the spoken word **Mmm** yeh? **mmm** and getting into non spoken communication **Mmm, mmm** and what wants to be said, what wants to be heard. What it's done for me as a therapist myself is actually I find I can hold anything **Mmm** um that the clients brings me **Mmm, mmm** um because I can hold the non verbal **Mmm** and very often that's um quite hard **Mmm, mmm**. Um it's a good point, it's a very good point um around language, um uh so body therapists, which...I've done a...done a training in body psychotherapy, they will of course go beyond language.

**Mmm, mmm, mmm, and in your final experience of...of counselling Yeh were there, was there anything um about it, any times when you felt that you weren't heard by him?**

Yes I did have one experience – again I don't know what the word you use – but total empathic failure **Mmm, mmm** is you know you feel no one is there for you **Mmm**. What happened in my um...while I was doing that psychosynthesis training was, I was obviously in a group um and um, at the Trust, um and um, it's very interesting because when people in a group – what happens to a person when they don't feel heard? Um they go right into their own personal deep wounding and say 'I'm not being heard **Mmm**, it reminds me...it's like when I was a small child **Mmm** and I wasn't heard' **mmm, mmm** um and so having me in the group and I literally didn't hear – because in a group I don't hear **Mmm**, I don't **Mmm**, I actually don't, I might hear the person next to me, um but once you're that far away I don't hear you **Mmm, mmm** so, and I can't usually see well enough either um because the room's a bit dark or whatever, so large numbers of people in the group did not feel heard by me **Mmm** because I didn't actually hear them **Mmm** and they went into their deep wounding about that and tried to project it onto me, and I struggled and struggled for two years with that group you know, 'It's your projection, you take it back' and then they would try to manipulate the – all kindly and unconsciously - manipulate the situation to make sure that I could hear, because they did not like not being heard, **Mmm** so they wanted to make sure I could be heard, so they would put the lights up for me and this and everything and I said 'Look can you just accept that I am just never actually always going to always hear you' **Mmm** and it was amazing how hard they found that **Mmm, mmm** um they would not allow me to be deaf, **Mmm** it was too painful for some of them that I should be deaf, they wanted to



sort me out **Mmm, mmm** and that was actually a whole new experience and it was my third therapist, [therapist's name] who...who allowed me to be deaf and just said 'No, that's who you are, if they've got a problem with not being heard, it's their problem' **Mmm, mmm, mmm** um but in deep encounter groups people don't like not being heard **Mmm, mmm** and...and it was just extraordinary how much it got sent my way as to, 'You're not listening to me'... **Yes** 'I want...' **everything put onto you.** Yeh 'I want to be heard by you', because I tend to hold the position of mother in a group anyway because apparently I have that kind of, you know, put it out you know um, and of course it got all into their wounding about 'My mother hasn't heard me.' **Mmm, mmm, mmm.** That was really painful **Mmm, mmm** having to try and sort out – especially all these good-will intentions of um 'Must make sure [participant's name] can hear' – which was natural good-will **Mmm,** but they didn't listen **Mmm,** they couldn't listen to the fact that maybe I just can't hear sometimes.

**Mmm, mmm, and sounds as though your...your personal therapy then was very important in unpicking that and Yes understanding what that was all about?**

Absolutely, and making sure what was mine and what was theirs **Mmm** and really being clear about the boundaries because I think that's the other very important thing with this limbo state of being on the hard of hearing spectrum as you write, is...is boundaries **Mmm.** What's yours and what's theirs **Mmm, mmm,** you know, it's very hard **Mmm, mmm,** um and...and that's where language gets in a muddle **Mmm, mmm** um, yeh and I think my sisters would say that – you know, what's yours and what's mine, **Yes** and we all have that to a certain extent don't we, **Yes, yes** but it's magnified, the problem is magnified **Mmm-mm, mmm-mm** when you're in between **Mmm, mmm,** um in the hearing **Mmm,** and yeh that was a very frustrating two years **Mmm, mmm** with that course um because they're all lovely people **Mmm** um but I could not...found it incredibly hard to accept that...couldn't – (pause) they couldn't hear **Mmm** that...that I – and...and the point for me was that I was also having to really accept that yes I really was deaf. **Yes, yes.** And that's what it was about for me because I'd spent my life saying 'No I'm not really' you know, but I was having to accept that I really, really was - because without these hearing aids I can hear virtually nothing **Mmm-mm, mmm-mm** um except very low rumbling noises.

**Mmm, and makes me think about them in some way trying to pull you back Yeh into sort of the hearing world and...and...**

And I'm saying 'No, I really need to accept' and so there was with...with, your original question, with that therapist there were um three...around three sessions, I used to see him fortnightly for two hours because he lives so far away, um when I experienced that same total empathic failure **Mmm** with him, and um and...and I recognised it was about me having to really say 'Yeh [participant's name] you really actually have...this is who you are, you are actually a profoundly deaf person' **Mmm, mmm, mmm** and having to fully accept myself as that **Mmm** and it was so painful **Mmm** um and he was just present, he didn't put anything into it **Mmm, mmm,** he was just present **Mmm.** Because he hadn't actually done anything, it was the group that had thrown it up for me **Yes, I see** um but he just was present and so you know, just saying 'I'm hearing that's what you're saying, you're saying that you are really...actually really very deaf'.

**Mmm, mmm, and that sounds as though it was very powerful Very powerful that being there.**

But it didn't feel...it felt painful **Yes, yes** at the time because sort of coming to that realisation you know that I've struggled all my life saying 'No I'm not deaf, I can cope, I've got...' you know, but having to think 'No I am **Mmm,** I really am.' **Mmm, mmm.** It's very empowering **Mmm, mmm** ultimately, because you then can start using the potential of that person.

**Mmm I see, I see. Is there anything else that you feel you haven't said that you...would be important?**

Um I feel I've said an awful lot um, **Mmm, mmm** and I'm sure that I'll think of something but I um, I think the main points were around the frustration and the identity – what's...what's my core identity?

