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# 4

## *The Psychological Effects of Social Stigma: Applications to People with an Acquired Hearing Loss*

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In many societies, negative stereotypes and prejudices are attributed to people who have hearing loss. The general population perceives individuals with hearing loss as being “old,” “cognitively diminished,” “poor communication partners,” and generally “uninteresting” (Blood, 1997; Doggett, Stein, & Gans, 1998; Erlen & Garstecki, 2002; Franks & Beckmann, 1985; Hallberg & Jansson, 1996; Kochkin, 1993, 2007). Partly because of society’s view of deafness,<sup>1</sup> many individuals who acquire hearing loss in adulthood are stigmatized. Often, individuals with hearing loss hold the same stereotypical and prejudicial views of deafness as

does the general population. Hence, their social identity (how they perceive themselves) is altered due to society’s perceptions and due to their own conscious (or unconscious) prejudicial views of hearing loss. This phenomenon, known as stigmatization, is very prominent in many western societies (and perhaps in others as well). The negative stereotypes and prejudices held by society and self-stigmatization that often develops within people who are the target of social stigmatization may have a negative effect on one’s physical and psychological well-being as well as participation in activities of daily living.

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<sup>1</sup>The general population does not readily recognize degrees of hearing impairment; mostly, people are thought to have normal hearing or no residual hearing. Hence, to members of the general population, people have “normal hearing” or they are “deaf.”

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Often, people who feel discriminated against by others, and who have a poor self-image are ashamed of themselves due to their discreditable attribute (e.g., hearing loss). Because the presence of hearing loss is not visible, some individuals may choose to conceal, deny, or minimize their hearing impairment. A variety of strategies are used to hide hearing impairment from others. One (maladaptive) coping strategy employed by some people who perceive themselves as being stigmatized due to hearing impairment is to isolate (and insulate) themselves from the world around them. As a result, individuals with hearing loss withdraw from family life and other social activities. By doing so, they can avoid responding inappropriately when someone interacts with them, and as a result they benefit by not disclosing to others that they have a personal attribute (hearing loss), that is, discredited by themselves and by society (Vignette 4-1). In fact, concealing one's hearing loss prevents individuals from

using communication strategies, as these strategies would inform and disclose the presence of their hearing loss. Moreover, significant cognitive and emotional resources are expended in attempts to conceal hearing loss and the effects of hearing loss on communication. The stress induced by this process may have a deleterious effect on psychological well-being as well as physical health. This may lead to a decrease in overall quality of life and may be the underlying cause of a number of health related problems (Leary, Tamlor, Terdaly, & Downs, 1995).

The stigma related to hearing loss constitutes a major obstacle to audiologic rehabilitation (AR). A person who denies having a hearing loss and conceals his or her hearing difficulties (and its effects) from others is not likely to seek services from an audiologist. Hence, the individual is deprived of rehabilitation services that are potentially helpful, such as obtaining hearing aids and other hearing assistive technologies (HATs), and

#### **Vignette 4-1** ***Avoiding Social Interactions***

Mr. A is a 55-year-old man who has worked in noisy industrial plants for more than 25 years. He and his wife have three daughters and six grandchildren. Mr. A's family, including the three sons-in-law and the grandchildren, has dinner together to celebrate special occasions. Over the past couple of years, Mr. A has noticed that he has more difficulty following the conversation when everyone is having dinner in the dining room. He suspects that his problems are due to hearing loss because his last hearing test at work indicated a significant hearing loss in the high frequencies. Mr. A wants to keep his hearing loss secret because he fears his sons-in-law will make fun of him. Recently, in order to avoid misunderstanding the others during the special family dinners, Mr. A finds an excuse to leave the table early after the meal. He goes to the living room to read his newspaper or he naps. By doing so, his chances of experiencing a communication breakdown are decreased and also he doesn't have to disclose his hearing loss to the members of his family. The avoidance strategy used by Mr. A has been very successful in concealing his hearing loss. However, he feels badly about not being honest with his family, and his concealment behavior induces some stress every time there is a family gathering. Lately, due to his unexplained "awkward behavior" and the tension that it brings about in the house, some family members have found excuses not to attend family dinners. As a result of these developments, some tension has been created between Mrs. and Mr. A. Mr. A feels terrible about the outcome of the situation. He has been moody, tends to isolate himself more and more from family interactions and activities.

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learning to request and apply communication strategies that are known to be effective. These individuals deny themselves the opportunity to improve their communication skills and increase their level of participation in activities that are essential or considered important to them (Vignette 4-2).

Crocker, Major, and Steele (1998) have defined stigma as: the possession of, or the belief that one possesses, some attribute or characteristic that conveys a social identity that is devalued in a particular social context. Stigma is a social phenomenon that can be investigated from many different perspectives. For example, investigations may be conducted to explain why some people develop stereotypical (prejudicial) perceptions of subgroups of individuals who display certain characteristics. Or, investigations may attempt to understand how some discriminatory behaviors are formed and how they develop over time. Some examples of investigations from this area have focused on groups such as persons with mental illness, epilepsy, who are HIV positive, members of the gay and lesbian communities, and persons with visible stigmas such as women and African Americans. It is generally recognized that stigmatization involves a power relationship between a dominant group (the *outsiders*) and a minority group (the *insiders*; people who share some deval-

ued characteristic that distinguishes them from the *outsiders*) (Link & Phelan, 2001, 2006; Oyserman & Swim, 2001). Many studies have focused on investigating the relationship that exists between *outsiders* and *insiders* relative to certain social phenomenon (e.g., American of European descendants vs. Americans of African descendants). Some investigations are designed to gain insights on the attitudes, beliefs, or behaviors of members of a specific *outsider* group towards members of a specific *insider* group (Hetu, Getty, & Waridel, 1994). For example, studies have described the perceptions of people with normal hearing toward people who wear hearing aids (the hearing aid effect: Blood, 1997; Doggett et al., 1998; Kochkin, 1993, 2007). Investigations involving *outsider* groups are useful to gain an understanding of the social determinants of stigma.

Studies of the perceptions, attitudes, beliefs, and behaviors of members of *insider* groups have revealed that there are similarities and differences in perceptions, behaviors, and attitudes across groups of individuals who are the target of stigmatization based on a specific set of attributes (e.g., the differences and similarities in the perceptions of educational opportunities by female college students who are American of African descent versus the employment opportunities of gay men

#### Vignette 4-2

##### ***Stigma as a Major Obstacle to Audiologic Rehabilitation***

Ms. B who is in her mid-fifties suspects that she has a progressive hearing loss because of recently misheard information in conversations, and because of her family's history of progressive hearing loss. Mrs. B's impression of people who have hearing loss is not positive (she holds a stigmatizing view of people with hearing loss). She thought that her grandmother and her aunt who had hearing loss were social misfits because people always had to repeat things to them, and because they often replied inappropriately during conversations.

Because of her past experiences with people who have hearing loss, Ms. B decides that she will conceal her hearing loss from others. She will not consult a hearing health care professional because she does not want to use a hearing aid. She is unaware that rehabilitation services extend beyond the recommendation to use hearing aids. She also is unaware that, by not seeking services, she deprives herself from learning the communication strategies that can be effective to optimize speech understanding during conversations.

diagnosed as being HIV positive). A major finding of these studies was that large individual differences exist among members of the same *insider* group. Moreover, the results of investigations indicated that the perceptions and behaviors of individuals from the same group can change as a function of different variables. These findings led to studies that investigated the role of individual differences among people who were members of the same *insider* group (Brown & Pinel, 2003; Pinel, 1999). Investigators observed that several factors served to modulate the perceptions of people who were the target of stigmatization (Lightsey & Barnes, 2007; Vauth, Kleim, Wirtz, & Corrigan, 2007). The results of these investigations led to the development of conceptual models that describe the phenomenon of stigmatization from the perspective of people who are the target of prejudicial attitudes (Corrigan & Watson, 2002; Corrigan, Watson, & Barr, 2006).

The present chapter addresses issues relevant to describing and understanding the effects of social stigma on individual members of a specific *insider* group. Throughout the chapter an attempt is made to relate the information presented to adults who have an acquired hearing loss.<sup>2</sup> It is our view that a better knowledge of the factors that influence the social identity of people who have an acquired hearing loss, as well as a better understanding of the effects and consequences of being stigmatized, will be helpful to audiologists. Moreover, this knowledge should make it possible to develop intervention programs that will cater to the specific rehabilitation needs of people with hearing loss who are vulnerable to the negative effects social stigma. In the next section a definition and a description of social stigma is presented. Then, in the following section, the work of Héту (1996) related to the stigmatization and normalization processes experienced by people with hearing loss is summarized. Later, we

describe a generic model of stigma-induced identity threat and the possible effects of this threat on the persons who are stigmatized. Finally, based on the conceptual framework described, in the last section we discuss the types of intervention services that could be offered to individuals who show signs that their personal identity is diminished due to the fact that they have a hearing loss.

