1997

The experience of hearing loss in older women: Patterns of human becoming.

Lavin Reed Rowe
University of Alabama at Birmingham

Recommended Citation

Rowe, Lavin Reed, "The experience of hearing loss in older women: Patterns of human becoming." (1997). *All ETDs from UAB*. 6160.
https://digitalcommons.library.uab.edu/etd-collection/6160

INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor MI 48106-1346 USA
313/761-4700 800/521-0600

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.

THE EXPERIENCE OF HEARING LOSS IN OLDER WOMEN: PATTERNS OF HUMAN BECOMING

by

LAVIN REED ROWE

A DISSERTATION

Submitted to the graduate faculty of The University of Alabama at Birmingham,
in partial fulfillment of the requirements for the degree of
Doctor of Science in Nursing

BIRMINGHAM, ALABAMA

1997

UMI Number: 9818850

UMI
300 North Zeeb Road
Ann Arbor, MI 48103

ABSTRACT OF DISSERTATION
GRADUATE SCHOOL, UNIVERSITY OF ALABAMA AT BIRMINGHAM

Degree DSN Program Community Mental Health Nursing

Name of Candidate Lavin Reed Rowe

Committee Chair Penelope Paul

Title The Experience of Hearing Loss in Older Women: Patterns of Human Becoming

The purpose of this study was to explore the meaning that the lived experience of presbycusis has for women age 65 or above. The Parse human becoming theory provided the conceptual basis for this descriptive exploratory study.

Two research questions were answered. These questions follow: (a) What are the health patterns of older women with hearing impairment? and (b) Is the human becoming theory model appropriate as a conceptual basis for studying the health patterns of older women with hearing loss?

Six participants were interviewed three times for 1½ hr each time. Tape recordings of the interviews were made and transcribed after each session. Participants were asked to describe important people and life events during the first interview in order that the experience of hearing loss could be situated within the context of life in a holistic way. Seven directional ideas were designed to assist the researcher during the second interview in guiding the participant to describe personal experiences related to having presbycusis. These directional ideas related directly to the principles of the human becoming theory. Interview 3 was utilized to verify and clarify information.

Data were analyzed in three ways: (a) coding to provide a means of data retrieval, (b) deriving themes, and (c) relating the data to the theory concepts. Five participants were interviewed a fourth time in order to provide opportunity for participants to verify the findings.

Findings indicated that participants experienced hearing loss in individual, yet similar, ways. Health patterns that evolved out of the hearing loss were influenced by past life experiences and patterns. Some participants demonstrated reaching levels of originating new ways to conceive of the experience, transforming the experience by relating to the experience in new ways, and cotranscending the experience into a meaningful life event. Use of the human becoming theory as a conceptual framework enabled the phenomenon of hearing impairment to be explored in a new way through the principles of multidimensional meanings, rhythmical patterns of relating to the world, and cotranscending the possibles.

ACKNOWLEDGEMENTS

I wish to offer my sincere appreciation to the many people who have graciously helped me to complete this project. I am grateful to my Graduate Committee, Dr. Anne Foote, Dr. Pamela Fordham, Dr. Renita Goldman, and Dr. Cecelia Pierce, who offered guidance throughout this process. Dr. Penelope Paul, as Committee Chairperson, has provided superb leadership and has been especially encouraging in this endeavor.

I would like to thank Dr. Rosemarie Parse for providing guidance about appropriate methodology for this study when we spoke by telephone in December 1995. I am greatly indebted to my secretary and friend, Sarah Edmundson, who has spent countless hours on this project; to Dr. Sue Bobek, who served as a peer reviewer; to Mr. Richard Gresham, audiologist, for assistance in recruiting participants; and to Martha Davies for her artwork.

Family always pays a price when one of its members chooses this path, and I would like to express appreciation to my husband, Art, for his support, encouragement, and help during this time.

Finally, I am grateful to my mother, Blanche Reed, who, because of her hearing impairment, became my source of inspiration.

TABLE OF CONTENTS (Continued)

TABLE OF CONTENTS (Continued)

Page

CHAPTER

APPENDICES

TABLE OF CONTENTS (Continued)

LIST OF TABLES

LIST OF TABLES (Continued)

LIST OF FIGURES

CHAPTER 1

INTRODUCTION

This study was intended to enable nurses and other interested persons to better understand the lived experiences of older women with hearing impairment. Participants in the study had been diagnosed with presbycusis, a common type of hearing impairment in older persons. Parse's (1981) theory of human becoming served as the conceptual framework for this descriptive exploratory study which examined the health patterns of these hearing impaired older women.

Although figures vary widely as to the incidence of hearing loss in the United States, hearing loss does appear to be one of the most prevalent chronic conditions of older persons. Kausler and Kausler (1996) wrote that almost all persons who are age 65 and above have presbycusis; 10% of these persons have severe cases. People begin to lose high-frequency sounds while in their 30s, and by age 65, 30% have noticeable hearing loss.

Prevalence rates of persons with hearing impairments for the years 1990, 1992, and 1994 are demonstrated in Table 1. These prevalence rates represent the latest data available.

According to the U.S. Bureau of the Census (1996), the four most prevalent chronic conditions for men ages 65-74, listed in order of frequency, are (a) arthritis, (b) heart disease, (c) hypertension, and (d) hearing impairment. However, for men age 75 and above, hearing impairment is listed as the leading chronic condition.

1996). The majority of studies pertaining to older persons--as well as to hearing impairment--have been conducted primarily on male populations. The ever increasing population of older female persons, most of whom live alone (Garner & Mercer, 1989), makes it imperative to study this population.

The significance of this study should become evident as an overview of the study is presented in this introductory chapter. Chapter 1 is intended to introduce the following elements of the study: (a) the purpose and research questions, (b) the research objectives, (c) the conceptual framework, (d) related constructs, (e) the assumptions of the study, and (f) the significance of the study.

Purpose and Research Questions

The purpose of this study was to explore the meaning that the lived experience of hearing loss has for older women who live alone. The rhythmical and evolving health patterns of the participant's life were explored.

The study included two research questions:

1. What are the health patterns of older women with hearing impairment who live alone?

2. Is the human becoming theory model appropriate as a conceptual basis for studying the health patterns of older women with hearing loss?

Research Objectives

The research objectives, as the researcher began this study, were as follows:

1. To describe the health patterns that occur as older women with hearing loss derive the meaning that the hearing loss has for them.

2. To describe the health patterns that occur as older women with hearing loss relate to the world.

3. To describe the health patterns that occur as new ways of living and/or viewing familiar concepts evolve as a result of living with hearing loss.

It should be noted that the researcher recognized that modification of the objectives might be appropriate during the course of the study as participants shared personal experiences related to living with hearing impairment. Thus, the researcher planned to change objectives, if necessary, as new questions arose out of the data obtained.

Conceptual Framework

Parse's (1981) theory of human becoming served as the conceptual framework for this descriptive exploratory study. A human science approach was utilized to enable the researcher to better understand the nature and meaning that a particular experience of health has for a particular individual.

The first name given to the theory by Parse was man-living-health. Parse changed the name of the theory due to the dictionary definition of the term man changing from "mankind" to "male gender" (Parse, 1992). "The name, human becoming, reflects the unity of the construct man-living-health which is still the focus of the theory" (Parse, 1992, p. 37). This unfragmented view of humankind is revealed in Parse's assumptions defined as the assigned meaning or significance that is given to something (Parse et al., 1985).

2. Parse (1992) defined valuing as "the process of living cherished beliefs while assimilating the new into a personal worldview" (p. 37). Valuing is defined by Cody and Mitchell (1992) as "the process of choosing, owning, and prizing: valuing reflects the relationship between self and all that one experiences" (p. 54). Valuing is thus the interpretation or ramification of meaning (Parse et al., 1985).

3. Languaging is "expressing valued images" (Parse, 1981, p. 46). It is "showing meaning of personal experiences through speaking, moving, gesturing, and being silent" (Cody & Mitchell, 1992, p. 54). Languaging is thus the way meaning is explained (Parse et al., 1985).

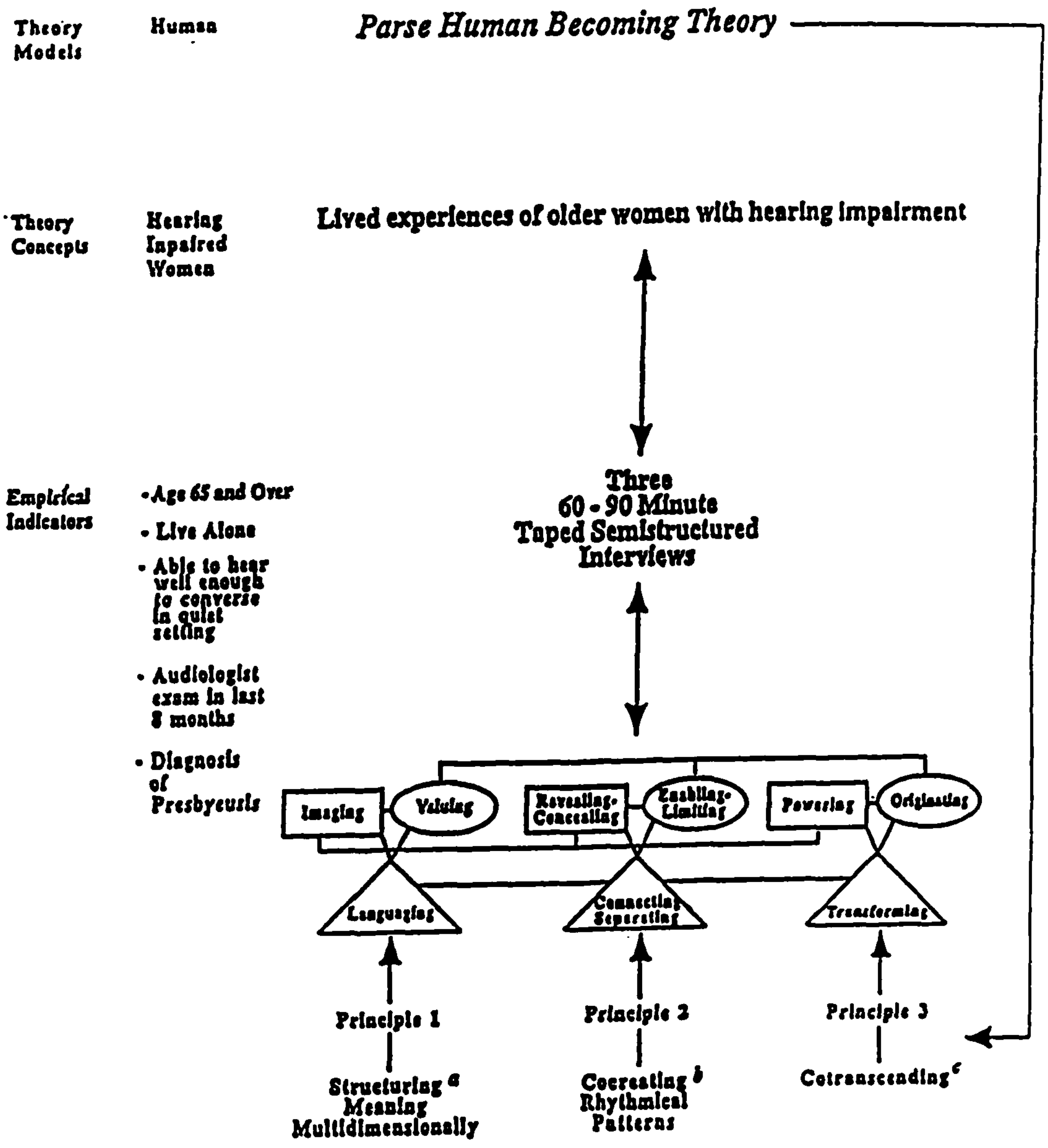
Principle 2: "Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating" (Parse, 1981, p. 50). Principle 2 is described as an "unfolding cadence" (Parse, p. 50) or rhythm that is reflected in how humans live in the world. Revealing-concealing is defined as a "rhythm in the pattern of relating to others" (Parse, 1992, p. 38). This rhythm is evidenced by patterns of disclosure-indisclosure in relating to others (Parse et al., 1985). "Enabling-limiting is a rhythmical pattern of relating" (Parse, 1992, p. 38). The choice one makes may move one in one direction while limiting movement in other directions. Revealing-concealing is the directional movement or the chosen focus of life (Parse et al., 1985). "Connecting-separating is a rhythmical process of moving together with one phenomenon and moving apart with another phenomenon" (Parse, 1992, p. 38). It is the movement in a direction closer to or farther away from others (Parse et al., 1985).