**Yes, Yeh and having that recognised by someone.**

Having it fully recognised, what's my core identity and from there, and being able to make my own choices about how to use that and not feeling that I've got to do what everyone tells me **Mmm** because uh and not have to be how they would need me to be **Mmm**. I mean it's interesting for me because I have two daughters – well a son and two daughters, but one daughter um is deaf and one isn't **Mmm-mm** and my youngest daughter whose not deaf has found it hugely frustrating **Mmm** having a mother – it had caused a lot of problems for herself **Mmm** you know, about feeling not heard **Mmm** whereas my deaf daughter kind of, we're on the same wavelength **Yes, yeh** you know so it's never been an issue for her **Mmm** um...

**Makes me think as well um about your...your experience...experiences of therapy that if you hadn't done your training you might never have had that positive experience** Yes **that...Exactly that really changed things for you.**

Yeh, totally, totally changed things for me and, I think it's also about – the whole thing for me is around loss **Mmm**. Um because I think we've all kind of got this sense that we're...we've lost a bit of something you know **Mmm, mmm** um - not many people I know who feel completely full **Mmm, mmm** um and...and not only do they feel full but they don't even have to be conscious of the fact they feel full they just are full **Mmm, mmm** and they can just walk into life as that **Mmm** and I think lots of us, I mean my experience of...of listening to my clients is...is that there's something they've lost **Mmm, mmm** and...and that was **A big part of it** mmm a big part, and I think when you've lost a physical part of yourself **Mmm, mmm** um it feels very major. I think the last thing I want to say is...is that this particular third therapist really felt like my missing twin **Right, yeh right** – he...he actually confided to me at the very last – he said 'I don't normally disclose anything' but actually his birthday is virtually the same as mine **Gosh** and I just thought that was a wonderful um er synchronicity **Mmm, mmm** if you like, um um I mean obviously he's not my missing twin, but he was...was almost um age wise sort of the closest **Mmm, mmm** um to that, so that was my missing twin yeh, um yeh, I'd like to write something about it **Mmm, mmm**, I'm not quite sure how I'd do that.

## Example Analysis Stage

### Dominant Discourses

#### PSYCHOLOGICAL/THERAPEUTIC

**Counsellor being aware there was 'something missing' due to the dominant medical model discourse of disability. 'Psychologically minded' is from the counselling discourse and something that has taken on a reality for her. He can only operate within psychological discourse – 'not getting something as a child'.**

...my second therapist really did...he was very present and he was very um aware that there was something I still was missing, um but again you know he was...he was very psychologically minded and he put it down to um 'Well you know it's something you didn't get when you were a child.'

**Adopting the psychological discourse again of parents 'being there', but highlighting it shows her resistance to it. 'Compassionate' and 'empathic' - the interpersonal discourse of counselling as the only limited ways of 'hearing'.**

It still came down to the more personal thing, 'Well your mother wasn't there for you, your father wasn't there for you' and all this stuff we do as counsellors you know, but it didn't feel to me like that, it felt like something a bit more. Um, so I felt very much not 'heard' absolutely by either of these um on the specific issue of having a hearing problem, I mean in every other respect I felt very much 'heard' so I couldn't possibly discount them as...they were both very good experiences. Um...but I don't think it's possible for...if you've got an in between where you're neither deaf and you're neither hearing, I don't think it's possible for the person with ordinary hearing to ever know what it's like I think all the other person can be is compassionate and empathic.

**Medical model disability discourse of loss being a universal thing because comparing to the norm. Loss in counselling discourse.**

Yeh, totally, totally changed things for me and, I think it's also about – the whole thing for me is around loss. Um because I think we've all kind of got this sense that we're...we've lost a bit of something you know um - not many people I know who feel completely full um and...and not only do they feel full but they don't even have to be conscious of the fact they feel full they just are full, mmm and they can just walk into life as that...

**Medical model disability discourse of loss because comparing to the norm.**

...so one of the big themes that came out of all of this, as we sort of worked through this, was the whole question of loss, and things being taken away from me, and so obviously the hearing came into that because it was just one more thing.

**'Dealing with it' and 'handling it' are part of the Western counselling discourse of independence and individualism that do not allow for the social context.**

I wasn't...I wasn't being 'heard' and I think – this is one of the notes I've made here - I think it is because I...I personally have managed to deal with it in my way, that when I go to see people they think 'Well she's asking advice on how to deal with the relationship but she's fine, because she's handling it', because I'm going to them.

**The depression is objectified as part of the medical discourse of mental health. Hearing loss not included by the counsellor as the social aspects of disability not viewed as relevant. The individualism of counselling clashing with this.**

Yes, the psychologist was trying to get to the...more the root of what was causing the depression (*laughing*) and now...now actually looking back on it...it was a lot more to do with my hearing than what I thought at the time, and sitting through those sessions now we probably should have had more discussion about the hearing loss than we did, I think that was probably key.

**'Adversarial environment' takes on a reality that oppresses.**

...so when I was going for um marital counselling that was a different adversarial environment um and there was lots of emotion going on there and I couldn't have anybody there...

**And again.**

No, and it was very much a sort of more adversarial, emotional charged environment where it's more difficult to...to...to try and...it's like you're trying to derail the conversation and the moment by saying 'Oh I didn't hear that', rather than keep...you know.

**The 'neutral' counsellor objectified. 'Neutral' associated with medical model??? 'Giving your emotion' associated with counselling discourse but oppresses.**

Part: ...for the counsellor to be what she was meant to be which was the sort of neutral, it wouldn't...it wasn't gonna work because I wasn't able to pick up what was being said.

Int: So already the balance is...is different isn't it?

Part: It is yeh, and...and when you...and when there's such an emotional environment and you're trying to understand what's being said and give your own emotion, it's almost impossible, if you can't hear, because it only takes one or two words different like 'is' and 'isn't', to completely misunderstand what's being said, and I'm sure there was quite a lot of that, misunderstandings of what had been said and what hadn't.

**Therapeutic terminology of 'relaxation' but has alternative affect on client. 'Not getting too heated'. Discourse of therapy clashing. It is not relaxing for the client – multivoicedness of language.**

Part: I mean sometimes they would just think you're being awkward. And the other...the other way that the situation was created was that they wanted it to be a relaxing environment so we'd all sit back in these comfy chairs and we'd be quite far away from each other and that just didn't help at all. We would be sitting close, but I guess the...the distance was to keep us, you know, from not getting too heated and that, but anyway, it was not...