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## Definition of Stigma

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Originally, individuals who were stigmatized were people who had a physical trait or characteristic that was considered “deviant” or “abnormal” relative to a reference group (i.e., the *outsider* group) in a given society (Goffman, 1963). The people who displayed these traits or characteristics were devalued as individuals and discredited as a member of their society. Any deviant trait or personal attribute (physical, behavioral, personality, psychological, etc.) that brings discredit to a person may be the source of stigma. Goffman (1963) suggested that stigma signified marks that designate the bearer of a spoiled identity and that this person was less valued in society. A wide variety of personal attributes may be the source of a social stigma. For example, in many western societies stigmatized individuals include people who have a history of psychiatric disorders as well as ex-convicts, pedophiles, and homosexuals. Stigmatized individuals may also include people who are obese, short, HIV positive, diagnosed with a genetic syndrome such as trisomy 21, who smoke tobacco, belong to a given ethnic or a specific religious group or sect, or who speak with a foreign accent. Stigmatized individuals are the target of prejudicial and discriminatory threats (Miller & Major, 2000). In most western societies (and perhaps in others as well), people who have

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<sup>2</sup>In preparing the chapter it became apparent that, even among the population of people with hearing impairment, the specific factors that create an identity threat and the effects of perceiving oneself as being stigmatized would differ according to several factors, including: the degree of hearing loss (e.g., individuals with a moderate to moderately severe hearing loss vs. those with a profound hearing impairment), whether the hearing impairment was present at birth (or before the normal period for acquiring oral language) or whether it developed in adulthood; and, the age range of the population of interest (children vs. young adults vs. older adults). Consequently, a decision was made to focus the content of the present chapter to issues related to stigmatization among adults who acquire a hearing loss in adulthood.

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hearing loss are stigmatized. It is interesting that Goffman (1963), a sociologist who authored a major treatise on social stigma, used hearing loss (he used the term deafness) to illustrate how an individual's distinguishing attribute could be generalized to other personal characteristics that carry a negative connotation. He noted that hearing loss is often misunderstood as an intellectual challenge or a deficiency in personality and character. The origins of stigmatizing persons who have congenital hearing loss can be traced back to Babylonian laws, pre-Christian laws, religious texts, and to the writings of Aristotle and Saint Augustine: persons who could not hear or speak were likened to animals that were not capable of having intelligence or faith in God (Roots, 1999).

Based on the above description, two characteristics of social stigma are worthy of discussion in relation to hearing loss. First, stigma is a social construction (a label attached by society; a phenomenon defined by society, Major & O'Brien, 2005). Within this context, the term "society" is defined from a sociological perspective, meaning: "a group of persons regarded as forming a single community" or "any organized group of people joined together because of some interest in common" (McKechnie, 1976). Personal attributes that are stigmatizing in one society may not be stigmatizing in another society. For example, being overweight may have a negative connotation in some societies but it may be a valued personal trait in another society. In a recent interview, Rihanna (a well known pop star) stated that in the United States of America being skinny was very much valued. She remarked, however, that in her country of origin (Barbados) it is women who have "curves" that are considered beautiful (*Allure Magazine*, 2008). A given personal attribute may be viewed as positive (or neutral) in one "micro" society (e.g., adults with hearing loss who are members of groups such as the Hearing Loss Association of America) whereas the same attribute may be viewed negatively in another "micro" society (an adult with a significant hearing loss who is a member of a highly competitive bridge club). Moreover, within a given society (e.g., North America) a given trait may be viewed as positive or neutral at one given point in time, and the source of stigmatization at another time. For

example, only a few decades ago, smoking tobacco did not carry much of a negative connotation among most middle-class Americans of European descent. People smoked in a variety of social settings. Nowadays, in many respects, smokers are generally viewed negatively. To various extents, people who smoke are devalued as individuals and discredited as a member of society; they are stigmatized. The issue raised here is that stigmatizing attributes are defined by the collective perceptions and values that members of a society (*outsider* group members) hold at a given point in time. Related to hearing loss this is reassuring. It is possible (one would hope!) that the negative and prejudicial attitudes currently associated with hearing loss may change over time. Perhaps as baby-boomers get older and society's views become less conservative, the negative connotations associated with hearing loss will subside.

A second issue related to social stigma is especially noteworthy because it applies to hearing loss. In the social sciences, it is readily acknowledged that aspects of social stigma may differ depending on whether or not it is possible for the individual to conceal the personal characteristic that defines their stigma. Quinn (2006, p. 84) defined a concealed stigma as, "a stigmatized identity that is not immediately knowable in a social interaction." For example, a person with a history of mental illness or a person who is HIV positive may decide to conceal his or her stigmatizing attribute from some people with whom they interact. This option is not possible to someone who has a conspicuous stigma (e.g., skin color, visible physical deformity). Hearing loss is an invisible impairment that an individual can conceal from others. Social stigma research has shown that, relative to conspicuous stigmatizing attributes, having an invisible stigma has some advantages and some disadvantages.

People who have a concealable stigma may decide not to disclose their stigma and thus avoid being stigmatized. Alternatively, they may be able to decide if, when, and to whom they disclose their stigma. For example, an individual can decide if or when to reveal to another person that they have a hearing loss.

One drawback related to concealing a stigmatizing attribute is that there is always discomfort



associated with the possibility of having the trait disclosed during a social interaction. Studies have shown that concealing one's stigmatizing trait increases the cognitive load required to take part in social interactions (Lane & Wegner, 1995; Smart & Wegner, 1999, 2000). For example, in addition to exerting the cognitive effort normally required to participate in a conversation, a person who is attempting to pass as normal will have to expend extra cognitive resources in order not to divulge any information, signal, or cues that would betray his or her attempt to conceal (Vignette 4-3). This may be particularly stressful for a person who has a hearing loss, given that due to the nature of the impairment, any normal conversation (even those where disclosing hearing loss is not an issue) invariably will require expending more cognitive resources than those typically required by persons with normal hearing who perform the same task.

It has been shown that the amount of stress associated with participating in a social interaction

will vary according to the importance given to unwillingly disclosing the stigmatizing trait and the likelihood of that happening. For example, for someone who has an eating disorder that is not physically apparent to others, the stress associated with a conversation will be less when the topic of discussion does not center around food and eating whereas it will be more stressful when the discussion centers around food and eating. Hearing loss may represent a unique dimension of this situation. For people with hearing loss, in most social situations, they risk causing communication breakdowns due to their hearing impairment. Every time they converse, they risk revealing their stigmatizing attribute to others. This may explain why people with hearing loss often avoid social interactions altogether, as this is a safe strategy to ensure that they will not unwillingly disclose their stigma.

Results of investigations have also shown that the manner in which a stigma is disclosed and the timing of this disclosure will influence how well

### **Vignette 4-3**

#### ***Additional Resources Required to Conceal Hearing Loss***

Mr. C was recently diagnosed as having an acquired high-frequency, moderately severe hearing loss. Only immediate family members know about the hearing loss. He has chosen not to disclose this information to others. Since the hearing loss was diagnosed, Mr. C noticed that effective communication at work is much more effortful than it is at home. He finds that due to his hearing loss, taking part in work-related conversations requires a lot of concentration to limit the number of communication breakdowns that occur. In addition, unknowingly, Mr. C expends considerable resources making sure that he doesn't disclose his hearing loss to his work colleagues. Mr. C cannot understand why communicating in the workplace is more effortful than communicating at home and why more communication breakdowns occur in his work setting than at home.

Eventually, Mr. C consults an audiologist about the communication difficulties associated with many of his daily activities. He was surprised to learn that his communication difficulties at work may be associated to the additional cognitive resources he must expend to conceal his hearing loss in that setting. Specifically, he learned that, due to the nature of communication, persons with hearing loss must expend more effort to communicate effectively. He also learned that, due to the nature of communication, the risk of inadvertently disclosing his hearing loss is increased every time he interacts with colleagues at work. This makes him realize that the combination of work responsibilities, the stress associated with taking part in social interactions, and the effort expended to conceal his hearing loss left him depleted of resources to communicate effectively.

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this information is received by others. For example, if someone's stigma is unwillingly disclosed by a third party, or if it is divulged only after a trusting relationship is formed, the stigmatized person may be seen as being dishonest or untrusting (Herek, 1996). If it is disclosed too soon after meeting someone, there is a danger that others will perceive that this disclosure was used as an excuse to explain some incompetence or social inaptitude (Bairan, Taylor, Blake, Akers, Sowell, & Mendolia, 2007; Corrigan & Matthews, 2003; Joachim & Acorn, 2000; Pachankis, 2007).

Studies also have shown that there is a direct relationship between the desire to conceal a stigma and the importance given to the stigmatizing trait. For example, Major and Gramzow (1999) showed that the more women felt that abortion was a stigmatizing attribute, the more they attempted to keep their own abortion secret from others. Extending this to hearing loss, one would presume that the greater the amount of negative stereotypes that someone attributes to having a hearing loss, the more effort that person will expend to try to conceal the hearing impairment from others.

Finally, a unique aspect of concealable stigmas is that the stigmatized person is more likely to know what family members, friends, and workmates think about that stigmatized trait. That is, because they are not aware that someone in their midst has a stigmatizing trait, close others are more likely to express their attitudes about that specific stigmatized attribute. This is different from a conspicuous stigma (e.g. obesity) because in the presence of a person with a visible stigma, others are likely to be more diplomatic (politically correct) about how they express their attitudes about the specific stigmatizing trait. This information may be of value for rehabilitation. Knowing the attitudes of significant others toward hearing loss should provide insights on how to proceed in disclosing the hearing loss to others. For example, the person with hearing loss may choose to first disclose the impairment to someone who is less prejudicial toward people with hearing loss. In addition, they may solicit their help in using repair strategies during conversations. This strategy will enable the person with hearing loss to improve his or her self-esteem and to gain confidence as a communication partner. When this

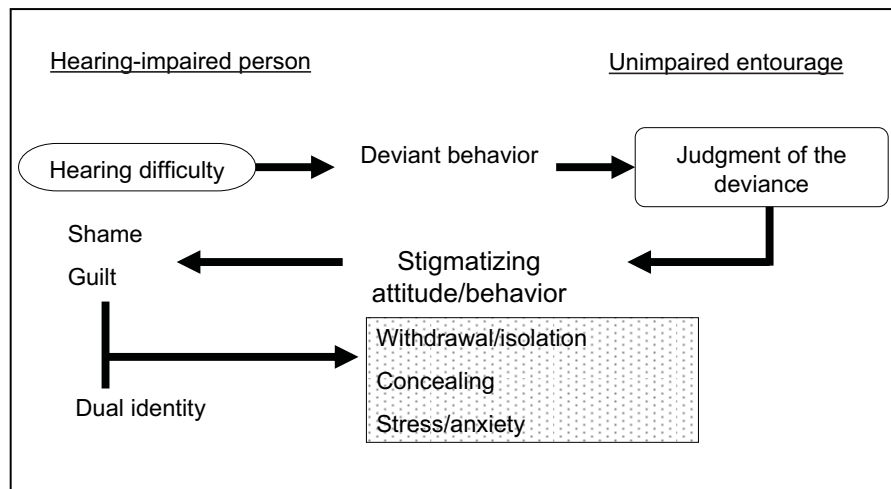
occurs, it will become less stressful to employ the same strategies (disclosure and seeking help from communication partners) with people who have stronger stigmatizing views of hearing loss.