Principle 3: Cotranscending with the possibles is "powering unique ways of originating in the process of transforming" (Parse, 1981, p. 69). "Powering is the pushing-resisting rhythm of all . . . interrelationships" (Parse, 1992, p. 38). When pushing-resisting occurs, conflict surfaces. This conflict enables persons to clarify views previously unexamined. It is the movement towards living intended goals (Parse et al., 1985). "Originating" means creating new ways of living and new ways of viewing familiar concepts. It is the process of creating the not yet (Parse et al., 1985). "Transforming" is the change that occurs as threads in the fabric of life are woven in new ways (Parse, 1992). It is a change of perspectives or development of a different view (Parse et al., 1985).

These concepts became an integral part of the research plan as the researcher utilized them as a conceptual basis when deriving health patterns and themes that unfolded as data were analyzed. In Figure 1, lines connecting the concepts derived from various principles indicate the three theoretical structures identified by Parse. These theoretical structures are as follows:

1. Relationship of concepts in squares: Powering is a way of revealing and concealing imaging.
2. Relationship of concepts in ovals: Originating is a manifestation of enabling and limiting valuing.
3. Relationship of concepts in triangles: Transforming unfolds in the languaging of connecting and separating. (Parse, 1981, p. 69)

These concepts and interrelationships, along with other possible combinations of concepts, can be connected from each principle in order to derive new theoretical struc-



[a] Principle 1: Structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging.

[b] Principle 2: Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing and enabling-limiting while connecting-separating.

[c] Principle 3: Cotranscending with the possibles is powering unique ways of originating in the process of transforming.

(Parse, 1987, p. 69)

Figure 1. Conceptual-theoretical-empirical model.

tures (Parse, 1992). The theoretical structure does not serve as a gauge against which reported lived experiences are compared. Instead, the structure becomes a guide to determining the meaning of the lived experience (Cody & Mitchell, 1992).

Related Constructs

The following terms were defined as they were used in this study. These terms are described in more detail in Chapter 2.

Human Sciences--"The study of meaning: descriptive-interpretive studies of patterns, structures, and levels of experiential and/or textual meanings" (van Manen, 1990, p. 180).

Qualitative Research Methods--Those research methods that "focus on description as their primary outcome and explicitly express a value for the thoughts, perceptions, and feelings of subjects about lived experiences" (Parse et al., 1985, p. 2).

Older Women--Women aged 65 and above.

Human--Open, continuously unfolding being who is different from and greater than the sum of the parts. This unique being carves a personal path from the available options and accepts responsibility for the life situation that is cocreated and based on personal values (Parse, 1981).

Lived Experience--The whole complex of human reality (Mitchell & Cody, 1992).

Health--A nonstatic creative process of becoming that evolves in individuals as belief systems, individual priorities, hopes, and dreams move towards an expanded consciousness (Parse, 1990a; Cody & Mitchell, 1992). It is "the way one lives

Significance of the Study

The significance of the study is revealed by the lack of literature available related to the meaning of the lived experience of hearing impairment to older women who live alone. Persons in the audiological and otolaryngological fields have conducted numerous technically oriented studies documenting audiometric changes related to hearing impairment. These same groups of professionals have studied hearing aid styles, types, and fits. Very few studies in these fields have focused on the impact of hearing loss in old age.

The literature review of the Cumulative Index to Nursing and Allied Health (CINAHL) in the years from 1982 to 1995 revealed only 40 articles related to hearing loss. Eleven of these 40 articles related to hearing loss in older persons. Topics discussed in these 11 articles included screening for hearing impairment, nursing care of institutionalized hearing impaired patients, and hearing aid benefits.

Only 4 of the 11 articles relating to hearing loss in older persons were actually nurse-conducted studies. Two of these four studies related to loneliness (Chen, 1994; Christian, Dluhy, & O'Neill, 1989). One study dealt with hearing screening protocol (O'Rourke, Britten, Gatschet, & Kein, 1993), and one study compared persons who experience hearing loss early in life with those who develop hearing loss in later life (Magilvy, 1985).

A review of the CINAHL for the years 1996 and 1997 revealed that further studies had been conducted on hearing loss during those years. Twenty-three studies had been conducted related to hearing loss in children, 15 studies were not age specified, and 10 studies had been conducted utilizing the elderly. All of these studies were conducted outside of the field of nursing. Eight of these studies were on the topic of screening for hearing loss, while other studies tended to focus on amplification devices, hearing handicaps, and communication problems.

Only one nurse-conducted study on the topic of hearing loss was found for the years 1996 and 1997. This study related to psychosocial/physiologic functioning.

There were no studies found in the CINAHL for the years between 1982 and 1997 on the topic of lived experience of hearing loss. Neither has any study on the phenomenon of hearing loss been published which utilizes Parse's human becoming theory as a conceptual basis. Other studies deal with specific aspects of the phenomenon of hearing loss such as loneliness associated with hearing loss or difficulties in communication arising out of the impairment. No study considers the meaning of hearing impairment from a perspective of holism as does this study.

This study, therefore, should contribute to the existing body of research by (a) increasing knowledge related to the meaning of the lived experience of hearing impairment in older women who live alone; (b) enabling nurses and other health professionals to respond with increased understanding to persons experiencing this phenomenon; (c) expanding the body of research related to older women; (d) serving as a guide to practice as nurses learn to assist in the enhancement of quality of life from the client's perspective, rather than their own; (e) helping "expand and specify the theory through an interpretive linkage with the concepts of the theory" (Cody & Mitchell, 1992, p. 60); and (f) helping to enlarge the theory of health as expanded consciousness (Newman, 1994; Parse, 1990b).

CHAPTER 2

LITERATURE REVIEW

The purpose of this chapter is to review the literature related to the research. This literature review provides supporting evidence for research decisions made by the researcher. The following bodies of literature are explored: (a) literature related to hearing impairment, (b) information related to the human science approach to research, (c) research related to Parse's human becoming theory, (d) research related to qualitative research methods as a research methodology, and (e) writings related to the concept of health.

Hearing Impairment

Hearing impairment is a decrease in the ability to hear. There are five basic types of hearing impairments. One type of hearing impairment is a conductive loss. Conductive loss results from a dysfunction of the external or middle ear related to problems with "cerumen, foreign bodies, a perforated tympanic membrane, pus or serum in the middle ear, and otosclerosis" (Jarvis, 1996, p. 354). Persons with conductive losses can hear if sounds are amplified enough to enable them to reach the nerve elements in the ear.

The second type of hearing impairment is a sensorineural loss. Sensorineural loss involves the inner ear, cranial nerve VIII, or the auditory areas of the cerebral cortex. A person with this type of hearing loss may not understand words better even after the volume of the sound is increased. Sataloff and Sataloff (1993) classified the sensorineural hearing losses as shown in Table 2.

Table 2

Classifications and Causes of Sensorineural Hearing Losses

Gradual Onset	Sudden Bilateral	Sudden Unilateral	Congenital Hearing Loss
1. Presbycusis	1. Meningitis	1. Mumps	1. Heredity
2. Occupational hearing loss	2. Infections	2. Head trauma and acoustic trauma	2. Rh incompatibility with kernicterus
3. Sensorineural aspects of otosclerosis and chronic otitis media	3. Functional	3. Meniere's disease	3. Anoxia
4. Sensorineural aspects of Paget's and van der Hoeve's diseases	4. Ototoxic drugs	4. Viral infections	4. Viruses
5. Effects of hearing aid amplification	5. Multiple sclerosis	5. Rupture of round window membrane or inner-ear membrane	5. Unknown causes
6. Neuritis of the auditory nerve and systemic diseases (diabetes, etc.)	6. Syphilis	6. Vascular disorders	
7. Unknown causes	7. Autoimmune diseases	7. Following ear surgery	
	8. Unknown causes	8. Fistula of oval window	
		9. Following general surgery and anesthesia	
		10. Syphilis	
		11. Unknown causes	

(Sataloff & Sataloff, 1993, pp. 209-210)

The third type of hearing impairment occurs when there is a conductive as well as a sensorineural hearing loss. This type of hearing loss is labeled a mixed loss. The prognosis of a mixed hearing loss depends upon the amount of loss that is conductive and the amount that is sensorineural. A slight sensorineural loss in proportion to the amount of conductive loss has the best prognosis as conductive losses can often be surgically corrected (Sataloff & Sataloff, 1993).

Central hearing loss constitutes the fourth type of hearing loss. This type of loss is related to a lesion occurring between the auditory nuclei and the cortex (Sataloff & Sataloff, 1993). Central hearing loss results in more discrimination loss, message interpretation loss, and attention span loss than in dB loss. A poor prognosis is usual (Sataloff & Sataloff).