Int: But for you...you needed that closeness.

Part: I needed the closeness to actually understand. And in some cases I think that you can be perceived to be rude if you don't hear something and you don't answer because they think you've heard but you're not answering, but you've just not heard so you sit there and so...on a couple of occasions I felt that I was...I was being judged because I wasn't able to hear, yeh, that was a really difficult situation.

**Therapy discourse of 'neutrality' and 'balance' oppressing the client. The power of non-verbal communication in the positioning of chairs and the meaning that is constructed through this.**

Part: ...and for them to not sit in a neutral position, to sit closer to me, wouldn't have created a good environment if they had created a...an unbalanced environment which wouldn't have been good for everybody trying to resolve a situation.

Int: Because it's interesting because actually her sitting nearer to you would have actually made it more equal, but I think it would have seemed as though you were being favoured or...yeh.

Part: It would definitely seemed...it would have definitely have been perceived that way, so although it would have balanced us up equally on the hearing side it wouldn't have balanced us up equally on the spatial side, it would look two against one, if you know what I mean.

**Counselling discourse of 'resolving through conversation', therefore excluding.**

And so you...you don't have that instance so that you have a good interactive conversation where you can resolve things because that doesn't happen when you can't hear...you're spending a lot of time.....it's funny actually how you spend a lot of time figuring out what's being said. Just how, you know you can sit for maybe 10, 15 seconds and think 'What was that?'... Sort of processing...'What were they actually asking there?' because you've missed maybe a couple of key words, but the other words allow you to fill in those blank spaces.

**And again, together with his use of non-verbal communication.**

Yeh and you think 'Oh' yeh, and...and 'is' and 'isn't' and 'can' and 'can't' is just a huge and...and in an environment like that it's...it's difficult to have a proper conversation where you resolve things because you...you it's so, so easy to pick up the wrong message. Say something and that's it...it's just woوو because you've heard... Doesn't take long, to go from this to this (*mimes, laughing*).

**Therapeutic discourse of ‘understanding’ how a client feels and ‘processing’ is meaningless in this scenario.**

Part: So I think things happen too quick in that you’re expected to respond back because what they trying to do is understand how you felt and then...and give you more, to...to get some more back, it’s sometimes difficult to do that in that environment.

Int: Right, so the speed, the kind of pressure of the speed of it is difficult.

Part: Because processing the information to say what was being said, and they’re thinking you’re processing the information as to how you feel about what’s being said...

Int: But you’re not quite there yet...

You’re not there yet! And it can create some quite uncomfortable silences, because they think ‘Oh this has maybe thrown them a bit ‘ and you’re thinking ‘Wait a minute, I’m just catching up, ok I’ve got that now and now I’m trying to figure out what...what to say’ so that was hard.

**Being heard as validation.**

Through her I have learned that my hearing loss has played a pivotal role in defining how I see myself. With her I have felt heard, not in just what I say but in the unvoiced thoughts, and through my time with her she has made it safe for me to verbalize those unvoiced thoughts. She is the one that said I was not lazy but I was fearful and I reason to be fearful. She understood right away that a job at McDonald’s was not something that would be suitable for me. She validated my rejection of that suggestion, which was helpful. I’ve also noticed that she seems to know when I have physically have heard and when I am too tired to hear, sometimes even before I do. She is not afraid to challenge me when I say I have heard her when I really have not. These actions make me feel safer and consequently I have opened up to her the most.

**Discourse of trust. Her individual experience not recognised.**

With the first two, there was no feeling of trust and no acceptance that hearing loss has shaped my life. I am reluctant to enter another professional counselling situation because of this.

**Therapeutic discourse of relaxation clashes. Topics classed as difficult in therapeutic and social discourse:**

She re explained about creating a relaxing aura by using low lighting would increase my confidence in discussing hurtful/difficult topics.

**Normalising discourse – hearing loss not being a ‘problem’. Therapeutic discourse of relaxation:**

She apologized and said she had forgotten that I could not hear well. She said it was not a problem; there was another room that we could use. I can remember saying something along the lines of, oh I’m so glad because I need all the lighting I can get because I lipread. She was nodding her head and then we went into the second room. There were two candles in that room! I said that is not enough, and she said not to worry she would talk loud, but this was needed to set the mood of relaxation. Relaxation???? I was anything but that and starting to get defensive.

**No adaptations made. The disability stopping the flow.**

Part: I have to keep saying pardon to her all the time, um she’s not that clearly spoken. She fingers a bit, she repeats, she has no problems with patience, but I’m still forever trying to get the communication sorted out before I can understand what she’s saying and then I can start talking. This delays my answers in counselling, and this is bad, because it’s not an automatic thing in counselling, where somebody says something you get back to it, nor can I lie on a couch, look at the ceiling, I’ve got to look at somebody’s face, lips, I’ve got to do that and concentrate 100%, so you sit in two easy chairs opposite each other you see. Um -that’s so important, it messes up the fluidity of the counselling. And she probably knows that it gives you a chance to think of more things as you’re trying to work out what she’s saying, you thought she said this, and she says it again a couple of times after, ‘Oh no, no I see what you mean now’, and then you give an answer but it’s not what counselling should be. Yes and it’s not the first immediate answer that comes. But this chap, because he was an actor and clear spoken and so on I knew what he was saying to me straight away, it came across. She won’t write thought, one thing is she just won’t write anything down, it’s incredible, she does it entirely by repeating or finger spelling, ‘til I eventually get a...as you know a human being, without having anything written, she won’t write down one word for me. Key words are important you know for all deaf people and if you miss the key word of the question you can’t work out what it is.

Int: And would you like her to write things down?

Part: Yes, but...I have asked once or twice but she just carries on 'til I get it. It's interesting because other people do if I ask them to write a word down, you know, I don't want them to write a whole sentence, just one word, write the word...

Int: And has your hearing ever been something that you've talked about in the counselling?