## Self-Stigmatization and Persons with Hearing Loss

To our knowledge, Héту (1996) was the first scholar to address the issue of stigma associated with hearing loss from the perspective of individuals with an acquired hearing loss. In his seminal article, "The stigma attached to hearing impairment" (Héту, 1996), based on the generic literature available on stigma from the social sciences and on the results of interviews with adult males with an acquired hearing loss (and their spouses) he proposed two models: one that described the *stigmatization process* and another one that described the *normalization process*. According to Héту (1996), people who are discredited (stigmatized) because of their hearing impairment experience shame. In this context, shame is the emotion that accompanies threats to one's sense of social belonging. It is a social control mechanism that serves to instill acceptable behavior and inhibit unacceptable behavior. According to Héту (1996), the *stigmatization process* is the result of the communication breakdowns and other "deviant" behaviors that may occur when people with hearing loss interact with people who have normal hearing (Figure 4-1). The demeaning and discriminatory reactions of the communication partners to the "deviant behaviors" of the person who has a hearing loss leads the latter person to feel shame and guilt about themselves due to their hearing loss. As a consequence of the stress induced and the feelings of incompetency that develop, the person's self-esteem and social identity are diminished. The strategies often used to avoid the stress and the feelings of incompetency associated with unsatisfying social interactions (and the effect on their self-esteem), lead people with hearing impairment to conceal their hearing loss from their communication partners. In addition, many people decide to withdraw from social activities and isolate themselves (Vignette 4-4).

Héту (1996) also described a two-step *normalization process* designed to help the person with

## Stigmatization process



**Figure 4-1.** Stigma: Héту's (1996) model of the stigmatization process (taken from Héту, 1996).

### Vignette 4-4

#### *The Consequences of Hearing Loss on Self-Esteem and Social Identity*

Mr. D is a retired person, and a devoted family person who held an important position as a corporate executive for many years. He has always prided himself for being a keen golfer and for being well informed about the professional golfing tour (PGA). For many years, Mr. D played several rounds of golf with his grandchildren every summer. However, he has found that the last few outings to be less satisfying. Often, because of his hearing loss, Mr. D is unable to follow the conversation when he plays golf with his grandchildren. When he makes inappropriate comments his grandchildren make fun of him and tease him for becoming a "deaf and senile old man." When he asks his grandchildren to repeat a comment they typically respond "Never mind. It wasn't important." More and more, the grandchildren tend to exclude Mr. D from their golf conversations. Although playing golf with his grandchildren used to be a very important activity for Mr. D, recently the golf outings have not been satisfying. These golf outings make Mr. D feel old, inadequate, and an uninteresting grandparent. His self-esteem is affected to the point where he decides to stop playing golf. Gradually, he even stops taking part in other activities with his grandchildren. He would rather stay at home and feel sorry for himself than to be devalued by his grandchildren.

hearing loss overcome feelings of shame and guilt associated with hearing impairment and regain a more favorable social identity (Figure 4-2, step 1). The first stage of the *normalization process* involves

meeting and interacting with other people who have a hearing loss (members of the *insiders*), so that together they can share their experiences of hearing difficulties and the resulting unsatisfac-



tory social interactions. This therapeutic activity helps the participants realize that unsatisfactory social interactions are the result of the hearing loss, rather than to other factors that may be unjustifiably attributed to them (e.g., being unwilling to communicate, or otherwise responsible for the communication breakdowns). Furthermore, the stigmatized person realizes that it is not unusual for people with hearing loss to feel denigrated, diminished or ashamed of themselves. They come to realize that other people with hearing loss have the same feelings of inaptitude and self-denigration. These realizations serve to trigger the *normalization process*. The individual realizes they are not alone in their feelings about their hearing loss and how they behave because of the hearing problems. They realize that other people experience the same feelings and that these feelings are “normal.” As a result of this process, people with hearing loss start to feel better about themselves. The process of restoring a more positive social identity is initiated and they are more willing to engage in social activities and interactions. They may learn appropriate coping strategies and experience success in using these strategies when they interact in this favorable social environment (i.e., in the presence of others who have hearing loss).

In the second stage of the *normalization process* (Figure 4–2, step 2), people with hearing loss are encouraged to interact with people in their entourage who do not have a hearing loss. Moreover, they are taught and encouraged to inform their communication partners that they have a hearing loss, and to solicit the use of communication strategies that will optimize the exchange of information. Under these circumstances, communication partners are more likely to acquiesce to the requests of the persons with hearing loss. It is likely that communication will become more efficacious and more satisfying for both communication partners. The result of participating in more satisfying verbal conversations (social interactions) serves to further restore a more favorable social identity for the person with hearing loss. As the process of restoration continues, the person with hearing loss will gain more and more confidence in the ability to be a satisfying communi-

cation partner. As a consequence, they are more likely to participate in valued activities that include people who do not have a hearing impairment (members of the *outsiders*) and likely will regain a more positive image of themselves. Héту’s contribution of providing a conceptual model of stigmatization and guidelines for rehabilitative services that serve to restore a favorable social identity constituted an enormous contribution to audiological rehabilitation as well as to the social integration of adults with an acquired hearing loss.

In recent years, there have been significant breakthroughs in the conceptualization of social stigma from the perspective of the persons being stigmatized (i.e., self-stigma). In the next section, we describe one contemporary model of stigma. In our view, most of the concepts described in the model are applicable to the social stigma associated with hearing loss, and to the way that people with hearing loss feel and behave when their self-image is diminished because of the social stigma associated with their impairment. Moreover, we believe that audiologists will benefit from having a better understanding of the self-stigmatizing process and its effects on people who have a hearing loss. Integrating aspects of this model into the domain of AR will serve to complement and extend the current level of knowledge that is available to us, largely due to Héту’s work. Undoubtedly, a more comprehensive understanding of the self-stigmatizing process will lead to the development of more appropriate rehabilitation services for people who are stigmatized due to their hearing loss.

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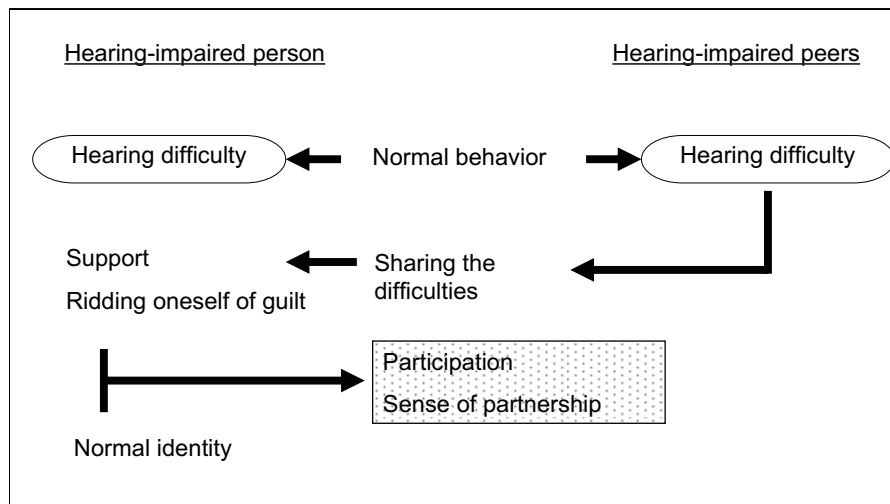
### **Model of Stigma-Induced Identity Threat**

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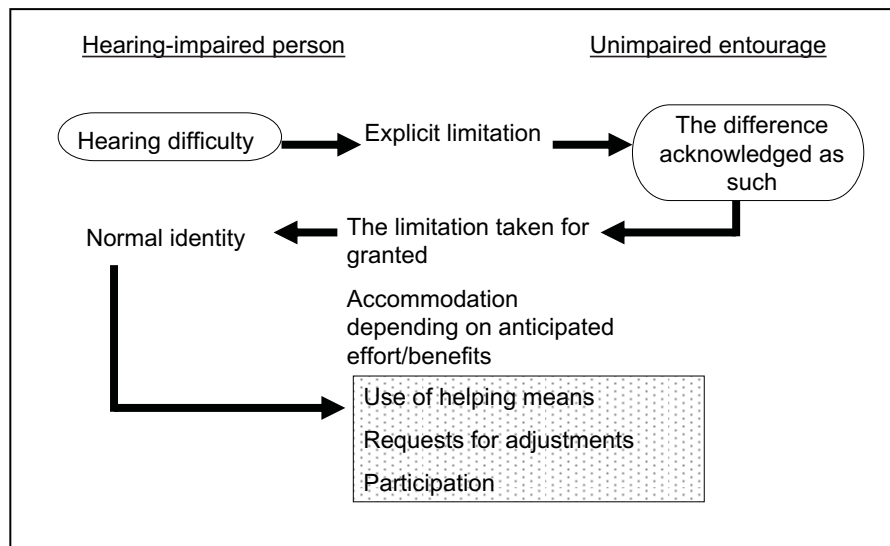
Major and her colleagues have proposed a model of stigma that is based on two premises. The first premise is that stigma puts a person at risk of experiencing threats to his or her social identity (Crocker et al., 1998; Major & O’Brien, 2005; Steele, Spencer, & Aronson, 2002). The second premise is that having one’s social identity devalued leads to a potentially stressful situation. Furthermore,