The fifth type of hearing loss is a functional or psychogenic hearing loss. The person diagnosed with this type of loss is unable to hear as a result of psychological or emotional factors. No organic basis can be found for this type of hearing loss. Sataloff and Sataloff (1993) wrote that this type of hearing loss is an unconscious defense mechanism created by the affected person in order to escape an intolerable problem. Functional hearing loss results in a uniform flat tone bilateral hearing loss.

Bone and air conduction hearing loss is measured in terms of decibels. A decibel is defined as "a unit of comparison--a ratio--between two sound pressures" (Sataloff & Sataloff, 1993, p. 15). A decibel is not a unit of measurement but, rather, a reference level (Sataloff & Sataloff). Levels of hearing impairment are described in terms of dB losses. Normal hearing falls in the 0-25 dB loss range, while mild hearing loss is hearing loss in the range of 26-40 dB. Forty-one to 55 dB hearing loss is considered to be moderate, while a 56-70 dB loss is severe (Weinstein & Ventry, 1982). Sataloff and Sataloff (1993) wrote that a 40 dB loss indicates that 40 dB more sound pressure is required for a sound to be heard. "A sound of 60 dB is a sound that is 60 dB more intense than a sound that has been standardized at the reference level" (Sataloff & Sataloff, p. 15).

Presbycusis

The participants of this study had been diagnosed with a particular type of sensorineural hearing impairment--presbycusis. Presbycusis is one of the most widespread types of hearing loss among older persons (Weinstein & Ventry, 1982).

Definition of Presbycusis

> Presbycusis refers to the decline in hearing associated with various types of auditory system dysfunction . . . that accompany aging and cannot be accounted for by extraordinary ototraumatic, genetic, or pathological conditions. The term presbycusis implies deficits not only in absolute thresholds but in auditory perception as well. (Willott, 1991, pp. 2-3)

Development of Presbycusis

Presbycusis develops gradually and affects both ears at nearly equal rates (Armstrong et al., 1992). This condition affects both the audiometric threshold and sound perception. Sensory hearing loss may occur prior to neural loss (Sataloff & Sataloff, 1993). It is believed that epithelial changes occurring in the cochlea in early stages of hearing loss lead to damage of the nerve elements, the cortex, and central pathways.

Some researchers have indicated a diagnosis of presbycusis is nonspecific and is used to label any gradual increase in hearing loss that results in (a) loss of hearing in the higher frequencies and (b) a disproportional decrease in speech recognition scores (Paparella, 1978). Lowell and Paparella (1977) wrote that the term presbycusis should refer to hearing loss resulting from normal aging and not from other causes such as genetic or familial etiologies. Kryter (1983) argued that a presbycusis-like hearing loss can be the result of noise or environmental conditions, but these hearing losses are not related to age and should not be labeled presbycusis. Willott (1991) indicated that it is impossible to separate the aging person from normal noise, environmental chemical contaminants, and genetic predispositions and that, consequently, these elements are a part of and often the cause of the aging process. However, where excessive noise, unusual environmental conditions, trauma, and disease processes can be identified, these conditions should be noted and alternative labels utilized for the resulting hearing loss (Willott).

Further study will be necessary before the exact cause of presbycusis can be determined. The theories which connect presbycusis to arteriosclerosis, noise, chemical irritants, age, sex, and genetics continue to be under investigation and studies provide mixed results (Hinchcliffe, 1991; Sataloff & Sataloff, 1993).

Types of Presbycusis

Four types of presbycusis have been defined by Schuknecht (1989). These types include (a) sensory presbycusis, (b) neural presbycusis, (c) strial presbycusis, and (d) cochlear conductive presbycusis. Sensory presbycusis, which causes damage to the basal loss is much greater in populations from 80-89 years old than for populations aged 60-69 years and those aged 70-79. Likewise, results indicated that when the hearing loss was above 30 decibels the older groups had larger discrimination losses than younger groups.

Gimsing (1990) and Lutman (1991) indicated that an excess word discrimination inability may occur with increasing age related to a deterioration of the

> supra-threshold peripheral auditory functions, such as frequency, intensity, and temporal resolution, and/or deterioration in central auditory nervous system performance, although there is some evidence that neither excessive loss of frequency nor temporal resolution can explain excess disability with age. (Lutman, p. 239)

The sounds that are difficult to distinguish include the consonants. Thus, persons with presbycusis have difficulty distinguishing words "like yes, yet, jet, and get" (Sataloff & Sataloff, 1993, p. 214).

A distortion of sounds and an increase in sensitivity to loud sounds may also occur in presbycusis. More time may be required for the person to interpret words (Sataloff & Sataloff, 1993).

Impact of Impairment on Life

Whatever the specific cause or diagnosis related to hearing impairment, studies indicate that the impairment impacts on the person's life in multiple ways. People experience hearing loss on three levels. The first level is the primitive level, like the background noise of traffic or birds. This type of noise, while it may be subconsciously heard, makes people feel that they are part of a wider world. The second level is the warning level, or sounds heard that enable people to live safely. These sounds include the doorbell, sirens, and the ringing telephone. The third level is the symbolic level, or the sounds of communication or speech. Persons may not notice a gradual decrease in the ability to hear first and second level sounds. Third level sound deficits, however, produce communication problems and may entice persons to seek help (Joensen & Saunders, 1984).

The level of hearing loss, as measured in decibels, does not predict the amount of hearing handicap experienced by the person. Frequency losses in the 2000-3000 Hertz (Hz) range are often more functionally handicapping than those on higher frequency ranges. The term hearing handicap refers to how a change in hearing decreases performance of activities of daily living. A very mild disability may be more handicapping to a younger working person than is a more severe disability to the older nonemployed individual. The degree of physiological change in hearing does not correlate with the amount of dysfunction (Mulrow et al., 1990). Bess, Lichtenstein, and Logan (1991) wrote that people may experience different levels of hearing handicap with equal amounts of hearing impairment. Older Americans may tend to understate the handicapping effect of hearing loss when the disability is 55 decibels or below (Lutman, 1991). Ninety-two percent of persons who have hearing loss report that this impairment does not limit their activity (Lutman). Bess et al. (1991), however, demonstrated that physical and psychosocial scales are impacted negatively as hearing acuity decreases. Persons unable to hear shouted speech demonstrate increased hearing handicap upon self-assessment. The physical subscales measured by Bess et al. included ambulation, mobility, body care, and movement, while the psychosocial subscales measured consisted of social interaction, communication, alertness, and emotional behavior. Additional measures assessed included sleep, work, home management, recreation, and hobbies.

Persons who assess themselves as having higher hearing handicaps experience a "greater sense of isolation, loneliness, and inferiority" (Weinstein & Ventry, 1982, p. 597) than those who do not assess their handicap as being very great. Taylor (1993) wrote that persons who cannot hear others well enough to communicate effectively develop a defensive posture in which they appear to be preoccupied, paranoid, and unsociable. The individual may isolate from others in an attempt to protect the ego. Certainly the hearing loss that affects communication strains relationships, affects safety and security, and interferes with medical self-care activities.

Chen (1994) studied loneliness and self-esteem in relationship to hearing handicap. The Roy adaptation model (Roy & Andrews, 1986) served as the conceptual framework for this study conducted on a selected group of more highly educated persons within one geographic location. Four participant-administered instruments were utilized in this descriptive correlational study. Demographic factors were compared to hearing handicap, loneliness, and self-esteem. The instruments utilized included (a) a demographic data form, (b) The Hearing Handicap Inventory for the Elderly, (c) the University of California at Los Angeles (UCLA) Loneliness Scale, and (d) the Rosenberg Global Self-Esteem Scale. Forty-five men and 43 women participated in the study.

Chen (1994) reported that hearing handicap is significantly correlated with loneliness and self-esteem. However, the correlation coefficients were low. Hearing handicap correlated with loneliness at a level of $r = .23$, $p = .02$, and with self-esteem at a level of $r = .26$, $p = .01$. Correlation values between loneliness and low self-esteem were reported to be $r = .27$, $p = .001$. Chen wrote that this value indicates that "the higher the level of loneliness, the lower the self-esteem" (p. 25).

Chen (1994) divided data into subgroups in order to test men and women separately. The correlation coefficients for hearing handicap and loneliness were r = .19 for men and r = .26 for women. The relationship between hearing handicap and self-esteem was reported at r = .16 for men and r = .32 for women. This figure demonstrates little, if any, correlation for men and a low positive correlation for women. A marked difference between men and women was noted when emotional difficulty of hearing impaired persons was correlated with loneliness and self-esteem. The value for men was r = .16 and for women was r = .36. These values may indicate that women suffer more emotional difficulties secondary to hearing loss.

Christian et al. (1989) studied 61 volunteer subjects age 65 and above to examine the relationship between hearing loss and loneliness. The sample consisted of 51 women and 12 men. These participants all lived in one of three urban housing units for the elderly. Thirty subjects were between the ages of 65 and 74, and 33 were aged 75-94.

Researchers collected data in a one time meeting. The interview sequence included (a) an explanation of the consent form, (b) a demographic data sheet, (c) administration of an audiometric hearing examination, and (d) administration of the UCLA Loneliness Scale.

Forty-four persons demonstrated either normal hearing or a mild hearing loss when tested audiometrically. These individuals had a mean loneliness score of 32. Nineteen subjects evidenced serious to severe loss. This group demonstrated a loneliness score of 36. Therefore, the data suggest that elderly persons whose hearing impairment is more severe tend to exhibit more loneliness.

The studies reviewed reveal that some physiological and psychosocial factors involved in hearing impairment have been studied in some detail. Various approaches have been utilized to study various parts of the whole such as studies of specific physical and psychosocial impacts of hearing impairment. Much less research has focused on the impact of hearing loss as it affects the very personhood of the individual. No study acknowledges reviewing this phenomenon from the perspective of human wholeness. Parse's human becoming theory has not yet been utilized to research the meaning of hearing impairment as a lived experience of health. The primary interest of this study is in the meaning of the experience to the individual as the individual continuously unfolds or creates the patterns of becoming. Thus, the study is unique in its approach to the exploration of this commonly experienced phenomenon of health.

Human Science

Parse (1992) wrote that nursing is a human science. The subject matter of human science is humans and how humans experience meaning through participation with the world (Parse). The intent of human science is to gain an understanding into the connectedness of life while acknowledging that the complexities of life make total understanding inaccessible. The desire of the human scientist is to discern the indiscernible, to describe the indescribable, and to find the consequential in the inconsequential (van Manen, 1990). Human science research returns to the lived world, to the very phenomenon itself. This research approach varies from traditional reductionist research in that it is (a) relative, not absolute; (b) value laden, making no pretense of being valueless; (c) inductive, not deductive; (d) ipsative (nonconforming), not normative; (e) subject, not object oriented; (f) a creative, intuitive process of discovery, not product oriented; (g) abstract, not concrete; (h) philosophical, not analytic; and (i) tacit, not expressed (Watson, 1988).