The only thing that I dread in the counselling is my hearing loss because it's not going to be an easy flow, and this one I'm having at the moment I know I'm going to have lots of stumbling blocks along the way when I'm not hearing two or three words and I'm not able to put the whole thing together, what she's asking me, or what she's saying. Normally in the counselling I do the talking, she talks back to me you see, from what I've been saying but even then it's important because I have a train of thought, now when she says something the train of thought goes on, see, if she says something the train of thought stops and 'What was it you said?' you know and I go off. The fluidity goes, goes off in a different direction. It's different from me waffling you see, I mean she stops me if I waffle obviously, but if I have a train of thought and then she's saying something on that train of thought to keep it going, I can't hear what it is, it breaks it all down, it wrecks the counselling.

You're stopping the flow of thought that should be there. The whole point of counselling is to get your thinking...make things better for you, you see and stop at a hurdle every time you don't hear a word or a phrase and you have to fix that hurdle before you can go ahead.

### **Normalisation of counselling – thoughts in the 'correct areas'. The right way to be.**

...it's just a breakdown, the communication breakdown, and it's not so much you know finding out what's being said it's just busting up the whole point of counselling which is the thought and getting your thoughts into what you might call the correct areas, smoothly, you know things just flowing, it doesn't happen.

Well I don't talk about my hearing loss, it's an everyday thing, um I just talk about it when I need to. I talk about other things that have happened in my life, that might you know have upset me in some way or been happening or whatever it is, any kinds or relationships or anything like that that have been important so that comes into it very much indeed. So I wouldn't say I've concentrated on my hearing loss at all. All this counselling is not about hearing loss, the hearing loss gets in the way of the counselling and messes it up...

I don't think it helps because the counselling's not for that you see, it's not for my hearing loss at all. I'm just saying the counselling I have - unless you have special counselling for your hearing loss – counselling I have is for something else and the hearing loss just mucks it up, messes it about you know as I don't get the communication sorted out. And then if I guess a question, of course you know the same old problem comes, you know, 'But I didn't ask you that', you know or something like that, or you just guess it, you know deaf people, sometimes I just nod my head yes or no and I haven't even heard it you know, just see if it might work or not, it's the easy way out sometimes but I get caught out now and again, this lady knows a bit about deaf people so she's aware of the tricks we have up our sleeves to make life a little bit smoother and easier.

### **The difference in session seen as a waste of time and not therapeutic.**

...the whole point is, time and money would be wasted, instead of having - the counselling sessions are 50 minutes I think, you have to stop as soon as 50 minutes is up, I'm used to that now - out of 50 minutes, 25 of them would be you know trying to find out what was said you know and dealing with the hurdles that are brought up with that you see, so the time and money would be wasted with somebody who is not deaf aware. Uh as I say it's an exception if somebody is an actor with a perfect voice, a trained voice, makes themselves clearly spoken and so on, and pitches everything, and he knows me and how I cope, that's an exception.

### **And again.**

But even if they're deaf aware, they've passed the exam and they're deaf aware, she's obviously done it but she's still no 100% easy but she's very patient, I mean she knows that I'm having to put up with a hearing loss, but it's still a waste of counselling time as a counsellor. If I was faced with somebody I couldn't understand you know it would just be a waste of time, everything written down, saying pardon, you'd be wearing the other person out.

### **Any education as separate from the counselling. Training required.**

Well if they went to the basic, what's it called, Signature now, the Deaf Awareness course, the OCOCDP, they have a good Deaf Awareness course for beginners and they have communication

tactics as well, both of those courses really put you...I mean I know so much of it myself anyway but somebody whose not done it before it's all brand new and makes them think 'Oh gosh I never thought of that' just simple things you know, like if I sit here, the light makes you into a silhouette you see, don't think you see, um that's just a simple example, and how close to be with someone when they're signing, lipreading, all that comes into it as well, now if they had all that behind them it would help, it would help tremendously, otherwise, like when you have a new CEO in a deaf charity who has...doesn't know anything about deafness, you spend the first two or three months probably explaining it all you see, a waste of time, so if the counsellors done it beforehand, had a bit of practice, comes in, it would help tremendously. If they don't have it, then you have to teach them as you're going along which takes up the counselling time, unless you have meetings beforehand or an interpreter.

### **Counselling as only helpful for the youth.**

Int: Would you ever think about having counselling again in the future?

Part: I don't know, I'm kind of happy with where I am, I might come up with things, I don't know if it would be considered that where I am would be a particularly healthy place. At my age...yes that's it, at my age I can't see much purpose in it. One of the things that's depressing about getting older is when you're younger and something goes wrong it's 'Oh well start...start off in a different direction' and um when you're 75, all of a sudden...

### **The disability seen as separate from the self – and 'issue'.**

I think it was just a side...a side issue, I hate that word issue. A side issue. I don't remember if we discussed the counselling...in the counselling.

## **SELF/IDENTITY**

### **Deaf part becomes a subject; the 'deaf person', due to dominant medical model discourse of disability and becoming empowered by adopting the label. Being deaf in comparison to what is 'normal' – the counsellor did not understand this as he thought she was 'normal'.**

Because I have this experience of um not...not being 'heard' for who I am as a deaf person. And this was I think around my parents' choice to send me to a normal school where it...I was told 'Don't tell anyone you can't hear' and so um that part he didn't really...get...

### **Counselling as having individual responsibility.**

...in hindsight it probably impeded a lot of the progress and speed of progress because I wasn't understanding what was coming back, um, and in those environments when...when it's easy for you to control a situation, control a...a discussion then you know what's coming next, but with a counsellor or psychiatrist it's not so easy to know what they're gonna throw back at you and so that for me was probably the most difficult thing and I think the...the whole episode went on a lot longer because of that, I would come out and think....and then I would have to talk about it with the other person that had been in the room to...to kind of get a better idea of what had been discussed. It was a horrible feeling actually when...when these discussions go on and you only pick up bits and pieces and...and I must have at the time been putting bits in that I thought were being said, so you hear maybe every third word and you just put in what you think, and then what you do afterwards is you then go out of the room and you...you piece it all together on...based on what you think.

### **Again, the 'deaf person' as separate from the person. Reaction to the dominant medical model discourse of disability.**

...this was a male therapist and he really 'heard' me as a person, but, I was frustrated by the whole experience because he never 'heard' me as a deaf person.