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## Normalization process—Step 1



## Normalization process—Step 2



**Figure 4-2.** Héту's (1996) two-step model of the stigma normalization process (taken from Héту, 1996).

according to this model, responses to stigmatization may be similar to responses that may occur in any stressful situation. A diagram of the stigma-induced identity threat model proposed by Major and O'Brien (2005) is presented in Figure 4-3. In this model, responses to stigmatization are dependent on the stigmatized person's assessment of the

demands of the situation. An event is deemed to be potentially stigmatizing (see box D) when the individual appraises the demands imposed by a stigma-relevant stressor as potentially harmful to his or her social identity, and when the stress induced by the situation is judged to exceed the resources available to cope with those demands.

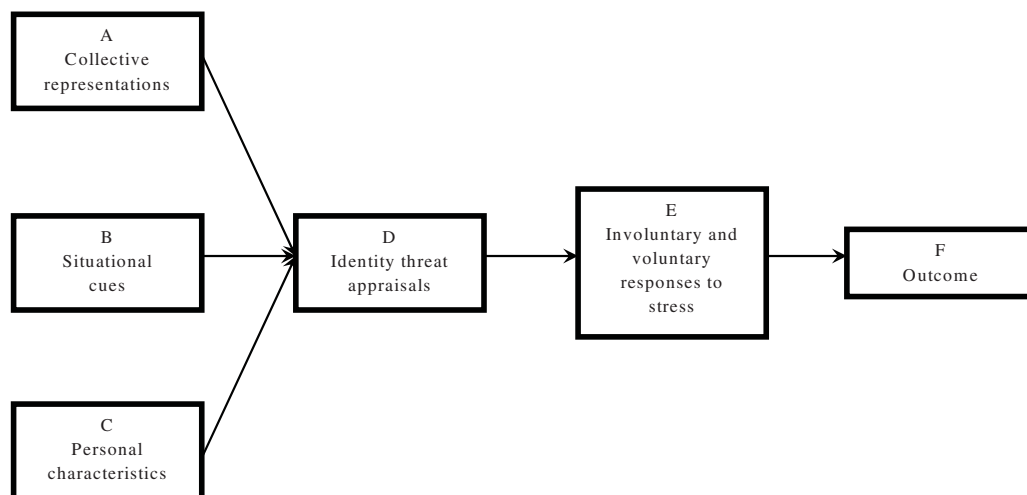
Appraisals of one's identity threat (box D) are determined by the interaction of three constructs: collective representations (box A), situational cues (box B), and personal characteristics (box C). Responses to an identity threat can be involuntary (e.g., coping responses in the emotional, physiological, behavioral and cognitive domains: (box E) or voluntary (e.g., coping responses primarily in the behavioral and emotional domains) (box E). The outcomes of coping responses (box F) consist of attitudes (e.g., self-defeating, pessimistic), feelings (e.g., self-esteem, shame, fear, lack of confidence), or behaviors (e.g., academic achievement, communicative abilities, health) that emerge from the stigma-related experience that is taking place. Although not illustrated in the diagram, it is important to note that the model is recursive, in that the responses to an identity threat (box E) may feedback to the first level (boxes A, B, and C) and the second level (box D) of the model. These feedback processes may attenuate or exacerbate the effects of stigmatization.

In the following sections, we describe the components of the stigma-induced identity threat model and the process of self-stigmatization. Examples will be used to illustrate how the components of the model may be applied to understanding stigma associated with hearing loss from the perspective of the individual with hearing loss.

## Collective Representations

Collective representations are the shared (societal) understandings and beliefs about stigmatizing conditions (Crocker, 1999). Based on prior experiences, as well as exposure to the dominant culture, members of stigmatized groups develop shared understandings of the dominant view of their stigmatized status in society. Importantly, even if they themselves do not endorse the dominant cultural representation of their stigma, it is assumed that members of the stigmatized group are aware of the dominant cultural stereotypes (Major, 2006; Steele, 1997). These collective representations include awareness that they are devalued in the eyes of others, a knowledge of the negative stereotypes held by the dominant society (the *outsiders*) concerning their stigmatized attribute, and the knowledge that they could be victims and targets of discrimination (Crocker et al., 1998). Collective representations influence how the stigmatized individual perceives and appraises stigma-relevant situations.

As mentioned in a previous section, several studies conducted in western societies have reported that hearing loss is a stigmatizing condition. People who have hearing loss are generally judged (by the members of the *outsiders*) as being, old, senile, cognitively diminished, poor, and uninteresting communication partners (see the descrip-



**Figure 4-3.** Conceptual framework displaying the elements of the stigma-induced identity threat described by Major and O'Brien (2005).

tion from Kochkin, 2007). Héту, Getty, and Waridel (1994) reported that men with an acquired hearing loss were aware of the stereotypical representations that society holds concerning hearing loss. In fact, some individuals held the same prejudices before being informed (diagnosed) that they had a hearing impairment. Héту, Riverin, Getty, Lalonde, and St-Cyr, (1990) reported that the cognitive dissonance (their general view of people with hearing loss versus the more positive view they have of themselves despite their hearing loss) was sometimes difficult to reconcile. Women with occupational hearing loss in Hallberg and Jansson's (1996) study reported that the attitudes of others negatively affected their self-image and social roles. The perceptions that people with hearing loss share with members of the *outsiders* will serve to denigrate and contribute to the appraisal their own devalued social identity.

According to the model, the strength of the collective representations held by society, as well as the stigmatized person's own view of the stigmatized trait will contribute to whether or not the person perceives an identity threat. It is interesting to note that in the first step of the normalization process described by Héту (1996), it is proposed that individuals with hearing loss interact with other individuals with hearing loss. Relative to hearing loss, it is very likely that the collective representations of a group of adults with a hearing impairment will be less negative than the collective representations held by the general population. Thus, as described by Héту (1996), when in the company of others with hearing loss, a strong identity threat is less likely to be triggered, thus making a supportive environment in which to initiate a rehabilitation process geared toward improving the social image of people with hearing loss.

## **Situational Cues**

Situational cues are factors that are related to the physical and social environment in which a given activity takes place. However, it should be noted that one's perceptions of a situation does not always correspond to the reality of the situation. That is, one's "perception" of the level of threat associated with a given situation is more impor-

tant than the actual objective level of threat present in that situation. Steele et al. (2002) reported that an identity threat is modulated as a function of the (perceived) situation in which the threat is appraised. For instance, Hallberg and Barrenas (1995) reported moderate identity threat appraisals by blue collar workers when they conversed with coworkers in the work area of the manufacturing plant (because it was very noisy so communication partners tended to speak more loudly and also because communication was difficult for everyone). However, in a previous study, Hallberg and Carlsson (1993) had reported that workers found the noise in the lunchroom particularly troublesome, presumably leading to more severe identity threat appraisals. Referring again to Héту's (1996) work, recall that the first step of the normalization process involved interactions among people with hearing loss. In this physical and social context, the appraisal of one's identity likely will be less threatening than in a situation in which a person attempts to conceal his or her hearing loss from the others. The recognition that the physical and social situation in which an activity takes place influences the level of identity threat that a person with hearing loss perceives (relative to stigmatization) is a concept that can be used advantageously within the context of a rehabilitation program. For example, coping strategies used to overcome the involuntary responses (such as shallow breathing) to a threatening situation may be trained. First, these responses could be progressively practiced in less threatening physical and social environments (e.g., in the therapy room, at home, at a friend's home). Later, the same responses would be introduced in settings that are more threatening (e.g., at social gatherings with acquaintances, at work, at social gatherings attended by many strangers).

## **Personal Characteristics**

The personal attributes of individuals may also modulate identity threat appraisals. These may include (but are not restricted to) age, gender, hearing impairment, educational level, occupation, aptitudes, attitudes, motivation, confidence level, importance given to one's self-esteem, level of opti-

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mism/pessimism, level of stigma-consciousness, and locus of control. Within the same stigmatized group, some individuals appear resilient to prejudice and display positive well-being, whereas other members of the same group do not (Friedman & Brownell, 1995). In addition, the research on stereotype threat demonstrated (Steele & Aronson, 1995) that the same individual may show different responses to prejudice as the context changes. Differential responses to stigma are observed between stigmatized groups, within stigmatized groups, and indeed within the same individuals across contexts. Several individual characteristics modulate the extent to which people appraise situations as relevant to their stigma. One is the extent to which an individual identifies with his or her stigmatized identity (Major, 2006). An example of how occupation modulates one's identity threat appraisal was provided in the Heiligenstadt testament that Beethoven wrote in 1802 (Appendix 4-A). In his testament, Beethoven mentioned that it was unconscionable that someone with his stature as a musician and composer have a hearing impairment. Because of his appraisal of the identity threat caused by his hearing loss, Beethoven tried to conceal his hearing loss from others. One strategy that Beethoven used to avoid having to reveal his hearing loss was to avoid unnecessary contact with others.