Human intentions and motivations are valued, not discarded, in human science (Chinn & Kramer, 1995). The participant's inner experience is valued and the meaning of that experience is explored as the researcher and participant communicate, relate, and connect to each other while neither tries to deny personal subjective inner worlds (Watson, 1988). The researcher enters the study with an awareness that the researcher will affect the study outcomes, not only in the approach taken towards participants but also through the selection of the very subject matter itself (van Manen, 1990).

Human science emerges from the simultaneity--not the totality--paradigm (Parse, 1992). These two paradigms call for opposite investigative approaches. Researchers utilizing the totality paradigm view human wholeness as a sum of parts and often study these parts--body, mind, and spirit--separately and from a cause and effect perspective (Parse). The simultaneity paradigm, however, sees human beings first of all as "whole entities," consisting of "patterns" rather than parts (Parse, p. 35). This view of human beings leads to a holistic approach to research that seeks to view the human being in a universal context, blending science with art, esthetics, and metaphysics.

Giorgi (1985) wrote that human beings need to be studied as persons who are experiencing beings. Giorgi would recommend the human science approach over the positivistic reductionistic approach to studying human experience.

Human science is rigorous in that it is soulful; that is, it is morally and spiritually sensitive to the need to interpret experience in a responsible way. Mitchell and Cody

(1992) asserted that human science is science at its best and is science that truly incorporates an unfragmented, dynamic unity of experience. The present study manifests a human science orientation.

Human Becoming Theory

Parse (1981) utilized the human science approach in the human becoming theory. It is important to understand the ontological base from which the human becoming theory was derived. The philosophers who influenced the basic tenets of the theory are introduced in this section.

Four studies that utilized the human becoming theory as an ontological base are also reviewed. These studies are assessed to determine (a) appropriateness of the theory for the subject matter and (b) author's utilization of the methodology prescribed by Parse.

Supporting Theories

The supporting theories for Parse's model include Heideggerian existential phenomenology (made known through the works of Jean-Paul Sartre, Merleau-Ponty, and others) and Rogers's science of unitary human beings (Parse, 1981). "Existential-phenomenological tenets and concepts of intentionality, subjectivity, situated freedom, coexistence and coconstitution permeate the assumptions, principles and concepts" of Parse's theory (Smith, 1991, p. 5). Parse (1981) wrote that freedom is a situated freedom as humans are influenced by culture, language, assumptions, and presuppositions.

Heidegger (1977) wrote of a freedom which "lets beings be as they are" (p. 127). The human becoming theory proposes that the researcher meet the participant where he/she is without imposing personal standards, realizing that humans are freely choosing beings who bear the responsibility for their own choices (Mitchell & Cody, 1992).

Merleau-Ponty (1974) also wrote of having a commitment to the world as it is experienced. This commitment is grounded in phenomenology and further supports the tenets of the human becoming theory.

Sartre's influences are also easily recognized in Parse's human becoming theory. Sartre (1957) wrote that the existential philosophers have a common belief that existence precedes essence. These philosophers wrote that first there was the human being and afterward that being defined its essence. Sartre wrote: "Not only is man what he conceives himself to be, but he is also only what he wills himself to be after this thrust toward existence" (p. 15). Thus, humans are only what they make of themselves (Sartre).

Sartre (1957) wrote that humans are responsible for themselves individually and collectively. The individual images chosen by persons become the image of all of humankind. Sartre wrote that "man is condemned to be free" (p. 23) and is responsible for every act. Humans thus become the series of undertakings in which they choose to participate. Choosing not to choose is also a way of choosing. Sartre thus reported that the world is "an opportunity made use of, lacked, or neglected" (p. 58).

Assumption 1 of the human becoming theory reflects Sartre's (1957) writing concerning humans as freely choosing beings. This assumption becomes the underlying antecedent for the concepts and structures of the theory.

Martha Rogers's science of unitary human beings heavily influenced Parse's human becoming theory. Rogers (1970) wrote that humans can make choices to rearrange personal environments in order that personal potentials can be fulfilled. Parse (1981) built upon Rogers's (1970) writings by stating that persons bear responsibilities for personal decisions and for the meanings that are given to individual situations. Further concepts utilized by both theorists include those of multidimensionality, unitary human beings, continuity of rhythms, and boundary absences (Rogers, 1990). These concepts are readily apparent in the principles of the human becoming theory. The principles of the human becoming theory are utilized throughout this study.

At least 13 research studies were conducted during the years between 1982 and 1995 utilizing Parse's human becoming theory as a conceptual base (Banonis, 1989; Butler, 1988; Butler & Snodgrass, 1991; Mitchell, 1990a, 1990b; Mitchell & Heidt, 1992; Nokes & Carver, 1991; Parse, 1990a, 1990b, 1993, 1994a, 1994b; Smith, 1990).

A review of the CINAHL for the years 1996 and 1997 demonstrated that there has been a proliferation in human becoming theory studies during those years. Two studies utilizing the theory were published by Parse while seven other studies were published by other authors (Baumann, 1996; Bunkers, 1996a; Cody, 1997; Daly, Mitchell, & Jonas-Simpson, 1996; Markovac, 1997; Mitchell, 1996; Parse, 1996a, 1997).

Studies Utilizing Parse's Human Becoming Theory

Four studies utilizing Parse's human becoming theory were selected for review. While all four studies shared a common conceptual base, they differed in study entities and research methodologies utilized. The first article reviewed is entitled "Parse's Research Methodology With an Illustration of the Lived Experience of Hope" (Parse, 1990b). Parse wrote that the purpose of this article was two-fold. The first purpose was researcher who has chosen to videotape an interview reads the transcript, listens, and watches the recorded interview all at once. This multisensory experience becomes an important part of this methodology.

4. The fourth process of the Parse methodology is entitled heuristic interpretation. Parse (1990b) described two processes of heuristic interpretation. The first process of heuristic interpretation is structural integration. Structural integration occurs when the researcher moves "the structure of the lived experience up another level of abstraction" (p. 11). The second process of heuristic interpretation is described by Parse as conceptual interpretation. Parse wrote that the researcher utilizes the concepts of the theory at this level to create a specific theoretical structure for the particular lived experience under study. The study results could indicate that a new theoretical structure is demanded. This finding may result in an expansion of the theory.

The final steps of this process of conceptual interpretation involve connecting the theoretical structure to the theory principles and interpretation of the study results in relation to the ontological base from which the Parse human becoming theory is derived. Parse (1990a) wrote that the data analysis methodology appropriate for the human becoming theory is distinct from other data analysis methods in that it requires that the researcher enter into true presence with the participant through the medium of a dialogical engagement. The researcher using Parse methodology is required to be further engaged in the research process in a personal way as the data are analyzed. A multisensory experience of reading the typed script while simultaneously listening to the audiotape is recommended.

Parse's (1990b) second purpose in this article was to provide an example of a research study utilizing the human becoming theory and Parse's research methodology. The concept of "hope as a lived experience of health" (p. 12) was selected for study. Parse provided excerpts of the extracted and synthesized essences of 3 of 10 participants in the study. Propositions devised by the researcher based upon the results of the extraction-synthesis process were reported for all 10 participants. Core concepts were then extracted from the propositions and the structure of the lived experience of hope identified. Last, the structure of the lived experience was taken to the level of the theory concepts and principles. Study results were compared to findings from other studies on the topic, and implications for future practice were identified.

Banonis (1989) utilized the human becoming theory as a conceptual basis for a study on lived experiences of recovering from addiction. Like the Parse (1990b) study, a phenomenological approach to research was utilized to devise a structural description of the lived experience.

Banonis (1989) wrote that a clearer understanding of the structure of recovering from addiction could be obtained from the person who was actually experiencing the recovery than could be obtained from an observer's perspective. The approach taken by Banonis was congruent with Parse's theoretical framework, which defines nursing as a human science emerging from the simultaneity paradigm and returning to lived experience in order to gain an understanding of a concept (Parse, 1992). Banonis (1989) obtained descriptions of people's experiences with recovering from addiction by having them write descriptions of situations in which they were aware of themselves in recovery.

Parse et al. (1985) wrote that data for phenomenological studies can be obtained through either an interview or a written description. The dialogical engagement is the form of data gathering technique recommended by Parse when the Parse methodology is to be utilized for data analysis. However, Banonis (1989) did not devise a study entity appropriate for the Parse methodology and did not use the Parse methodology for data analysis.

Banonis (1989) divided each participant's descriptive account of the experience of recovering from addiction into scenes, themes, and focal meanings. The researcher wrote that themes and focal meanings were composed for each scene of the participant's written description. Each participant's themes and focal meanings were then synthesized into a single situated structural descriptive statement. Last, the situated structural descriptive statements of all participants were combined into one general structural description.

The approach taken by Banonis (1989) to phenomenological data analysis is synonymous with that recommended by Patton (1990). Banonis (1989) wrote that this technique was derived from Giorgi's (1985) modification of phenomenological data analysis.

Nokes and Carver (1991) utilized one of the three theoretical structures of Parse's human becoming theory as the conceptual framework for studying the meaning of living with AIDS. The theoretical structure selected was "originating is a manifestation of enabling-limiting valuing" (Parse, 1981, p. 69).

Fourteen persons (11 men and 3 women) who had a diagnosis of AIDS were interviewed for this investigation. Participants in the study had contracted AIDS through

8. Do you think that you can make your hopes and dreams come true now?

9. How is your life different now?

10. Is there any way in which your life has gotten better since you were diagnosed? (Nokes & Carver, 1991, p. 176).

Nokes and Carver (1991) wrote that their study utilized an exploratory methodology. Parse et al. (1985) wrote that use of interview questions is appropriate to this type of descriptive study. The interview questions are derived from and relate to the objectives of the study. Parse (personal communication, December 1995) confirmed that the exploratory approach was an appropriate approach for the entity of study selected by Nokes and Carver (1991).

The investigators reported that they reviewed and transcribed the taped interviews themselves. The major themes from each interview were identified and then interpreted by the researchers, who synthesized the themes into categories of thought.

Nokes and Carver (1991) reported that three central concepts emerged as the interviews were analyzed. The researchers combined these three central concepts into a single statement reporting the results of the research on the meaning of living with AIDS. The statement is as follows: "Living with AIDS is an abrupt shift in patterns of becoming sparked by unpredictable changing relationships with others as different hopes and dreams unfold amidst suffering" (Nokes & Carver, 1991, p. 177). The final step in the research process of this study occurred as the researchers related the research findings to the human becoming theory concepts of originating, enabling-limiting, and valuing.