### **Therapeutic discourse of 'identity' – something that becomes a subject and has taken on a reality. 'Identity' related to the individualism of psychological therapy. This identity relates to being hard of hearing in reaction to the dominant medical model discourse of disability – wanting her deafness to be recognised. Being 'different' is due to the normalising nature of the medical model of disability.**

My core identity which is essentially not a hearing person. My core identity is around um something – somebody who has had quite a different way of interpreting the world. And it's something my sister

and I and my daughter really feel – it's a bit like we're slightly different and yet we don't look it, we look just like everyone else.

### **Discourse of responsibility, not advice – empowerment?**

Because they don't give you advice, they try and make you correct yourself, you see you have to do it all yourself, that's what counselling's about as far as I can understand yeh, they don't advise you do they, oh no, they get inside you and bring it out.

### **Wanting to be defined by her deafness. Being empowered by taking on the medical model disability discourse.**

So what this third therapist did was to really say 'In this room here it's just you the deaf child, you the deaf person, you the deaf adult, you the deaf human being', and so it was just fantastic because he really 'heard' that part of me that had never been quite heard before.

### **And again.**

I recognised it was about me having to really say 'Yeh [name] you really actually have...this is who you are, you are actually a profoundly deaf person' and having to fully accept myself as that and it was so painful um and he was just present, he didn't put anything into it he was just present. Because he hadn't actually done anything, it was the group that had thrown it up for me um but he just was present and so you know, just saying 'I'm hearing that's what you're saying, you're saying that you are really...actually really very deaf'.

### **The discourse of counselling as improving the self. Discrimination.**

Now the problem was I had been in prison in 2003 after a conviction 2002 when I was inside for 10 months. And I knew which counselling I needed and I pleaded with the authorities, 'Please may I have this counselling, it's to show that I want to better myself'. 'Sir we've got no money', was the response, all the time, 'We've got no money', 'But it's not fair, all these other people who've done things worse than me or not so bad as me they're on the course now, why can't I?' 'Because you're deaf, we can't afford to bring anybody in to help you'. So I was getting mad by this time, and I made 3 different attempts, one before um, one dur...um in the first prison, the Deputy Psychologist said 'Yes you must get on it', she was overruled by the main psychologist, 'Can't afford it'.

### **Again, 'identity' has taken on a reality as though it is something to be discovered. Her awareness of not having the words.**

...the frustration I was struggling with and the sense of trying to find my identity and who I was, was not being addressed just by looking at personal issues. Um and there was...there was some way in which he hadn't got who I was, and some way in which I couldn't say who I was and so there was this whole shadow area that was not brought into the relationship.

### **And again.**

I was always trying to get him to see this other part and what was happening there was in...in trying to get him to see it I was also trying to get myself to see it as well...

### **Deaf part is objectified by the 'experts', which relates to the medical model of disability. She is seeing an individual separate to her deafness. The medical model discourse of 'getting well' from 'mental health problems'.**

...they're seeing a deaf person and thinking 'How do we deal with this deaf person?' and I know the person that's on the other side of that deaf issue...deafness issue so um...so it...so I think then I had the best...they dealt with me the best way they could, I was referred to psychiatric care here although my psychiatrist when I finally...I finally...it was my husband who was worried about me coming off medication and things like that, um my psychiatrist said to me 'I wish that everybody got as...all my patients got as well as quickly as you do...'

### **Counselling running smoothly**

But with all counselling I'm frightened of the fact that the counselling process is hindered by deafness and your thought train is messed up once too often and the...it means that you don't get the smoothness that other people probably get through perfect communication, whatever disability they might have, if they can talk and listen, then the counselling shouldn't be so much of a problem, also you can lie down on the bench and do what you're supposed to, look at the ceiling, go back and the memories and so on, work out...I can't do that.



**The notion of counselling running smoothly.**

If I could pick everything up straight away, say I had a personal palantypist....if I had that, I could read it, counselling would run smoothly.

**The constructions of 'female issue' and 'deafness issue' as part of medical model counselling discourse in which labels are created in contrast to the 'norm'.**

Ok, at that time I think I was being 'heard' because they were recognising that this was a typical, almost a wom...a female, not a deafness issue but a female issue...

**The label of being deaf adopted to enable empowerment and to be 'heard'.**

...so deafness was never...never the issue in the counselling process, it is...it is...it is now only in the sense that I'm saying 'Please I can't do anymore because I'm deaf', I'm tired, I want a rest, I don't want to go on fighting for the rest of my life trying to make my husband understand...right, understand me, understand that he's married to an intelligent woman who just happened to be deaf...

**Reaction to the medical model of counsellor as 'expert', but counselling become a commodity.**

You find a counsellor that suits you. I mean she's more into being a therapist as a person and she was just you know, when the...when the Cancer Resource Centre said uh 'Do you want this? Do you want that?' I said 'I'll have everything that's going' and you like some of it and you don't like other things...

**Showing what meaning the body can construct and interpreted in certain way by counsellor so as to fit with the dominant counselling discourse of 'normality'.**

Part: That's the thing, it's the emotional piece that...that you lose. And...and they probably pick up wrong emotions as well, because your hearing loss creates probably a different facial expression than what they would expect sometimes because it might be, you know you'll do that (*does an expression of concentration*), and they're thinking 'Oh you're very thoughtful', and you're thinking 'I don't know what was said there! How can I answer that?'

Int: Yeh, 'I just can't hear you!'

Part: Yeh, and that's...I've learnt that...to do that quite a lot and I'm trying to get out of the habit because it's not useful to do that and yet I think when you go through the early stages of deafness you tend to do that because you don't want other people to realise that you've got...you're hard of hearing, so you will try strategies that make you appear normal.

**The 'deaf person' as separate from the person. Reaction to the dominant medical model discourse of disability.**

I think that maybe that's where I feel she's not quite 'hearing', that this is the deaf...now the deaf person in me maybe, appealing for you hearing people to sort it out for me, I can't do anymore. I think...I think so yes, maybe...so yes, all...all my young life maybe my youth has helped me to overcome the deafness and...and maybe I have come over to other people as coping. Now I'm tired and I want other people...but...but I think she's listening and she's certainly listening to the horror stories that I tell her I still have to put up with...