Results of investigations have shown that younger adults are more likely to reject hearing aids (presumably have their identity threatened) than older adults (Kochkin, 1993). For women, the stigma associated with hearing loss tends to decrease as they get older (Erler & Garstecki, 2002; Gilhome Herbst, Meredith, & Stephens, 1990). Differences in personality traits may explain (at least in part) variances in identity threat appraisals that are observed across individuals with similar degrees of hearing loss. Several individual characteristics modulate the extent to which people appraise situations as relevant to their stigma. For example, a person with a hearing impairment who is less conscious of the stigma associated with hearing loss, or someone who personally does not ascribe to the stereotypes concerning people with hearing loss, likely will have a higher threshold of identity threat than someone who holds strong prejudices toward people who have a hearing impairment.

A thorough summary of the effects of different personality traits on participation in rehabilitation programs has been reported by Kricos and colleagues (Kricos, 2000; Kricos, Erdman, Bratt, & Williams, 2007). In the future, it may be of interest to investigate the effects of specific personality traits on identity trait appraisal. This information may be useful in identifying the type of rehabilitation services that may be most appropriate for individuals with specific personality traits.

### **Identity Threat Appraisal**

Identity threat appraisals are judgments made by the stigmatized person concerning a potentially stressful event. The person evaluates whether the present threat is relevant to personal goals or values, and determines if he or she has the necessary resources available to cope with this situation (Lazarus & Folkman, 1984). If the threat is perceived as taxing or exceeding one's personal resources, then the event is deemed to be a threat to one's identity. Contemporary perspectives on stigma emphasize that conscious and unconscious appraisals of a devalued social identity contribute to self-identity threat. Stigma-induced identity threat occurs when an individual appraises the demands imposed by a stigma-relevant stressor as potentially harmful to his or her social identity, and as exceeding his or her resources to cope with the demands. The appraisal process can be automatic, nonverbal, instantaneous, and occur outside of consciousness (Smith, 1991).

Major and O'Brien (2005) mention that, within the appraisals of stigma identity threat, there is the possibility that a given activity judged as potentially threatening and that a person assesses that he or she does have sufficient coping resources to meet the challenge of the demand (Vignette 4-5). Recently, Southall (one of the authors of this chapter) conducted personal interviews with people with hearing loss who were involved in activities designed to promote the well-being of people with hearing loss (e.g., they wrote books or plays that addressed the effects of hearing loss; they were members of the executive boards of self-help groups for people with hearing loss; they devoted



hours as volunteers to provide services to people with hearing loss). In almost every case, it was reported that one of the reasons that prompted these individuals to get involved in such activities was the fact that at some point during their lives those individuals felt the deleterious effects of being stigmatized due to hearing loss. Perhaps, their proactive involvement was due to the fact that, when they were confronted with an identity threat, these individuals determined that they had the resources required to undertake the challenge of defending the rights of people with hearing loss.

Audiologists should be aware that some people with hearing loss have the resources to overcome the potential identity threat challenges they may encounter. In designing rehabilitation programs to enable people with hearing loss to overcome identity threats, it may be worthwhile to gain an understanding of the characteristics of people who are able to meet (and even surpass) the demands of a situation. The information gained from their experiences may be helpful to people who perceive identity threats when taking part in the same (or

similar) activities. Moreover, perhaps meeting, either individually or in a group, they could serve as models to other people who feel stigmatized.

## **Responses to an Identity Threat**

One assumption of the proposed stigma-induced identity threat model is that experiencing a situation in which one's social identity is devalued is stressful. Women with occupational hearing loss in Hallberg and Jansson's (1996) study reported that most people in their surroundings were unwilling to adjust to their communication needs and that this caused emotional distress. According to Major and O'Brien (2005) the stress that accompanies a response to stigmatization has the same characteristics as the stress experienced in response to other instances. Major and O'Brien (2005) claim that the coping strategies used to deal with stress caused by an identity threat are the same as the coping strategies that an individual is likely to use in response to any other stressful

### **Vignette 4-5**

#### ***Reacting Positively to Perceiving Oneself as the Target of Stigma***

Notwithstanding the fact that she has a hearing loss, Ms. E, is determined that she wants to extend her yearly subscription to productions of the local theatre company. She is convinced that going to the theatre is a social activity that should be accessible to everyone, including those who have a hearing loss. Confronted with this self-imposed challenge, Mrs. E learns that some theatre companies make hearing assistive devices (HATS) accessible to persons who have difficulty hearing. Ms. E was disappointed to hear that her theatre company doesn't plan to purchase HATS because there has not been a great enough demand for those devices amongst the regular clients. Ms. E is convinced that the low demand is due to the fact that few people with hearing loss are aware that these types of devices exist and can be made available. Being distraught by the theatre company's response to her demand, Ms. E decides to take a very pro-active stand. First, she joins the local chapter of the self-help group for people with hearing loss. Furthermore, she agrees to be nominated to the executive board of the self-help group. Upon being named to the board, Ms. E convinces the other board members to organize an information campaign about the availability of HATS in public places, and encourages people with hearing loss to request HATS when they participate in activities that occur in public places (including the local theatre).

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event. Accordingly, Major and O'Brien (2005) claim that generic transactional models of stress and coping (Lazarus & Folkman, 1984; Smith, 1991) may explain how individuals react when they perceive an identity threat due to a stigmatizing event. A discussion of the transactional model of stress and coping is beyond the scope of the present chapter. Readers interested in more information on coping and stress, as it relates to hearing loss should refer to the counseling chapter (Chapter 9) in this book, as well as the work of Anderson and Willebrand's (2003) and Trychin (1986).

Coping refers to the efforts that are deployed to regulate emotion, thought, behavior, physiology, and the environment in response to stressful events or circumstances (Miller & Kaiser, 2001). Responses to stressful events are assumed to be a function of two key processes: how individuals cognitively appraise the event, and the coping strategies used to deal with the events that are appraised as stressful. Coping responses may be classified as *problem-focused* or *emotion-focused*.

For example, Vignette 4–5 illustrates an emotion-focused coping strategy whereby an individual with hearing loss joins a self-help group to ease the feelings of being disappointed and distraught. In the same vignette, the individual with hearing loss uses a problem-focused coping strategy when organizing a campaign to promote the installation and use of HATs.

The concept of coping is central to contemporary perspectives on stigma. In contrast to traditional views, these contemporary perspectives portray individuals who experience stigmatization not as passive victims, but as active agents attempting to make sense of their world by preserving their self-esteem (Major, 2006). Coping strategies may also be characterized as *engagement* versus *disengagement* strategies. Engagement coping strategies are often described as “approach or fight” responses, whereas disengagement strategies may be described as “avoid or flight” responses. An example of an engagement coping strategy is illustrated in Vignette 4–6. For an example of a

#### **Vignette 4–6** **Being Pro-Active Versus Being Negative**

Mr. F has a noise-induced hearing loss but he is too proud to disclose his hearing loss to people other than the members of his immediate family. Although Mr. F refuses to use hearing aids (because they would disclose his hearing loss), he agrees to sign up for a communication strategies course in order to improve his speechreading skills, and to learn to apply communication strategies that do not require him to disclose his hearing loss. Following the completion of the course, Mr. F reports that the speechreading skills and the communication strategies he learned (and uses) are very helpful when he interacts with others on a one-to-one basis at work. When asked about other activity limitations he experiences, Mr. F reports that he stopped attending the Bingo. When asked why, Mr. F replied that: ‘The person calling the numbers at the Bingo hall was incomprehensible because he mumbled when calling the numbers. The embarrassment of not being able to participate became too much for him to handle, so he stopped going. During the session with the audiologist, Mr. F was surprised to learn that his approach to his communication difficulties at work constituted an excellent problem-focused coping response. On the other hand, his decision to stop going to Bingo was a very maladaptative emotion-focused coping response. Mr. F was invited to participate in a rehabilitation program that would focus on identifying a solution that would enable him to resume attending Bingo.

disengagement coping strategy see Vignette 4-7. Hallberg and Jansson (1996) reported that women with occupational hearing loss used controlling (engagement) and avoiding (disengagement) strategies alternatively to manage demanding situations. Avoiding strategies were used to minimize or hide the hearing loss from others. Controlling strategies were used by women who disclosed their hearing loss to others as they strived to maintain social relationships. Another coping strategy used by persons who are stigmatized is to adopt a blaming discrimination approach. Major and O'Brien (2005) report that when members of stigmatized groups encounter negative outcomes, one way they may cope with the threat to their self-

esteem is by blaming the outcome on discrimination rather than on themselves (see Vignette 4-8).

According to Major and O'Brien (2005), the stress related responses and coping mechanisms that arise following an appraised identity threat may be *involuntary* or *voluntary*. An individual's involuntary responses to identity threats may include (but are not limited to) anxiety arousal, increased blood pressure, increase heart rate, increased (and shallower) breathing rate, and sweating. Not unlike any other stressful event, an individual's stress response due to an appraised identity threat can consume valuable resources. As illustrated in Vignette 4-3, the stress related to a person's preoccupation with being discriminated

**Vignette 4-7**  
***Disengaging Strategies***

Due to her hearing loss, Ms. G has difficulty understanding others, especially in noisy settings. Because she is a very proud person, Ms. G does not want to disclose her hearing loss to others. Even more so, she can't fathom the thought of embarrassing herself by responding inappropriately to a question that might be addressed to her. Ms. G decides to stop attending the social events of the local 4-H club. When questioned by her daughter about this decision, Ms. G responds: "Those events are so noisy and everybody there speaks too softly, and too quickly. It gives me a headache!"