Patton (1990) wrote that there are "few agreed-on canons for qualitative data analysis" (p. 372). The approach to data analysis that was utilized by Nokes and Carver (1991) is synonymous to the data analysis technique recommended for exploratory studies in Parse et al. (1985) and Patton (1990), in that data are categorized by themes derived. However, Patton wrote about coding data in order to derive themes, whereas Parse et al. (1985) never make reference to coding.

Nokes and Carver (1991) further followed the guidelines of Parse et al. (1985) for data analysis of exploratory studies by synthesizing the three central concepts derived from the data into one hypothetical statement. The final step in data analysis utilized by Nokes and Carver (1991) was to relate the findings to the human becoming theory concepts. This step in the process of data analysis is described by Parse et al. (1985) as a step appropriate for Parse's phenomenological method. It appears that Nokes and Carver's (1991) ability to provide correspondence between the "theory hypothesis and the theory of man-living-health offers support for the theory" (Parse et al., 1985, p. 105).

Davis and Cannava (1995) studied the "meaning of retirement for those older people who lived as performing artists and who are presently sharing communal living at the Casa Verdi di Riposo, Milan, Italy" (p. 8). Parse's human becoming theory was appropriately utilized as a conceptual framework for this descriptive exploratory study. The researchers utilized an interview guide while conducting unstructured interviews on 8 participants. Guide questions utilized related to the research objectives that were derived directly from the three principles of the human becoming theory. The data were transcribed and analyzed. At times, participants referred to various passages from opera music in order to describe their feelings. The researchers listened to tapes of this music while analyzing the meanings participants were trying to convey. The researchers then used a process of analysis-synthesis in order to derive themes. These themes were first written in the language of the participant and later transformed into the researchers' language. Last, themes were synthesized into a descriptive statement that answered the original research question. The methodology utilized for theme derivation was appropriate according to guidelines described by Parse et al. (1985).

The present study on hearing loss utilized Davis and Cannava's (1995) pattern of describing themes first in the participant's language and then in the researchers' language. Last, a synthesized version of the themes was derived.

A summary of the four articles reviewed can be found in Table 3.

Table 3

Comparison of Four Studies Utilizing the Human Becoming Theory

Study	Method	Data Collection Approach	Data Analyzation
Parse (1990a)	Phenomenology	Taped dialogical engagements	Parse methodology: extraction synthesis, propositional statements, extractural descriptions
Banonis (1989)	Phenomenology	Written descriptions	Giorgi's modification: scenes, themes, focal meanings
Nokes and Carver (1991)	Exploratory Descriptive	Taped interviews	Themes synthesized into categories, central concepts, single statement, theory concepts
Davis and Cannava (1995)	Exploratory Descriptive	Taped interviews	Themes carried from language of participant to the language of the researcher, synthesized and written as a description statement

Qualitative Methods

Two closely related qualitative methods are discussed in this section. The first qualitative method discussed is the phenomenological method, while the second method is the descriptive or exploratory method. Similarities and differences between these two qualitative methodologies are explored.

The goal of phenomenology is to help individuals become more fully themselves by grasping more clearly what it means "to be in the world as a man or woman" (van Manen, 1990, p. 12). Phenomenology aims to more fully express universal meanings and to analyze experiences humans hold in common, thus giving textual expression to the essence of a lived experience. The phenomenologist does not seek to problem solve but to derive a more in-depth meaning of situations in order that one can act more tactfully when exposed to a similar situation. This methodology is discovery oriented. It brings the researcher into contact with a previously obscure experience in order that the researcher may come to better understand what a phenomenon means from a participant's perspective (van Manen).

The phenomenologist is searching not for predetermined facts but, instead, for the essence of the experience that the person lives. The interpretation of the experience is never assumed to be the final word; the end result is seen as one interpretation, that of the researcher. The purpose of this type of research is to provide insight into the wholeness of the experience (Pallikkathayil & Morgan, 1991). No emphasis is placed on any particular part of the experience. It is the experience in totality that is the focus.

The phenomenologist does not presume that interpretations of phenomena will be free of bias, personal assumptions, and presuppositions. The researcher, instead, faces personal beliefs and frames of reference and attempts to put these beliefs at bay while realizing the possibility of developing new beliefs and insights into a life experience (Giorgi, 1970).

Parse et al. (1985) wrote that the phenomenological method "takes into account man's participative experience with the situation" (p. 5). Participants provide descriptions of the experience, and the investigator studies the descriptions by dwelling with the data in order to intuit, analyze, and describe the meaning of the experience. The themes that surface are "synthesized into a structural definition of the lived experience" (Parse et al., p. 5).

Adams and Schuaneveldt (1991) wrote that the purpose of the exploratory study is to "seek out new insights, ask questions, and assess phenomena in a different perspective" (p. 104). The researcher cannot be bound by an inflexible design but must retain the freedom to explore new directions as new insights are gained. The exploratory study can enable the researcher to discover much general information--even serendipitous information--about a phenomenon. The researcher utilizing an exploratory design must be adaptable and willing to let the data guide the study. The researcher begins the study with a particular focus but is not limited by that particular focus if the data lead in a different direction.

The descriptive method is utilized by the qualitative researcher to describe "the phenomenon in the context of a situation" (Parse et al., 1985, p. 6). Descriptions can be made after the researcher has gained sufficient insight into a phenomenon or situation. This method "focuses on discovering the meaning of an event in time" (Parse et al., p. 91). A set of persons having an identified common phenomenon is studied. Each person describes the phenomenon in light of the "remembered, the now, and the not yet" (Parse, 1987, p. 197). Descriptions can be made only after the researcher has gained sufficient insight into a phenomenon.

A structured or unstructured interview guide is used to obtain information related to the study objective. The very "interrelationship between the researcher and the subjects reflects the unitary nature of man and the connectedness of man with the environment" (Parse et al., 1985, p. 91). The descriptive method enables the researcher to study the human-environment interaction as a unit.

An exploratory descriptive study would, therefore, seek new insights into and formulate new explanations of a phenomenon. The researcher then endeavors to describe the meaning of an event at a particular time in view of the personal situation. The descriptive exploratory method originated within the social sciences and is without a specific ontological base (Parse, 1996b). It is legitimate, therefore, to utilize a nursing model as a conceptual framework for guiding a research study. The researcher using a descriptive exploratory approach analyzes the data obtained for patterns and themes. Parse (1990b) wrote that

> the data-gathering questions arise from the objectives of the study, which evolve from the conceptual framework . . . the findings of descriptive exploratory research enhance nursing knowledge when conceptualized and interpreted in light of a nursing framework. (p. 11)

Table 4 provides a comparison of the phenomenological and descriptive methods.

Parse (personal communication, December 1995) provided further insight into the difference between phenomenological and descriptive studies. Parse explained that in phenomenological studies there is no interview guide. When an interview is used in phenomenological studies, the interviewer begins the interview with only an opening keeping the original research question(s) in mind (Parse et al., 1985). The present study employed the descriptive exploratory method of qualitative research.

Lived Experiences of Health

Parse's human becoming theory is designed to be used to study lived experiences of health. Therefore, it provides a broad, holistic definition of health. Parse (1987) wrote that "the nature of lived experiences are that they are common human experiences surfacing in the man-environment inter-relationship; and that they are health related experiences reflecting: being-becoming, value priorities, negentropic unfolding, and quality of life" (p. 174). Parse et al. (1985) described health as an "ongoing participation with the world . . . a unitary phenomenon that refers to man's becoming through creating rhythmical patterns of relating in open energy interchange with the environment" (p. 39). Cody and Mitchell (1992) wrote that "health in Parse's theory is the human being's way of living day-to-day according to personal meanings, priorities, hopes, and dreams" (p. 56). Health is nonstatic; it continuously changes as the individual discovers new ways of being and makes choices from available options (Parse, 1990b). Parse et al. (1985) wrote that health "is man's lived experience, a non-linear entity that cannot be qualified by terms such as good, bad, more or less. It is not man adapting or coping" (p. 9). Health arises out of the personal commitment that each person chooses as the person becomes the creative author of life (Cody & Mitchell, 1992).

Parse concurs with Newman (1994) in embracing a unitary pattern of health through a new concept entitled pattern of the whole (Newman, 1994, p. 10). Persons espousing the pattern of the whole paradigm have given up the notion that disease is something apart from the person it occupies. Disease, instead, is one part of the person's total pattern. The task becomes one of assessing the person's total being. Disease is a "manifestation of the evolving pattern of person-environment interaction" (Newman, p. 17). A disease which manifests itself is a manifestation of an underlying pattern. Newman (1997) wrote that "even negative events, like disease, are part of the process of expanded consciousness" (p. 22). Newman asserted that Prigogine's theory of dissipative structures provides supporting evidence for the idea of disease as an element leading towards expanded consciousness. Prigogine (1976) wrote that disruptive events disturb the orderly system fluctuations and lead to higher levels of organization.

An outward manifestation of a disease may represent inner stress. Recognition of this pattern of inner stress might inspire an energy shift towards new ways of interacting with the environment. Some event occurs that causes disorganization. Old ways of thinking are challenged, consciousness is expanded, and new ways of thinking suddenly emerge. This sudden change involves "the whole all at once" (Newman, 1994, p. 82). The primary pattern will eventually be manifested. Newman wrote that this perspective and Parse's simultaneity perspective are congruent. Parse (1990b) concurred with this view in the article "Health: A Personal Commitment."

No boundaries exist between humans and the environment; humans and the universe are all part of one pattern. Continuous with the universe, humans are part of an evolving pattern of the whole (Newman, 1994).

The present study sought to examine the health of the participants from this holistic perspective. The experience of hearing loss was examined within the context of the participants' broader life experiences, out of the belief that health cannot be conceived apart from life itself.

Summary

The literature review has described the various causes of hearing impairment and provided examples of how each of these types of hearing impairment can change the hearing abilities of the affected person. It was stated that participants in the present study were persons who had been diagnosed with presbycusis. The types of presbycusis and the potential effects of presbycusis on those having the condition have been described.

The effects of hearing impairment on certain aspects of the lives of those experiencing it were examined in the literature review. Physical effects reviewed include word discrimination, hearing handicap, and types of sounds lost at various levels of hearing loss. These levels of loss included (a) the primitive level, (b) the warning level, and (c) the symbolic level. Studies were also reviewed that discussed the relationship between hearing impairment and loneliness/self-esteem issues in individuals who experience hearing loss.

The difference between the totality and simultaneity paradigms as investigative approaches was discussed. The human science approach to research is derived from the simultaneity paradigm in which human beings are seen as "whole entities [consisting of] patterns" rather than parts (Parse, 1992, p. 35). This approach leads to a holistic research methodology that is appropriate when studying humans and how humans experience meaning through participation with the world. Human science as a subject oriented, abstract, philosophical, intuitive process was identified as the approach taken by Parse (1981) in development of the human becoming theory.