**Both of us, participant and researcher, making a 'part' of her a reality, as a way of adopting a dominant medical discourse that identifies deafness, but using it to be 'heard' amidst the other medical model discourse of a labelled 'psychiatric condition'.**

Part:...I don't think deafness ever came into it before. I think it was a psychiatric condition or pseudo psychiatric condition and 'How do we deal with that?' Because...because that was what precipitated me into hospital, a...a...a crisis, it was a psych...I was admitted as an emergency, I can't remember what happened but ooh I wasn't well at the time, my brain was totally mad, um very...but, as I said the other side of me knowing all along, that's why I kept quiet, I just...very bizarre um...

Int: But its only really now that you feel the part of you has...has kind of emerged that is saying 'Please help me in some way?'

Part: It's the deaf part.

Int: The deaf part.

**An achievement of using the discourse of the medical model of disability to feel empowered by finding her 'deaf person'.**

...growing up in a hearing world had told me 'Don't do it the deaf way, do it our way, if you don't do it our way you won't survive' um and so with [counsellor's name] it was about learning all over again to completely trust myself as a deaf person and in that sense the work I did with him brought back the um the...the bits that was lost, the bit that was still out in the shadow there, and the bit that ultimately my mother had been a bit ashamed of.

**'Coming to terms' in relation to her disability and deafness as an 'issue', which is encouraged by the medical model.**

...with respect to talking to the counsellors um it's only now I think that my deafness is really becoming the issue because everything else, although I haven't achieved what I've wanted in life, and maybe I've just got to come to terms with that properly and recognise that I have achieved everything even though I've been lonely, whatever all my life, so that's for me to deal with, but...but it's um...it is now being recognised, my deafness and um...and...and I think I'm understanding for the first time that my deafness is an issue here.

**Similarly, she speaks of 'managing the relationship' which is an alternative discourse to the counsellor being 'expert'.**

...when I first meet a...a client, I'm always a little bit nervous in case I don't hear them very well, you know particularly when I'm the one that's actually there to provide the service (*laughs*), and so I worry in case I can't do it well enough um so that when I'm in...if I was to be um you know the client um, I would be managing that relationship for myself because I know... Do you know what I mean? I know what I need.

**And again, her alternative discourse to the dominant medical model – what is 'presented' to you, linking counselling to 'technology', a 'package' or 'menu'. These words describe a consumer any can be seen as an empowering discourse.**

Yes I think it...it would be much easier if was presented to you as part of, you know, what's available to you, you know, it's a medical thing that you go in with (*laughs*), but actually the impact of this is...goes way beyond that, and...and, you know, the things that are on...are on offer are not much to be honest, I mean the technology that's available to help with...with hearing loss is...I just find very disappointing generally, but at least you know to be given information about 'This is the technology that's available, these are the services that are available', you know either through the NHS or other bodies you know and just so...so you can see it as a package or as a menu, that you can say 'Well I don't really need that right now but I know it's there if I need it later.'

**A similar discourse of client as consumer – 'available and accessible' counselling.**

...I think it...I think it's...it's about how you present things to people in a way that they can then see it as being both available and accessible.

## MEDICAL MODEL/NORMALISATION

**Medical model discourse of counselling as 'treatment' and therefore something being done to her.**

...they used to give us free treatment there you know, you could have 6 counsell[ing] sessions with one and then that's it, and it was a free treatment...

**Adjusting to the norm – the medical model of disability and counselling – rehabilitation needed by an 'expert'.**

I wonder if there could be therapy with someone like you about how to adjust to it.

**The medical model discourse of 'expert' counsellor where certain 'issues' appropriate.**

Yes and in a counselling situation like that the last thing you want to keep saying is 'I'm deaf, I'm...I'm not hearing you' because they'll think that you're just being a nuisance (*laughing*), that's...that's a perception anyway that...that the important thing is to discuss the issue that you're there for, not to talk about or to raise, you know, their awareness of your hearing loss.

**Medical model discourse of mental health – getting better to return to 'normality' as with physical illness.**

It's because I'm a very open person, I just wanted to get better...

**The medical model of counselling in which counsellor is 'expert' - there is right and wrong content.**

I hadn't really thought of discussing it with my therapist because I usually talk about my emotions and family matters and I've had a couple of deaths this year – I've had bereavement counselling.

**Wrapped up in the medical model discourse of disability and counselling, wanting to be brought back to 'normality'.**

...getting counselling for my...whatever I have. That's what...I wanted that because maybe that would make me feel more...more better in myself to cope with the everyday life...

**Objectifying the depression connected to her hearing loss due to medical model discourse of mental illness.**

Int: And what do you feel you...you would gain from a group situation?

Part: (*pause*) Some confidence, day to day movements, hear from them how they cope, maybe hear what they say may help me to cope better. Or it may help me to get out of the depression because sometimes it gets me down I don't know, thinking about it all the time, most of the time, sometimes it really gets me down and I think there's other people maybe the same but at least we can talk about it.

**The medical model of counselling where there is an 'expert' deciding she is 'coping'. This discourse prevents access to counselling.**

With...with my hearing if (*pause*) When I...when I go back to the doctor and I...and I ask to see someone he says I can't just walk in he has to refer me, but he says if, because I have it so long and I'm coping I can carry on.

**Connected to medical model of counsellor as 'expert' wanting to educate.**

...from time to time she would give me stuff to read um which was helpful – and she actually gave me a copy of the...the mag...BACP magazine that had a whole issue about um therapy for deaf people - I think it was actually more deaf than hard of hearing - but it was I mean, you know, she was kind of in tune to the point of wanting to engage with me on the subject.

**The discourse of the medical model of having to adjust to 'normality' as 'missing out'. Hearing loss connected to 'disease' – something made reality against a norm.**

You know it ought to be, you know as soon as somebody discovers that they've...they've got a hearing loss that is bad enough to...to make them have to, you know, to...to feel that they are missing out on things or having to make changes to their lives or whatever, then some kind of counselling would be, you'd think would be the obvious thing to offer, as you would with any, you know when people um discover that they have other conditions and diseases you know?