**Vignette 4-8**  
***A Blaming Discrimination Approach***

Mr. H is a salesperson in an insurance company. He has a hearing loss. Although he has never disclosed this impairment to his colleagues, most of them know that he has difficulty hearing. Because of his difficulty hearing, his colleagues sometimes will unintentionally exclude him from their conversations at lunch (i.e., they don't naturally make any effort to accommodate Mr. H). Recently, having been left out of another conversation at lunch, Mr. H was angered and humiliated by being excluded (the incident had a very negative impact on his self-esteem). As a result of this experience, Mr. H decided to no longer interact socially with colleagues at work. When asked by his wife to explain his decision, Mr. H replied, "The young sales representatives think they know everything and they have no respect for older, more experienced salespersons."

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against, and the coping responses employed to address one's threatened identity in a given social interaction will require the use of cognitive resources. The cognitive resources deployed reacting to a perceived identity threat will limit the resources available to engage in the social interaction. Therefore, events that are stigmatizing (or potentially stigmatizing) invariably increase the probability of displaying observable signs and behaviors that will reinforce the prejudices associated with hearing loss (including, unsatisfactory communication exchange). Thus, almost all acts of communication with others will induce multi-

ple sources of stress (i.e., the stress associated to identity threats, the stress related to the fear of not being an adequate communication partner).

Another example of an involuntary coping response to a stressful event is *righteous anger*. Righteous anger is an adaptive and positive response to situations of stigma that may trigger self-advocacy work and attempts to improve systemic failings for other people who are experiencing similar problems (Corrigan & Watson, 2002). An example of a person displaying righteous anger is presented in Vignette 4-9. Another common coping response may be unconscious avoidance (see Vignette 4-10).

#### **Vignette 4-9** ***Righteous Anger***

Ms. I, who has a hearing loss, is on a train on her way to DeKalb, Illinois. The train is so noisy that she missed the conductor's call on the public address system stating that the next stop was her destination. When she realized that she missed her stop, she requested help from a train employee. Again, because of the noise level on the train, she couldn't hear the explanation given to her. Finally, she gave up, smiled politely at the attendant, and walked away. She got off the train at the next stop and had to buy another ticket to get back home. Needless to say, the whole incident was quite stressful for Ms. I. When she finally got home later that day, she wrote a nasty letter to the complaints department of the train company. The letter provided some suggestions on how the train company could improve their services for older adults who have difficulty hearing in noisy settings.

#### **Vignette 4-10** ***Unconscious Avoidance***

Mr. J has difficulty hearing, but does not use a hearing aid. He has been a member of a bowling team for several years. Over the past year, he often responded inappropriately when his teammates spoke to him. This happened so often that his teammates started to call him Mr. "Outerspace." Although his teammates intended this to be a joke, Mr. J did not appreciate being teased. Being teased made him feel sad and this resulted in him becoming more guarded and withdrawn with the group. Mr. J had not realized that the teasing was the cause of this emotional state. This fall, Mr. J decided that he would forego bowling and not join his team this year. When his wife asked about this decision, Mr. J replied that bowling no longer provided him with as much pleasure as it once did.

It may be useful for audiologists who provide rehabilitation services to know and understand that individual responses (voluntary and involuntary) to situations of perceived identity threat will be basically the same as their responses to any other stressful situations. The professional may question the person with hearing loss about the coping strategies he or she typically uses in response to stressful situations (including both stressful situations related to the hearing loss and situations that do not involve hearing loss). An evaluation of typical coping strategies employed may make it possible to identify appropriate strategies (adaptive and effective), and those that are maladaptive. This information may be used as a starting point for the development of preferred coping strategies, and for reinforcing the use of well-established appropriate coping strategies already in their repertoire.

Finally, it is noteworthy that every stigma-coping strategy has costs and benefits (Corrigan & Matthews, 2003; Swim & Thomas, 2006). People tend to adopt the coping strategies that they judge to be effective. However, in doing so, they may overlook or minimize the costs of employing the selected strategies. For example, as mentioned previously, by deciding to conceal their stigmatized trait in a given situation, an individual may reap the benefits of being considered unmarked in a social interaction. However, there is a heavy cognitive burden associated with using this coping strategy. First, throughout the activity the person must be careful not to unwillingly disclose the hearing loss. Alternatively, there is the possibility that someone else participating in the activity may disclose the fact that they have a hearing loss. Finally, due to the nature of the impairment (hearing loss), and because of the cognitive resources deployed to conceal their hearing impairment, the likelihood that communication breakdowns or inappropriate responses will occur are maximized. Hence, after considering both the benefits and the costs, concealing one's hearing loss may not constitute an effective coping strategy to avoid hearing loss identity threat (refer to Vignettes 4-1 and 4-2).

To eliminate the risk of being stigmatized, an individual may decide to completely avoid taking part in social activities, and thus avoid having to deploy resources that may be required by choos-

ing coping strategies other than avoidance. On the one hand, avoidance is an effective coping strategy because there is no risk of having one's stigma disclosed and the concomitant social identity threat. However, the cost of using this coping strategy is very high. First, the person with hearing loss may deprive him- or herself of participating in activities that are deemed interesting and important for the person (e.g., playing cards, golfing, bowling, and theatre). Second, in the long term, eliminating participation in all social activities, leads to social isolation, which in turn may have serious repercussions on physical and mental health. When discussing coping strategies with clients, audiologists should ensure that the client is aware of the costs as well as the benefits associated with a given coping strategy (Vignette 4-11).

## **Outcomes of Stigmatization**

As mentioned in the previous section, coping strategies are used in reaction to the stress brought about by an identity threat. The goal of using coping strategies is to return the body, emotions, and behaviors into a state of equilibrium. The extent to which this goal is achieved will vary according to the effectiveness of the selected coping strategies used in a given situation. Some coping strategies may not be successful. In fact, they may lead to negative outcomes (Vignette 4-12). Other coping strategies may be well adapted and have successful outcomes (Vignette 4-13). Whenever coping strategies are used (consciously or unconsciously) to deal with a stressful situation, the outcome may be positive, negative or neutral. The outcomes of coping efforts may have repercussions for the individual at many different levels including physiological, psychological, emotional, and behavioral. Moreover, one coping strategy may have several outcomes at different levels. For example, in an attempt to conceal one's hearing loss by not responding appropriately in a given situation, one coping strategy may be to occupy all the conversational space by not giving the others the opportunity to express themselves. This strategy may be successful in relieving the potential stress of

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**Vignette 4-11**  
***Long- and Short-Term Effects of Coping Strategies***

Ms. K is a retired business executive who is a very proud person. She has a hearing loss, however, she denies this and refuses all rehabilitation services, including wearing hearing aids. Nonetheless, Ms. K experiences much difficulty communicating with others, especially in noisy environments. Because she fears that these communication problems will reveal her hearing loss to others, she gradually stops attending social events that take place in noisy settings. Mainly she stays at home, where she reads and plays bridge on the Internet. She finds her new activities less stressful because she doesn't have to worry about not being able to follow verbal conversations. At home there is little risk that she will unwillingly disclose her hearing loss to her friends and acquaintances. However, when she takes the time to really think about it, Ms. K does acknowledge that she is now a lonely person, and that she misses many of the social activities she used to participate in and enjoy. Her loneliness has led her to be somewhat depressed, and physically, she is not well; she has digestive problems attributable to acid-reflux. Both of those health problems are sufficiently important that Ms. K required medical care.

**Vignette 4-12**  
***Coping Strategies May Lead to Negative Outcomes***

Mr. L is a middle-aged man who has a hearing loss attributable to noise exposure caused by his leisure activities (cutting trees with his chainsaw on his farmland). Mr. L is a sales representative in a large motorcycle store. Because his clients are mostly young adults, Mr. L refuses to use hearing aids. He feels it is important for him to portray the image of a young adult, like his clients. All of the other sales representatives in the store are younger than Mr. L. Recently, because of the stress associated with his desire to portray an image of a young, normal-hearing adult, Mr. L lost his temper and used very aggressive and abusive verbal language during an argument with another sales representative. As a consequence of his extreme reaction to the stressful event, Mr. L was transferred to another department. Although it was not stated implicitly, this lateral move within the company essentially eliminated any possibility that he had for a promotion within that firm. Mr. L is very unhappy in his new position.

inadvertently disclosing one's hearing loss. However, it may have a negative consequence in that many potential communication partners will shun the person with hearing loss because their social interactions are not particularly satisfying (Vignette 4-14).

Six issues are noteworthy concerning the outcomes of using coping strategies to deal with the stress created when one's social identity is threatened by stigmatization. First, as described by Major and O'Brien (2005), one must consider the feedback loops that may occur at different levels of the

**Vignette 4-13**  
***Coping Strategies May Lead to Positive Outcomes***

Ms. M is a blue collar worker at a tire manufacturing plant. She has had a hearing loss for many years and she wears her hearing aids at work. Because she possesses innate leadership skills, she recently was elected to be the union representative on the health and safety committee for her company. Many plant managers sit on this committee. Their presence on the committee is a bit intimidating to Ms. M. She feels shy and ashamed of having a hearing loss. Also, she is disappointed because she thinks that company managers should be more aware of the communication difficulties that many employees experience due to the fact that they have a noise-induced hearing loss. To express her feelings/reactions concerning this issue, Ms. M decides that she will use her membership on the health and safety committee in the hope that she can convince the other committee members that the company should organize a symposium on the effects of hearing loss on communication and the use of effective communication strategies. In her proposal to the committee members, Ms. M promotes the idea that the symposium should be attended by both the blue collar workers and the people holding management positions within the firm.