The supporting theories for the human becoming theory were discussed in this chapter, and examples of research studies that have utilized the human becoming theory were provided. Each of the studies was critiqued in relationship to Parse's recommendations. Differences between phenomenological and descriptive exploratory research methods were outlined.

Finally, the present study was identified as oriented to the human science approach, the human becoming theory, descriptive exploratory research methodology, and a holistic understanding of the concept of health.

The researcher cannot deny having preconceived ideas about the lived experiences of elderly hearing impaired women who live alone. Therefore, the researcher was aware of the need to be fully present to the participant during the interviews and later during data analysis so that the researcher interpreted the meaning of experiences from the participant's and not the researcher's point of view. The researcher cannot and should not deny, however, that a personal worldview was ever present throughout the research process (Parse, 1990a).

Limitations of the Study

The researcher is the primary research instrument. Therefore, the results depend greatly upon the investigator's (a) skill in interviewing the participants, (b) ability to appropriately analyze the data received (Wolcott, 1990), and (c) ability to overcome personal assumptions and truly grasp the meaning of the experience from the participant's point of view. The study probably overcame the latter limitation if final descriptions rang true for others when compared to the original data (Parse, 1990a). A small convenience sample was utilized. Generalization to a larger population was not appropriate.

Target Population

Women aged 65 or above who live alone comprised the target population. Further criteria that participants in the study met were the following:

1. Presbycusis, defined by a history of a "decline in hearing associated with various types of auditory system dysfunction that accompany aging and cannot be

accounted for by extraordinary ototraumatic, genetic, or pathological conditions" (Willott, 1991, pp. 2-3), was present upon audiologic examination.

2. An audiologic examination was conducted during the 8 months prior to selection of participants.

3. Mild (26-40 dB), moderate (41-55 dB), or severe (56-70 dB) hearing impairment was experienced by the participant as a result of presbycusis.

4. Participants had the ability to hear the researcher's responses as evidenced by appropriate conversational exchange between the researcher and the participant before the interview began.

Participant Selection

A convenience sample was utilized. The researcher negotiated a plan for recruiting volunteer participants through an audiologist in northwest Alabama who offered to contact potential participants by telephone. These potential participants had undergone audiometric examination by him not more than 8 months before the interviews and met other indicators previously outlined under Target Population.

The audiologist told the potential participants that

> A study is being conducted by Lavin Rowe, a doctoral student in nursing, on the experiences of women who have difficulty hearing. The researcher would like to talk to you about your experiences and obtain tape-recorded interviews. The types of topics that would be discussed in the interview would include
>
> 1. "Tell me about the most meaningful persons and events in your life--beginning with your childhood" (Newman, 1994, p. 147).

2. What it is like to not be able to hear well.

3. Any ways that your feelings toward yourself have changed since you noticed that you had a hearing loss.

4. How you have or have not tried to live as usual since your hearing impairment began.

5. Changes in your relationships with others since you became hard of hearing.

6. New ways of looking at things that have developed since your hearing loss began.

7. Changes that you have made in your life since the hearing loss began.

8. Your vision of the future.

Three interviews would be necessary. The interviews would last 60-90 min and be 6-10 days apart. The interviews could be done in your home or at another agreed upon location. The researcher may want to spend some of the interview time reading parts of a transcript from your earlier interviews and giving you the opportunity to determine whether the researcher interpreted correctly what was said. The researcher may want to ask additional questions that emerge as the interviews proceed.

The audiologist asked for the potential participant's consent to give her name and telephone number to the researcher. The audiologist then telephoned the researcher and provided the names and telephone numbers of those persons who agreed to participate. In the event that he was unable to provide enough participants, another audiologist had offered to serve as a backup source for participant recruitment.

Sample Size

The researcher's initial plan was to include a minimum of 6 participants. This number was subject to change as the study proceeded, however. The researcher interviewed participants until the information became redundant. The researcher sensed that data saturation had been reached when a pattern began to occur in the interviews (Parse, 1990a).

Researcher's Role

The researcher

1. Sought human use approval from the Institutional Review Board of The University of Alabama at Birmingham. An application for expedited status was filed as the research was of minimal risk to human subjects. The Institutional Review Board was supplied with the expected interview methodology and directional guidelines.
2. Provided a copy of the proposed research to the audiologist.
3. Sent a letter to the audiologist outlining our agreement and requested a confirmation of the plan.
4. Notified the audiologist by telephone when it was time to begin obtaining participants.
5. Telephoned the persons whose names were supplied by the audiologist as potential participants and arranged interviews.
6. Repeated the information provided to the participants by the audiologist.

7. Told the potential participant that it was necessary to have a quiet place to talk and that the researcher would either come to her home or meet her at a mutually agreeable place.

The address and directions to the place of the interview were obtained from the potential participant. The potential participant was then thanked for taking her time to talk with the researcher. If agreement was reached as to the time and place for an interview, this time and place were repeated before the conversation ended.

8. Prepared for the interviews by reviewing materials on performing semistructured interviews. The researcher also reviewed (a) information related to ways hearing impaired persons compensate for hearing loss and (b) methods of communicating with hearing impaired persons (Appendix A).

9. Made a list of personal biases and assumptions about hearing loss in older persons before conducting the first interview.

10. Obtained participants' written consent to perform the interviews. The researcher read the Consent Form to the participant or allowed the participant to read the form. The participant was given a copy of the form to sign and a copy to keep (Appendix B).

11. Helped participants complete the Participant Data Form (Appendix C).

12. Initiated and guided the interviews.

13. Made decisions during the interviews as to the necessity of obtaining a mental status examination.

The researcher was prepared to administer a Short Portable Mental Status Questionnaire (SPMSQ) (Pfeiffer, 1975) during any interview in which the researcher

Consent Form. The participant was required to sign the Consent Form (Appendix B). Participants were given a copy of the Consent Form to keep.

Participant Data Form

Once the Consent Form was signed, the researcher immediately began to ask the participant questions related to the Participant Data Form. The purpose of this form was to ensure that participants met the requirements for participation (Appendix C).

Instrumentation

The researcher was the primary research instrument for this qualitative, descriptive study. The researcher was in true presence with the participant as "the remembered, the now, and the not-yet surface all at once" (Parse, 1990a, p. 11). True presence was described by Parse as being a "unique way of 'becoming with' the participant" (Parse, 1992, p. 42).

Merriam (1988) wrote that the semistructured interview guide is appropriate when "certain information is desired from all respondents" (p. 74). The researcher developed and utilized a list of questions to help guide the interview but asked the questions in a random fashion at times when they fit naturally into the conversation. The researcher was not limited to but was guided by the planned interview questions. New questions emerged as the conversation evolved.

Data Collection Methods

Older women were asked to participate in tape recorded interviews in order that the researcher could come to better understand the experience of having hearing impairment from this human wholeness perspective. Patton (1980) wrote that interviewing enables the researcher to come to know the participant's perspective about things that the researcher cannot observe directly. The participant shared past and present feelings, thoughts, intentions, and meanings with the researcher.

The researcher conducted three interviews with each participant. The interviews were planned for approximately 6-10 days apart. Spacing the interviews 6-10 days apart was expected to allow the participant and researcher time to think about the past interview but not allow continuity between the interviews to be lost (Seidman, 1991). The researcher was aware that variations in spacing the interviews might become necessary in the event of scheduling conflicts. Seidman wrote that although variations in scheduling may be necessary, it is important to maintain the interview structure.

Interview 1

After Consent Forms were signed and Participant Data Forms were complete, participants were asked to make up a name by which they could be called during the interviews. Before questioning began during Interview 1, the researcher and participant first spent 2-3 min "centering." Participants were told to think about the most meaningful people and events in their lives--beginning with childhood. The researcher "centered self" through intentionally relaxing, focusing, connecting with a personal source of peace, and opening self in true presence to the participant as the participant reflected on the meaning the hearing loss has for her (Parse, 1990b; Smith, 1990).

Parse (1996c) wrote that as the researcher centers, it is important to think about "the values and beliefs of the human becoming theory in order to be with others without expectation and without distances or the desire for false cheerfulness" (p. 54). Centering helps the researcher to be truly present for another person through demonstration of unconditional regard for that person (Parse).

After these moments of silence, the researcher repeated the directional idea, saying: "Tell me about the most meaningful people and events in your life beginning with childhood." This directional idea served to situate the hearing loss into the participant's total life events, thus enabling the meaning of the hearing loss to be derived.

Seidman (1991) wrote that it is impossible to derive the meaning of an experience without exploring the context of the experience. Seidman thus encouraged researchers to explore the past lives of participants in order to understand the relationship of the present phenomenon to the assigned meanings. Gaining insight into a person's past may enable the researcher to understand the whole.

The tape recorder was turned on as participants began to relate meaningful life experiences. The interview then proceeded in a conversational manner with the interviewer responding according to the participant's responses. Additional and clarifying information was requested as the interview proceeded. Each interview was conducted using this conversational approach.

All first interviews lasted for 1½ hr, except for Participant 2, Azalee. There were many interruptions during this interview related to telephone calls and visitors dropping by. After an hour, the researcher decided that Azalee looked pale and tired and decided to stop the interview when yet another interruption occurred.

Interview 2

The interviewer began the interview by having participants sit quietly for 2 or 3 min and focus on the directional ideas pertaining to hearing loss. The researcher explored the present experience with the participant. These interview questions related to the human becoming theory principles.

Principle 1: "Structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging" (Parse, 1981, p. 42). Related directional ideas were

A. Tell me what it's like for you to not be able to hear well.

B. Tell me about your feelings toward yourself now as compared to when you could hear well.

Principle 2: "Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing, enabling-limiting, while connecting-separating" (Parse, 1981, p. 50).

A. How have you tried or not tried to live as usual since your hearing impairment began?

B. Compare your relationships with others now to how your relationships were before you became hard of hearing.

Principle 3: "Cotranscending with the possibles is powering unique ways of originating in the process of transforming" (Parse, 1981, p. 69).

A. What new insights have you had since your hearing loss began?

B. What changes have you made in your life because of your hearing loss?

C. Describe your vision of the future.

The researcher began Interview 2 with the following question: "What is it like for you not to be able to hear well?" Each of these interviews lasted 1½ hr.

Interview 3

The purpose of Interview 3 was to clarify information obtained during the previous interviews and to fill in the gaps where information was missing. The researcher reviewed information previously provided by transcribing the interview tapes between each interview. Contact Summary Forms (Appendix E) were then completed as the transcriptions were read. Information sought in Interview 3 was based upon information deemed missing or in need of clarification as the Contact Summary Forms were completed. The participants were guided to look at ways that past events might have impacted on present meanings and patterns of health. The researcher planned to again center the participant and then herself before beginning the interview. Ongoing data analysis resulted in the researcher asking new questions or asking the participant to describe a topic in more depth.