**Viewing disability as overwhelming and 'giving up something' due to the discourse of the medical model and having to have counselling to cope with this:**

Oh yes, or just to be told 'You might not need this now but at some point it may be that you suddenly feel a bit overwhelmed by all of this, you know, maybe if your hearing takes a turn for the worse or you have to go from not using hearing aids to using hearing aids or you're suddenly realising you've got to give up something, you know at those points you know, let us know if you know and then we'll point you in the direction of some therapy', because you know a lot of people don't really even understand what therapy is, I don't think I did until I started having it.

**'Mental instability' objectified and a blurring of the boundaries between physical and mental 'conditions' connected to the medical model. A separation of the self due to the constructed limitations of deafness.**

I was terrified that they wouldn't recognise that what I might say was related to being deaf rather than having a mental instability, and I was terrified they'd take my children away from me. As terrifying as that. And I remember the first thing I...and I wasn't well, I mean I knew I wasn't well, it was...it was very bizarre, I knew that my brain wasn't functioning well, and there was this normal side of [*name*] and this deaf side of [*name*], the...the...the side of [*name*] that was affected by the deafness, not being able to hear, not being able to get the information, the paranoia that developed from incomplete communication, right?

**The medical model discourse about ‘normality’ and objectifying ‘mental illness’. ‘Anxiety’ and ‘mental imbalance’ have constructed realities.**

I said to him ‘I had this peculiar thought’ and I told him about it and I said ‘Why?’ I said ‘That wasn’t normal’. And he – it was the first time I saw him smile - he said ‘I think its anxiety making you be like this’, in other words he was...what he was testing me for was to see if I was suffering from a simple human condition like anxiety or whether I really was mentally imbalanced.

**Again, the terminology of the medical model and when something can’t be understood it also gains a label – ‘bizarre.’**

...because it is down as a bizarre psychosis in my notes, it’s not psychotic but bizarre, in other words there were things they didn’t understand.

**The counsellor viewed as the ‘expert’ who defines a ‘problem’ and provides something to do. The confidence associated with the counsellor’s abilities.**

...the problem was identified to me. Your husband is very successful, you have this situation and this situation, and you’ve got to do something to assert yourself, you know, to improve your circumstances and she...yes she did give me ways of dealing with it, she must have done because I came out feeling much more confident...

**Labelling and normalising of medical model. The deafness not viewed as part of the person by the counsellor.**

...and one of those had been the hearing loss um I had also worked...worked with a manic depressive and he was my boss (*laughing*) and so with that and a hearing loss, it had created a...what is it called?...a um...it’s a situational depression that can be quite severe um and I think they placed more emphasis on the environment and the guy that had the manic depression that was kind of passing on that to me, than the...the hearing loss, but with both of those now I can see that the hearing loss would be a big part of that, but it wasn’t...it wasn’t seen as that at the time. So yeh that’s...but I think that there was a recognition that the hearing loss had caused some problems in things like meeting situations and so she was aware that we were talking about this as a..a thing, but I don’t think she remembered that in the [*counselling sessions*] I still had it! (*laughing*).

**‘Acceptance’ due the medical model of disability and seen in contrast to ‘health’.**

It is difficult to accept that you’ve got some sort of disability that makes you, you know, when you come from being very healthy and ok...

**‘Trying to fix’ is part of the medical model discourse of counselling and disability and a return to ‘normality’ rather than addressing the discrimination causing the isolation.**

It was more the result now I see of the hearing loss that we were trying to fix than look at the isolation that the hearing loss was creating.

**Medical model discourse of having to ‘treat’ or ‘cure’ medical and physical ‘illness’.**

Because they were treating the depressive illness with um medication, but there was nothing really being done about the hearing loss, so when I had the meetings it was mainly focused on how the medication was helping the...you know rather than ‘Well ok we’ve dealt with that piece but we still have to remember that you’ve got a hearing loss that we can’t cure’.

**The ‘mental health issue’ objectified as part of medical discourse.**

I think that was lost, because there was too much focus on the...the mental health issue rather than looking at maybe what was the cause of it. You know what I mean?

**‘Solving brain function’ is part of the discourse of the medical model of mental health.**

I think in general in the first experience, it was to do with the illness and to do with solving brain function but there was no thought about the input from the hearing. I think that was probably what I would say about my first experience was that there was a lack of really understanding...

**Labelling the self.**

Well I didn’t realise it but the counsellor pointed out and at first I thought ‘no that’s not me at all’, but I am a people pleaser, I mean I read all the definitions of people pleaser, and he even pointed out why.

**'Professionalism' indicates better communication, suggesting the 'expert' of the medical model of counselling.**

...because I wasn't there specifically for the hearing loss it was like something that was hidden so I think it was more to do with her professionalism that she was a good communicator.

**Medical model discourse around disability and comparison to the 'norm'.**

'Well your...you've got a hearing aid and so you'll be able to hear, and...and so your...your hearing's normal'...and it's not normal by any stretch you know.

**This relates to the medical model discourse of 'normality'.**

...she gets cross when [my counsellor] hears my husband telling me I need to see a psychiatrist, because she says 'You don't [name], you're fine, there's nothing wrong with you at all'.

**'Back on course' as back to normality and therefore the medical model of mental health and counselling.**

So I think...I think that particular issue did...that particular session did achieve what I think it intended to achieve which was to get me back on course again...

**Comparison to 'ordinary' people due to the normalising effect of the medical model.**

**Awareness of changing discourse of disability. Therapeutic discourse of knowing how to be with disabled people.**

Now, I don't think there is a single person who knows...who works with hard of hearing and deaf people who would treat them any differently from ordinary people because what email has done is unlocked their minds, and you can put everything in email which um helps the other person to...to understand you and ask the right sort of questions so they are not asking the questions of a deaf person, they are asking the questions of a person like themselves, right, so the counsellor now has grown up....is in that environment and she...and she also is aware of how to talk....she...she's part of a new age of people who know how to communicate with deaf people and how to listen.

**Normalising discourse of medical model of disability.**

I think that's one of the most difficult things to accept, is to know that you've got a level of hearing and then trying to put over what you can and can't hear and what's normal for somebody to hear and what isn't. And I guess I thought that I was still normal and it was just that I wasn't catching everything, not being aware that everybody else was picking it up.