**Vignette 4-14**  
***Maladaptive Coping Strategies***

Mr. N is a retired industrial plant worker who has a hearing loss. He denies having a loss by stating: "It is normal that at my age I don't hear as well as when I was 20 years old. But I'm not deaf!" Mr. N and his wife have five older children who have all left home. Whenever there is a family gathering, it is very difficult for Mr. N to follow the conversation around the dining room table because it is noisy and because everybody speaks at the same time. Unable to follow the conversation, Mr. N has reverted to simply staying at the table with the others and not even trying to understand what is going on. Often he looks disinterested and distracted ("in his bubble"). When someone asks him a question, he pretends that he doesn't remember, that he doesn't know the answer, or he answers inappropriately. Regardless of the topic of conversation (even when it deals with issues for which he once had a passion), he doesn't show any interest in participating in the discussion. Most of the family members are a little concerned about their father. They consider his behavior as being very antisocial and somewhat disrespectful. They think that he has aged significantly over the past few years and they wonder whether or not he is showing signs of senility. When his wife mentions this to him, Mr. N simply accepts the labels attributed to him rather than explaining that his behavior is due to the fact that he has trouble taking part in social activities because of his hearing loss.

model. For example, the coping strategies used in a given situation may have an impact on the level of stress induced due to the identity threat. They

may also have an effect on the collective representations (e.g., the reactions of others involved in that situation) and the personal characteristics

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(e.g., changing one's attitude, positively or negatively, concerning identity threat in that situation). Depending on the outcome that results from using a coping strategy, the feedback may be positive (a successful approach to dealing with the identity threat and the stress) negative, or neutral. Second, because of these feedback mechanisms, it is likely that over time the effect of using a given coping strategy will influence the level of identity threat perceived in a given situation. Thereby, this feedback mechanism will also alter the level of identity threat required to trigger the coping response. Third, because identity threat appraisals vary as a function of time, it is important to monitor regularly and evaluate the outcome (consequences) of the coping strategies used in a given situation. Fourth, in evaluating outcomes, it is important to consider both the short-term as well as the long-term consequences using those strategies. Some coping strategies may result in positive short-term outcomes but be appraised negatively when considered from a long-term perspective. For example, avoiding social interactions by staying home alone (watching television or reading) may constitute a successful short-term strategy to reduce the stress of concealing one's hearing loss from others; however, in the long term, avoiding social interactions and isolating oneself from others may have negative outcomes on one's physical and mental health status (see Vignette 4-1 as well as Beethoven's testament in Appendix 4-A). Considered from a short-term perspective, disclosing one's hearing loss to others may increase the stress level associated with a given identity threatening event/situation. However, in the long term, this strategy may turn out to be positive because it will make it possible for the person with hearing loss to employ adaptive communication strategies that will minimize the number of communication breakdowns that occur, and thus become a better and more satisfying communication partner. Furthermore, the feedback given by the communication partners likely will enable the person with hearing loss to develop a more favorable social identity as well as more positive self-esteem. Fifth, coping strategies may act on various dimensions of the individual including at the physiologic, psychological, personality, communication, social,

occupational, and economic levels. When evaluating the outcome of using a coping strategy to deal with identity threat, it is important to consider the outcome from a broad perspective. The consequences of using appropriate (or inappropriate) coping strategies may have far reaching consequences on several aspects of life. Finally, many issues related to the coping strategies used to respond to the stress induced due to an identity threat may be successfully incorporated into rehabilitation services for people with hearing loss.

### Implications for Practice

The stigma-induced identity threat model may be useful for audiologists who work with clients who are susceptible to the effects of social stigma. Without describing a specific approach to the type of rehabilitation services that could be provided, the conceptual model developed by Major and O'Brien (2005), offers many insights concerning the content of, and techniques used in rehabilitation programs that might provide benefit to people with hearing loss who are (or who perceive themselves) as being stigmatized. In this section we provide some guidelines for rehabilitation services that may be helpful for managing and overcoming the effects of identity threat due to hearing loss.

According to Major and O'Brien (2005), the coping strategies that people use to deal with the stress induced by an identity threat are not different from other coping strategies that people use to deal with stress induced by any other source. This observation implies that components of any rehabilitation program that addresses issues related to coping with stress may be useful for addressing issues related to social stigma. Several researchers and clinicians have described AR programs that incorporate coping strategies intended to attenuate the stress related to specific aspects of having a hearing loss (Jennings, 1993; Trychin, 1986; 2003a-e; Wayner & Abrahamson, 1996). Components of such an AR program are outlined in Table 4-1.

In our view, the stigma-induced identity threat model itself constitutes a helpful tool for

**Table 4-1.** Components of an Audiologic Rehabilitation Program That Incorporate the Use of Coping Strategies to Alternate Stress

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1. Persons with hearing loss are led in a group discussion that focuses on common situations where persons with hearing loss may experience stress related to communication difficulties, and instructed on how to recognize situations in which they personally experience stress due to hearing loss.
  2. Typical psychological and physical reactions to stressful situations are described, and discussion focuses on how to recognize personal, psychological, and physical reactions to the situations.
  3. Within the group setting, participants are oriented to, and role-play the use of specific strategies to manage stressful situations.
  4. Relaxation techniques for coping with psychological and physical reactions to stressful situations are described and practiced.
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rehabilitation as it provides a view of how stigma may occur from the perspective of the person who is stigmatized. Audiologists are likely to benefit from having a comprehensive description of the stigma creation process, as well as an outline of the reactions that people may have as a result of the stress induced from an identity threat. This model constitutes a valuable component of a cognitive approach to information counseling that addresses stigma with clients who perceive themselves as being stigmatized in some situations. A description of the model may even be included in general information courses (e.g., group communication strategies programs) designed to increase the awareness of the effects of hearing loss. People who may not be conscious of (or who deny) that they experience identity threat may benefit from this information by being able to identify the source of stress they experience in specific situations. Furthermore, this information may provide the impetus to reflect upon the types of coping strategies (and the effectiveness of the strategies) used in those situations. Similarly, a description of the model could be incorporated into individual intervention programs for people

who are susceptible to experience identity threats when participating in certain activities. The model would also be a valuable component of information courses designed for family members and health care professionals.

A close examination of the stigma-induced identity threat model also provides useful guidelines for the design of intervention programs. The heart of this model (conceptually as well as physically as represented by the block diagram in Figure 4-3B) is characterized by the stress that is induced by an identity threat. Logically, an intervention program would be considered successful if it managed to reduce the stress level experienced by the client. Thus, any rehabilitation program component designed to reduce stress would be useful for people who perceive an identity threat associated with their hearing loss. Trychin's (1986, 2003e), "Relaxation Training for Hard of Hearing People" manual and videotape provide useful examples of physical responses to distressing situations, how to identify distressing situations and reactions, the effects of muscle tension and anxiety on understanding, and training in the use of proper breathing and in the relaxation of various muscle groups.

Using the stigma-induced identity threat model as a guide, stress reduction can be achieved in two primary ways. First, a person's level of stress will be reduced if the identity threat is diminished. According to the model, the level of identity threat perceived is determined by an interaction of the three major constructs depicted at the front-end of the model, namely: collective representations, situational cues, and personal characteristics. Consequently, intervention programs that address one (or a combination) of those constructs may have an impact on the level of identity threat perceived. It is possible to address all three constructs. For instance, the intensity of the prejudicial attitudes or discriminatory behaviors associated with hearing loss may vary across subgroups of societies. For example, friends or acquaintances that one meets regularly at the local bar may hold stronger prejudicial views of hearing loss ('deafness') than would colleagues at work. Or, a spouse may be more sensitive to the effects of stigma than the regular clients at the

local bar. Disclosing hearing loss or attempting to use new coping strategies may be a more effective approach in the presence of some people than others. Trychin's workbooks provide a variety of activities that can be used in training strategies for disclosing hearing loss (Trychin, 2003a, 2003b, 2003c, 2003d). Similarly, personal identity threat will vary according to the situation (e.g., the physical setting or the social context). Again, some situations may offer a more secure environment to apply newly learned coping strategies. Given that the level of identity threat perceived by a person will be influenced by the situation and the other people involved in that situation, it is likely that a solution-centered problem solving approach to rehabilitation (Gagné & Jennings, 2008) could be successfully used as an intervention strategy to overcome appraised identity threats.

According to the stigma-induced identity threat model, the characteristics of the person with hearing loss will also influence the level of identity threat perceived. From that perspective it is likely that a cognitive-behavioral approach to intervention as described above could be used to reduce the level of identity threat perceived. Recently, intervention programs based on the principles of Perceived Self-Efficacy (PSE) have been promoted as an approach to the rehabilitation of people with hearing loss (Jennings, 2005; Smith & West, 2006). A priori it would appear that the underlying principles of Perceived Self-Efficacy (PSE) are consistent with rehabilitation services designed to reduce perceived identity threat. Human functioning is viewed as the result of behavioral, cognitive, and other personal factors, and events in the environment. Each of these factors works together, but has different levels of influence depending on the specific situation, the specific environment, and the individuals themselves (Bandura, 1986). PSE refers to a person's belief in his or her ability to organize and execute courses of action that are required to manage prospective situations (Bandura, 1995). The aim of a PSE-based rehabilitation program is to increase participants' levels of PSE, using specifically designed approaches including: enactive mastery, vicarious experiences, verbal persuasion, and somatic and emotional states. Related to the model

of stigma-induced identity threat, if the person has high levels of PSE, it is likely that the perceived demands of a relevant situation will not be appraised as exceeding his or her resources. On the other hand, for persons with low levels of PSE, it is likely that perceived demands of a relevant situation will be appraised as exceeding their resources, and a stigma-induced identity threat will result. PSE level will have an impact on volitional responses (i.e., problem-focused and emotion-focused coping strategies) as well as nonvolitional responses (i.e., arousal and increased blood pressure). For example, people with high PSE who have learned to identify their nonvolitional responses such as arousal and increased blood pressure are better able to interpret these responses as a "call to action." Thus, they are better prepared to use coping techniques to control the escalation of nonvolitional responses

Our interpretation of the stigma-induced identity threat model suggests that a person's level of stress will be reduced with carefully selected coping strategies. As outlined above, several rehabilitation programs are designed to teach clients how to use effective coping strategies (e.g., Jennings, 1993; Trychin, 1986; Tye-Murray, 2002; Wayner & Abrahamson, 1996). Communication training programs that promote and teach the use of anticipatory strategies, that emphasize assertive behaviors and the use of effective conversational strategies should also serve to reduce an individual's stress level (Heydebrand, Mauze, Tye-Murray, Binzer, & Skinner, 2005). Obviously, if someone who has a hearing loss learns appropriate conversational skills, the likelihood of communication breakdowns will decrease. If so, the stigma related stress associated with being an inadequate communication partner should also diminish. Similarly, the use of hearing aids (when appropriate) as well as other HATs (when called for) should reduce the probability of communication breakdowns and improve one's ability to participate in social activities (see Vignette 4-5).