The researcher began each interview by turning the tape on and enabling the participant to share experiences by becoming an inspiring presence that encouraged the participant to reveal the meaning of the phenomenon of concern. The interview process may have provided the participant with new insights or ah-ha experiences as meanings became illuminated and transcendence beyond the moment was mobilized (Parse, 1992).

The researcher used open-ended statements such as "tell me more about that" as the dialogue proceeded. The researcher refocused the conversation as needed by saying, "Let's talk more about. . . ."

The researcher adapted the interview style and content to the individual participant as the researcher grasped both the nonverbal and verbal aspects of the conversation, processed data immediately, placed data in context of the situation, and clarified understandings as the study evolved (Guba & Lincoln, 1981).

Data Analysis Strategy

The analysis of data began as the tapes were transcribed. The researcher personally transcribed the tapes in order to become familiar with the data. Early data analysis allowed the researcher to shift the emphasis of the interviews as necessary in order to obtain the most relevant information possible (Marshall & Rossman, 1995).

The researcher began data analyzation by "dwelling with" the data. "Dwelling with" is a way of centering for the researcher. It is a contemplative abiding with the transcribed discussion that requires reading the transcribed interview and listening to the tape at the same time. This multisensory experience encourages the researcher to be attuned to such speech characteristics as voice tone, hesitation, and pauses, which may be revelatory of participant feelings. Words and phrases can be listened to multiple times in order that both verbal and nonverbal messages are heard. The researcher assessed for both rate of speech and voice tone. The anxious person may speak at a more rapid rate, while a manic person speaks in a pressured manner. A very loud voice may indicate that anger is present, while a very soft, passive voice may indicate depression (Antai-otong, 1995). However, it must be remembered that hearing impairment itself may account for an alteration in the voice volume. The person with a sensorineural loss such as presbycusis may speak in a very loud voice because she is unable to hear herself (Bates, 1991). Nevertheless, listening for voice tone, hesitations, silence, and pauses can assist the researcher to grasp both tacit and explicit meanings that the participant shares.

The researcher reviewed the research questions and objectives in the early stages of analysis, which helped the researcher to focus on the intent of the research as categories were formulated (Merriam, 1988). Merriam wrote that although the data obtained may be far afield from the original questions, the original intent of the research must be addressed in the final report of the study.

The researcher then wrote initial impressions about data from each interview on a Contact Summary Form (Appendix E). The Contact Summary Form was useful to the researcher in that it (a) helped the researcher plan the next interview, (b) enabled the researcher to envision new codes, and (c) served to reorient the researcher to previous interviews held with participants. This form was "a practical way to do first-run data reduction without losing any of the basic information to which it refers. The Contact Summary Form also captures thoughtful impressions and reflections" (Miles & Huberman, 1994, p. 52). The entire data bank was subjected to three methods of data analyzation:

1. Data were coded into one or more of 12 categories. A variety of codes existed under each category. These codes were derived from the data themselves as the researcher globally analyzed the data when transcribing tapes and reading the written interviews. In coding, the researcher assigned labels of meaning to phrases, sentences,

page of data were extracted and written down, (c) these extracts were dwelled with until themes began to emerge, and (d) themes were then collapsed and combined as continued transformations occurred. Specific data were retrieved from the data bank that demonstrated evidences of the identified life stages, health patterns, and themes. Themes derived from each participant were then related to the theory principles and research objectives. A cross-case analysis of the themes was conducted. The themes were then "transformed into a higher level of discourse in the move from the subjects' language to the language of the researcher" (Parse et al., 1985, p. 94). The researcher then constructed a unified description of the findings and formulated a hypothetical statement related to the study's original objective (Parse et al.).

3. The entire data bank was subjected to categorization according to the human becoming theory principles and structures. The researcher subjected the data to this review by placing related data in one of three columns, each column headed with a different concept relating to a human becoming theory principle or structure. Placing data into columns enabled the researcher to demonstrate how data did or did not reveal the presence of a human becoming theory principle or structure.

Protection of Data

All data remained confidential. At no time was the participant's name attached to the data. The participant was asked to choose a made-up name to be called during the interview. As data were transcribed from the tape recordings to hard copy, the participant's made-up name was transcribed along with the data. Tapes were erased after data were analyzed. The participant was made aware that data were utilized in the report of the study.

Trustworthiness Features

Patton (1990) discussed three elements that must be addressed by the qualitative researcher. These three elements include (a) "rigorous techniques and methods for gathering high-quality data that is carefully analyzed" (Patton, p. 461), (b) the researcher's experience and credibility, and (c) the need for the researcher to think holistically and to agree philosophically with qualitative research and its methodology.

The researcher utilized a rigorous technique for data collection through obtaining multiple interviews with each participant, each lasting 60-90 min (Merriam, 1988). Guba and Lincoln (1989) wrote that increasing the time with participants allows for rapport to develop between the researcher and the participant, thereby increasing the opportunities for data obtained to be accurate. It is believed that the researcher who stays in the field longer becomes more immersed in the participant's setting and more deeply understands the elements and context of the descriptions provided (Lincoln & Guba, 1986).

The second course of action that the researcher took to obtain credible findings was to engage the help of a disinterested peer. The peer reviewer had an important role in that she collaborated with the researcher on the findings in order to ensure that the researcher remained true to the data.

The third safeguard that the researcher took to ensure that analyzations were credible was to check various interpretations with selected participants. Evaluation credibility was thus enhanced as the participant was given this opportunity to agree or disagree that the researcher got it right (Merriam, 1988). Guba and Lincoln (1989) wrote that "if the evaluator wants to establish that multiple realities he or she presents are those that the stakeholders have provided, the most certain list is verifying those multiple constructions with those who provided them" (p. 239).

The researcher established an audit trail when analyzing the data by keeping a notebook of analytical insights and decisional activities (Guba & Lincoln, 1981). This notebook was in enough detail that any person desiring to judge the authenticity of the study could determine exactly how data were collected, how categories were determined, and what themes were derived. Goetz and LeCompte (1984) wrote that "other researchers can use the original report as an operating manual by which to replicate the study" (p. 216). However, Guba and Lincoln (1981) wrote that qualitative studies are difficult to replicate because the interviewer influences the outcome of the study through the verbal and nonverbal cues transmitted to the interviewee in conscious or unconscious ways. Patton (1990) further expounded upon the problem of replication of qualitative studies by writing that "there are no ways to perfectly replicate the researcher's analytical thought processes" (p. 372).

The researcher has studied qualitative research methodology for 2 years while taking doctoral level courses. Three qualitative research courses have been included in the student's curriculum. The researcher tested the model for the study in one nursing course.

The researcher is comfortable with qualitative methodology and highly interested in the rich, descriptive data obtained through the phenomenological process. The idea of holism fascinates this researcher, who has read books such as Health As Expanding Consciousness (Newman, 1994) and feels at one with this way of thinking.

Justifications for Methodological Decisions

The researcher specified that participants should have been tested audiometrically during the last 8 months in order that there be a clear and timely diagnosis of the cause of the hearing impairment. The audiologist who provided the audiometric examination was a licensed audiologist and worked under a physician's direction. This audiologist, who saw patients 5 days a week, felt that he could easily obtain a list of at least 15 patients who met the criteria of the study. The researcher expected that this method would produce a sufficient number of qualified participants as the audiologist already has a relationship with these hearing impaired women.

The audiologist who was the backup audiologist works 2 half-days per week and was less optimistic about numbers of potential participants. The researcher believed that this source would have less potential for producing a sufficient number of participants if utilized alone.

It was likely that persons who utilized the audiology service were from varying backgrounds and varying parts of the Shoals area of Alabama. This factor added to the richness of the study.

A small sample size was adequate for this study as the purpose was to obtain rich descriptions as to the meaning of this lived experience for this group of participants (Parse, 1990a).

CHAPTER 4

FINDINGS

The purpose of this chapter is to review (a) sample composition, (b) recruitment of participants, (c) participant descriptions, (d) data collection procedures, and (e) findings. Rich descriptions of people, places, and dialogue were incorporated into this summated account.

Sample

Sample Composition

Six women were included in this study. Two of the participants were between the ages of 65 and 74. Three were between 75 and 84 and one was above 85. Each woman met the criteria for inclusion in that she was (a) age 65 or above, (b) had undergone an audiometric examination not more than 8 months prior to the first interview, (c) was diagnosed with presbycusis, (d) was able to converse with the researcher in a quiet setting, and (e) lived alone.

Recruitment of Participants

The total number of potential participants contacted by the audiologist and whether any who had been contacted declined to participate in the study are unknown to the researcher. All persons referred to the researcher by the audiologist agreed during the telephone contact to meet with the researcher in person. Potential participants supplied the researcher with their addresses if they were to be interviewed in their homes. One participant chose to be interviewed in the researcher's office. Mutually agreeable times and meeting places were arranged during the initial telephone contact.

Participant Descriptions

Participant 1

Liz was an 84-year-old active woman who died from a sudden-onset heart problem 5 weeks after she was last interviewed. The researcher attended Liz's funeral.

Liz was small framed and had grayish hair that she wore up in a bun. Wisps of curls fell around her face. She wore large, behind-the-ear hearing aids and glasses.

Liz's house was made of redwood and was located in a historical area approximately 3 miles from town. The house sat in a park-like setting and was surrounded by trees and colorful flowers. The house was homey, well furnished, and slightly cluttered but clean. Many family pictures were present on the walls of the dark-paneled den. A gray cat lurked around the house.

Liz provided a nickname for herself by describing herself as a Go-Go. She stayed on the go throughout most of her life.

Participant 2

Azalee is a tall, gray haired, 82-year-old woman who lives in a gray brick house with pale green trim. The house is in a moderately priced neighborhood and is close to grocery stores, medical facilities, and shopping malls. The backyard of the house shows evidence of Azalee's interests in plants and design. A long, straight, boxwood-lined

An ankle cast was in place on the first visit but not on subsequent visits. Her legs were elevated on the footrest of the recliner where she sat.

Susie's house was made of stone and sat on a country road about 2 miles east of the small northwest Alabama town. A large yard surrounded the house and a big garden was planted on one side of the yard. Both the yard and the inside of the house were neat. This writer has given Susie the nickname The Worker because the work ethic she learned as a child has been demonstrated throughout the other stages of her life.

Participant 4

Margaret is 90 years old. She lives in a low-rent, high-rise housing development close to a downtown area. Her apartment consists of a living room, a bedroom, a kitchen, and a bathroom. The apartment is neat and clean and is decorated with early American furniture and a blue color scheme.