**The compliance of the hard of hearing client to fit in with normality.**

I have a feeling I did probably ask, explain that I couldn't hear, and I did ask for things to be repeated, because I must have had counsellors that were really...took that into consideration, but I can't honestly remember, as you will know hard of hearing people very often nod and smile and er 'Oh yes I know what you mean' kind of thing when they don't, and I don't really remember doing that, but of course I was doing most of the talking you know so...

## Discourses of Resistance

### THE BODY/NON-VERBAL

**Her reaction to the dominant talking therapies, new discourses she has adopted.**

...this is another level, this is not strict counselling but you know we do have lots of forms of non-local communication and I...I, you know, deaf people tend to do that but as soon as you get into a school situation you are told 'No, no, no that's not what we do' and so a huge part of me yes, a huge part of me was just said 'That doesn't count', and yet for me it was very powerful, so that was the kind of thing, trying to get that back..

I have a huge number of esoteric interests which are entirely about my deaf person, because I see things at another level...

...what I was doing with my last therapist was getting beyond the spoken word yeh? And getting into non spoken communication and what wants to be said, what wants to be heard...

...so body therapists, which...I've done a...done a training in body psychotherapy, they will of course go beyond language.

**Communicating with me non-verbally illustrating the limits of words for her. Constructing meaning through her hands.**

...it's my ears that are here (*makes her hands into ear shapes over her heart*), everywhere (*makes ear shapes all over body*), uh I've got ears all over...

**New discourses adopted.**

...like this one man who does tapping you know, I don't know if you know that one, where they do different tapping...?

...all different kinds. Massage, Reflexology, all that...and then of course I...healing, you know, spiritual healing...

I did lots of drawings and I was...that's what, she's a visualisation sort of expert you know, and I think in pictures a lot.

**Her awareness of the non-verbal communication.**

He was on a high stool and I was sitting away from him on a low chair and I...I don't think er...no... I'm not expecting him to be warm to me but he's like this...[not the] approach I was looking for so...

**How the body communicates and constructs a reality whilst masking another experience.**

I think that when you sit and you look at somebody and you go – (*nodding*) 'Yeh yeh yeh', they think that you've got it all...

...as you will know hard of hearing people very often nod and smile and er 'Oh yes I know what you mean' kind of thing when they don't, and I don't really remember doing that, but of course I was doing most of the talking you know so...

**The power of non-verbal communication in the positioning of chairs and the meaning that is constructed through this.**

...and for them to not sit in a neutral position, to sit closer to me, wouldn't have created a good environment if they had created a...an unbalanced environment which wouldn't have been good for everybody trying to resolve a situation.

Int: It's interesting because actually her sitting nearer to you would have actually made it more equal, but I think, it would have seemed as though you were being favoured or...yeh.

Part: It would definitely seemed...it would have definitely have been perceived that way, so although it would have balanced us up equally on the hearing side it wouldn't have balanced us up equally on the spatial side, it would look two against one, if you know what I mean.

**Recognising the limits of words and using non-verbal communication with me.**

Int: It's very hard for you to explain to people....and because it's something invisible.

Part: I can't explain, I can't explain it. My ears and noise in my head...now it's like the wave and the sea coming in my head (*makes noise*).

Int: Mmm, and because it's something that's invisible other people...

Part: Can't explain it.

Int: Yes.

Part: Can't explain it.

## OTHER REACTIVE DISCOURSE

**An alternative discourse to viewing disability as a loss – seeing it as a 'gift'. A reaction to the medical model of disability.**

...so he wasn't saying 'Oh what a pity, what a shame, how you must have felt', this that and the other, he was just talking um.... 'This is a great gift' um and it was almost as if he could see the gift and, 'cause I always sensed that it was a gift um and he was going 'You have a great gift, let's develop it here and let's really bring it to light' and...and anything that's that kind of a gift is always light...

**'Warm', 'holding' and 'love' – an interpersonal discourse of counselling that is not connected to the medical model.**

But in other respects the relationship was extremely warm and with a lot of um....a very positive um...um holding – and love if you like.

**Her disability being a 'problem' due to the medical model disability discourse and medical model of counselling and her reaction to this.**

...there was a huge amount of humour and laughter in the relationship and that actually um that really made me feel 'heard' because there was no sense of heaviness about it, that sort of shame of you know and...and 'Oh this is such a problem', you know that weight, so it was the lightness um the lightness and the laughter and the humour um that really helped.

**What is being 'offered' suggests a reaction to the medical model of the counsellor as 'expert'.**

And it...it took a while to kind of get a sense of what she was actually offering me, um, and certainly the first few sessions, where mostly it was me talking and her listening...

**Personal images**

I spent my time with animals and climbing trees, kind of...kind of quite a wild child actually and that child had got totally and utterly lost and then went to school and it was kind of oomph you know, 'You've got to do it this way, you've got to fit in with these people' and so I had forgotten that child really and it was like I was trying to bring that one back into being and so I couldn't really remember who she was either and the fact he didn't provide a space for it, yeh, so there was a struggle there.

..you know the snakes and ladders board? And you've got a snake that...just as you get to the last square but one and you're almost home and then there's a snake and you go all the way back to the beginning again and you know I've experienced that and that's what my sisters will say and my daughter will say, it's just never quite being able to get into mainstream society, um and so there's always that disappointment, so I can't say it was – did I consciously feel disappointed with either of these two therapists? Because it was just so part of my whole life experience and I just kind of thought 'Well that's what happens.'

**Normal' hearing due to the medical model discourse of disability. Being 'heard' explained as 'being empathically met' which is the discourse of interpersonal counselling. She is showing her awareness of the counselling discourse of 'hearing' and challenging it.**

...it's an odd notion isn't it, um I...I'm the partially hearing client and you're the counsellor with normal hearing, it's kind of back to front in a way isn't it, because I would worry I can't hear you, why would I think that you would worry you're not 'hearing' me? I just kind of assume you can hear me. So it's odd isn't it? I know what we're looking at; we're looking at something deeper. From the face of it, as a partially hearing person I can say 'Oh well this person's got normal hearing, that's fine, she will hear everything I say, she will hear me...' The assumption would be you would hear me. So I'm wondering if it's different, if it really is different if you're a... because all clients feel 'Am I being 'heard?'" Am I being empathically met by this counsellor? Is she there for me? All those questions.