The challenge for the audiologist is to persuade the person with hearing loss (whose self-esteem may be low, and whose social identity may be threatened) to actively participate in a rehabilitation program that calls for overt behavior



change, such as the use of amplification devices, behavioral coping strategies, and expressive communication strategies. In our experience, it may be difficult to convince people who perceive themselves as being stigmatized, to use any strategy that entails the disclosure of hearing loss. However, people are more likely to agree to freely disclose their hearing loss if the strategies are believed to be effective in reducing the level of stress they experience in a given situation. It is our contention that it may be beneficial to adopt a cognitive-behavioral approach when designing rehabilitation programs that address social identity threats. The components of such an AR program are outlined in Table 4-2.

**Table 4-2.** Components of an Audiologic Rehabilitation Program Designed to Address Identity Threat

1. Describe and discuss the stigma-induced identity threat model to explain to the client the causes, consequences and the potential costs of the stress related to identity threat.
2. Establish a hierarchy of situations in which identity threat occurs.
3. Discuss, in parallel, the effectiveness of the client's typical coping strategies. Retain the strategies that are most appropriate or promising, and introduce new adaptive strategies.
4. Implement a problem-solving approach to address a situation of stigma-inducing identity threat identified by the client.
5. Train and encourage the client to apply the selected coping strategies in a secure environment (initially, implementing the strategies may be practiced during the therapy session).
6. Meet with the client to discuss the process of implementing and the consequences of applying the strategies (perhaps using the diagram of the model to identify the key elements).
7. Attempt a similar experience in a slightly more threatening situation/environment.
8. Increase the number of situations in which the client discloses his or her hearing loss and applies appropriate coping strategies, accompanied by reinforcing feedback rehabilitation sessions.

The use of appropriate strategies and the reinforcement obtained from the successful outcomes experienced should reduce the identity threat stress perceived in different settings. If this occurs, we would consider the rehabilitation program to be successful.

The stigma-induced identity threat model is consistent with the normalization process described by Héту (1996). In the initial stage of Héту's model (see Figure 4-2A), meeting other individuals who have a hearing loss serves to reduce the client's level of perceived identity threat by providing the participants opportunities to use and discuss coping strategies in a highly secure/protective environment. First, the client is invited to use the coping strategies in a secure situation (a therapeutic setting, in the company of a hearing health care professional). Second, the collective representation of that environment (i.e., other people who have a hearing loss) is encouraging and supportive to the individual group members. In this situation, the level of perceived identity threat and the level of stress induced by the identity threat would be reduced. Relative to the stigma-induced identity threat model, the feedback mechanisms involved at this level of the stigma normalization process will serve to alter aspects of the personal characteristics of the client (i.e., more confidence, less shame, higher self-esteem, improved social image, better communication skills). In turn, this will favorably influence the level of identity threat that the client will perceive when the second stage of the stigma normalization process is implemented (i.e., when the client moves forward to real-world situation and when interactions occur with people who do not have hearing loss). In addition, any appropriate coping strategies learned during the first stage of the normalization process (e.g. communication strategies, assertive behaviors) increase the level of resources the person will have at his or her disposal. Thus, later during the second phase of the normalization process and beyond, when the client is placed in a situation in which an identity threat is perceived, there is an increased likelihood that self-evaluation of the situation will lead to the conclusion that he or she has sufficient resources to confront the stigmatizing situation.

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## Conclusion

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Anecdotal clinical reports and research investigations have clearly demonstrated that the stigma associated with hearing loss constitutes a significant obstacle to rehabilitation for many individuals who have a hearing loss. Until now, little was known about the social stigma associated with hearing loss from the perspective of the people who are being stigmatized. During the last decade, mainly in the social sciences, significant inroads have been made to broaden our understanding of the processes involved in creating a threatened social identity. The goal of the present chapter was to describe one generic model of self-stigma, the stigma-induced identity threat model proposed by Major and O'Brien (2005), and to discuss its applications to hearing loss. As a first approximation, the model appears to provide a framework that can be used to understand the manifestation of stigma among people who have hearing loss. Furthermore, the model offers a conceptual framework concerning the types of AR services that could be provided to people with hearing loss who perceive an identity threat. Our goal was to introduce the stigma-induced identity threat model to the field of AR. Hopefully, the contents of the chapter will serve as an impetus for further discussions and research on the topic of stigma associated with hearing loss.

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### Appendix 4-A Beethoven's Heiligenstadt Testament (1802)

For my brothers Carl and [Johann] Beethoven

*O you men who think or say that I am malevolent, stubborn or misanthropic, how greatly do you wrong me, you do not know the secret causes of my seeming, from childhood my heart and mind were disposed to the gentle feelings of good will, I was even ever eager to accomplish great deeds, but reflect now that for six years I have been a hopeless case, aggravated by senseless physicians, cheated year after year in the hope of improvement, finally compelled to face the prospect of a lasting malady (whose cure will take years or, perhaps, be impossible), born with an ardent and lively temperament, even susceptible to the diversions of society, I was compelled early to isolate myself, to live in loneliness, when I at times tried to forget all this, O how harshly was I repulsed by the doubly sad experience of my bad hearing, and yet it was impossible for me to say to men speak louder, shout, for I am deaf. Ah how could I possibly admit such an infirmity in the one sense which should have been more perfect in me than in others, a sense which I once possessed in highest perfection, a perfection such as few surely in my profession enjoy or have enjoyed—O I cannot do it, therefore forgive me when you see me draw back when I would gladly mingle with you, my misfortune is doubly painful because it must lead to my being misunderstood, for me there can be no recreations in society of my fellows, refined intercourse, mutual exchange of thought, only just as little as the greatest needs command disposition, although I sometimes ran counter to it yielding to my inclination for society, but what a humiliation when one stood beside me and heard a flute in the distance and I heard nothing, or someone heard the shepherd singing and again I heard nothing, such incidents brought me to the verge of despair, but little more and I would have put an end to my life—only art it was that withheld me, ah it seemed impossible to leave the world until I had produced all that I felt called upon me to produce, and so I endured this wretched existence—truly wretched, an excitable body which a sudden change can throw from the best into the worst state—Patience—it is said that I must now choose for my guide, I have done so, I hope my determination will remain firm to endure until it please the inexorable parcae to break the thread, perhaps I shall get better, perhaps not, I am prepared. Forced already in my 28th year to become a philosopher, O it is not easy, less easy for the artist than for anyone else—Divine One thou lookest into my inmost soul, thou knowest it, thou knowest that love of man and desire to do good live therein. O men, when some day you read these words, reflect that you did me wrong and let the unfortunate one comfort himself and find one of his kind who despite all obstacles of nature yet did all that was in his power to be accepted among worthy artists and men. You my brothers Carl and [Johann] as soon as I am dead if Dr. Schmid is still alive ask him in my name to describe my malady and attach this document to the history of my illness so that so far as possible at least the world may become reconciled with me after my death. At the same time I declare you two to be the heirs to my small fortune (if so it can be called), divide it fairly, bear with and help each other, what injury you have done me you know was long ago forgiven. To you brother Carl I give special thanks for the attachment you have displayed towards me of late. It is my wish*

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that your lives be better and freer from care than I have had, recommend virtue to your children, it alone can give happiness, not money, I speak from experience, it was virtue that upheld me in misery, to it next to my art I owe the fact that I did not end my life with suicide. — Farewell and love each other — I thank all my friends, particularly Prince Lichnowsky and Professor Schmid — I desire that the instruments from Prince L. be preserved by one of you but let no quarrel result from this, so soon as they can serve you better purpose sell them, how glad will I be if I can still be helpful to you in my grave — with joy I hasten towards death — if it comes before I shall have had an opportunity to show all my artistic capacities it will still come too early for me despite my hard fate and I shall probably wish it had come later — but even then I am satisfied, will it not free me from my state of endless suffering? Come when thou will I shall meet thee bravely. — Farewell and do not wholly forget me when I am dead, I deserve this of you in having often in life thought of you how to make you happy, be so —

Heiligenstadt, October 6, 1802,  
Ludwig van Beethoven

N.B.: The sections in italics were selected by the authors of the chapter. In their view, these sections illustrate well some key issues addressed in the chapter including: identity threat appraisals (i.e., self-stigma), concealment of hearing loss, and the effect of stigma on self-esteem, social isolation, and general health.