Margaret is a small person with short white hair. She dresses in pants and a neatly ironed blouse.

Margaret wears glasses and two new in-the-ear hearing aids. She regulates the hearing aids with a hand held control.

The writer has nicknamed Margaret The Survivor. Her life has been hard, but Margaret is proud of her accomplishments.

Participant 5

Frances is an 85-year-old woman who lives in a four-room brick house, which sits on a street near the downtown area. The paneling on the walls makes the house dark, but it is comfortably furnished. The color scheme in the living room is green, brown, and orange. A small white dog walks around the house.

Frances is a small white-haired woman. She wears glasses and two in-the-ear hearing aids.

The researcher has nicknamed Frances The Acceptor because as a child and adult she was always willing to move and because, as an elderly person, she is ready to accept life as it is.

Participant 6

Max was the youngest of the participants. At 67, she appeared physically fit, had short blond hair and pierced ears, and was dressed in a stylish manner. Max chose to come to the researcher's office to be interviewed rather than have the researcher come to her home.

Max wore glasses and two in-the-ear hearing aids. Max believes that her hearing may be getting worse. However, she was able to hear the researcher well during the interviews.

Max has been nicknamed The Warrior. She has had to fight to survive her whole life. This image is also demonstrated in her relationships with people.

Short Portable Mental Status Questionnaire

It was not necessary to use the Short Portable Mental Status Questionnaire with any participant as no evidences of mental deterioration were noted.

Data Collection Schedule

The planned data collection schedule consisted of conducting three interviews from 6-10 days apart. The actual data collection schedules are shown in Table 5.

Table 5

Interview Schedules by Participant

Participants	Time Between Interviews	
	Interviews 1 and 2	Interviews 2 and 3
1. Liz	7 days	7 days
2. Azalee	5 days	14 days
3. Susie	7 days	8 days
4. Margaret	6 days	8 days
5. Frances	7 days	10 days
6. Max	7 days	7 days

The schedule of interviews for Participant 2, Azalee, varied from the planned schedule for data collection. Only 5 days elapsed between the first and second interviews, while 14 days elapsed between the second and third interviews. There were several reasons for this varied schedule. These included the following: (a) Azalee could not wait until a later date to begin the interviews because of a scheduled trip to visit a sister, (b) the researcher's scheduled vacation plans, and (c) an upcoming medical examination Azalee had scheduled in Huntsville.

Variations In Interview Procedures

The researcher had planned to begin the third interview by centering both the participant and herself and then saying the following: "The purpose of this interview is to clarify some of the things I had questions about as I reviewed what you have already told me." This approach was taken with 4 of the participants but not with the other 2. Participant 4, Margaret, had been upset over a possible move at the last interview date; therefore, the researcher asked Margaret about that situation before centering her on the topic to be discussed. Participant 6, Max, was very upset at her adult children on the day of the last interview. Max talked about this situation for 45 min before the researcher re-directed the topic towards clarifying previous information and asking questions to help obtain information not previously obtained.

Data Analysis

The data were analyzed as described in Chapter 3. A listing of coding categories and group codes, along with code descriptions, can be found in Appendix F. The coded data provided a method to catalogue the data in order that they would be easily retrievable.

Findings

The overall purpose of this research was to describe the health patterns of older women with hearing impairment who live alone. These health patterns were demonstrated as the researcher described the following in relation to each participant: (a) life stages and related-health patterns, (b) themes related to life stages, (c) data related to the directional ideas or questions asked each participant, (d) themes derived from each participant's communications as those communications related to each research objective, and (e) the relationship of the participants' responses to the human becoming theory principles and theory structures. An analysis of the participants' speech characteristics and body language was also provided.

Life Stages and Related Health Patterns

Descriptions of the life stages and related health patterns of each participant follow. A summary of the health patterns identified for each participant may be found in Table 6. Supporting examples from the data are provided in tables following the descriptions of each participant.

Participant 1, Liz (The Go-Go)

The writer has selected four of Liz's health patterns or characteristics for review. These include Liz's patterns of (a) being a responsible person, (b) struggling with her self-concept, (c) vacillating between assertiveness and non-assertiveness, and (d) being a go-go. These four characteristics have been woven together in such a way as to describe Liz's pattern of being at every life stage.

Table 6

Health Patterns

Liz	Responsible, Pollyanna, Life is an Adventure, Assertiveness Versus Nonassertiveness, Compassion, Negative Self-Concept, Go-Go
Azalee	Responsible, Control, Involved, Leadership, Designer of Life, Positive Self-Concept, Creativity, Pride, Positive Outlook, Acceptance of Life
Susie	Responsible, Able (I Can), Determined, Self-Sacrifice, Hard Work, Assertiveness Versus Nonassertiveness, Family Closeness, Compassion
Margaret	Responsible, Self-Sacrifice, Independence Versus Dependence, Control, Hard Work, Connecting-Separating, Fluctuating Self-Concept
Frances	Trust, Life is an Adventure, Inclusion Versus Left Out, Negative Self-Concept, Assertiveness Versus Nonassertiveness, Self-Sacrifice, Acceptance
Max	Anger, Negative Self-Concept, Selling Herself, Outgoing, Grief/Sadness, Guilt, Modeling Self After Others, Perfectionistic, Caretaker, Control, Enabler, Independence, Determination, Responsible, Survival, Fighting, Struggling with Self-Esteem

Stage 1--Liz grew up in a close family where she was one of seven children. The family lived in a small town in rural Alabama. Liz described the family home as being one of the largest houses in town. On occasion, the family tried to help out those less fortunate than themselves.

In spite of World War II, Liz had many good times as a teenager and young adult and saw life as an adventure. She and her friends enjoyed attending church events and street dances and playing bridge and tennis. Liz stated that her parents could trust her not to do things behind their back, and she was assertive with her peers when they would try to influence her to do something she was not supposed to do. At other times, Liz was nonassertive in relation to her peers. Although Liz had many friends and loved to dress up and go out with them, her self-concept was that she was neither smart nor beautiful. Liz had a good family and many friends and was constantly on the go; nevertheless, she struggled to maintain a positive self-concept.

Stage 2--Liz did not marry the person that she always thought she would marry but instead married a chemist at the Tennessee Valley Authority (TVA). She did not work outside of the home after she married but, like her friends, spent her time playing bridge and going to church and church-related meetings. The couple had one daughter.

Liz described her deceased husband as a man who liked to be in control. She never knew the intricacies of the family finances nor was she allowed to work in the yard during her married life. Liz demonstrated both assertiveness and nonassertiveness in relation to her controlling husband. Liz demonstrated that she was a responsible person during this period of her life. She tried to make the best of things and put things in a positive light as she lived her life. At the same time she struggled with self-esteem issues related to not feeling like she was as smart as her husband or her friends.

Stage 3--Liz was not fully aware of her hearing loss until an anonymous person sent someone to her house unannounced to test her hearing. Once she realized that she was not hearing, Liz took responsibility for her hearing loss, bought hearing aids, and tried to adjust to them.

Liz demonstrated both assertiveness and responsible behavior when she consented to having the hearing examination, realized her hearing deficiency, and bought and wore hearing aids. She demonstrated nonassertiveness when she never asked who sent the person to test her. Liz struggled with a negative self-concept as she adjusted to having a hearing loss and learned ways to maintain her active lifestyle in spite of the decline in her hearing. Even at this stage of her own disability, Liz demonstrated compassion for others with hearing loss.

Stage 4--Liz's husband suffered a stroke and was placed in a nursing home. This was a period of go-go but only to the nursing home. Liz had to adjust to her new responsibilities, as well as to living alone.

Liz demonstrated responsible behavior when she cared for her husband in the nursing home and assumed more duties at home after her husband's stroke. She was both assertive and nonassertive with medical personnel in relation to his care and struggled with her self-esteem related to some of the decisions she made at that time.

Stage 5--Liz's husband died 6 years ago. At first she wondered how she would ever make it without him. Liz felt less than smart as she gradually learned to care for the stocks and bonds her husband had refused to teach her about even when she had asked to learn. Over a period of time, Liz found new freedoms, became more independent and responsible, and learned to be more assertive in relation to her hearing as she dealt with her business affairs. Liz began to enjoy her friends and activities again.

Liz continued to struggle with a negative self-concept, although she was successful in managing her life on her own. She resumed her go-go lifestyle; however, as her hearing loss continued to worsen, her range of activities decreased.

accepting responsibility, handling self-esteem/self-concept issues, and being a go-go. Liz desired to give up some of her responsibilities related to managing her financial affairs. She wished her daughter and son-in-law would assume some of the responsibility in this area. However, Liz related the following in relation to her daughter and son-in-law: "Mary and John, they won't do anything they don't want. They are never here except on Saturday." Liz stated that she and her friends had lived their lives "doing what was expected of us." It was frustrating for Liz at this stage of life not to be exactly clear about what was expected of her.

As Liz aged and her hearing loss increased, her self-esteem/self-concept was spiraling downward. On the topic of aging, she related: "And I said Mary, here we are old crazies--too old to be here to begin with and we shouldn't get wet."

Liz's pattern related to being a go-go was also beginning to change as she gradually gave up activities and chose to stay home more. She related: "I'm a person who likes to go, and um I know I don't need to go, I need to be here at home--[laughs]--so I just don't [put answering machine on] so no one can call me."

There is also evidence that Liz's pattern of assertiveness had changed since her husband died. Liz had to assume more responsibility for her financial affairs after that time. She related that in order to be sure that she was hearing correctly, she learned to tell people what they needed to do to make her hear. The upward spiraling that thus occurred related to assertiveness as Liz lived Stages 5 and 6 of her life demonstrated a "process of evolving to higher levels of consciousness" (Newman, 1994, p. 36).

Examples of data related to each of Liz's identified health patterns are provided in Table 7.

Table 7

Health Patterns--Liz

	Responsible	Struggle With Self-Concept	Assertiveness Versus Nonassertiveness	Go-Gos
Stage 1	"He told me, did you know they're having a street dance in _______, and I said well, I can't go, my mother won't let me go--he said why don't you spend the night with _____ and ____ and we can go, I said, No, I don't do that."	"No, I wasn't gorgeous, I was skinny . . . but I always had fat legs." "It was one of the biggest houses . . . largest houses in town."	"I thought well he's been over there changing records. . . that's no way you do at a dance . . . so I walked over there and asked why don't you dance with me?" "So _____ and _____ got too much to drink . . . . I never want to see you again if that's the kind of family you have. I don't want to see you . . . but of course I did."	"And we went to MYF"[a] "Go swimming." "Went to that dance." "When we went to Chicago to the World's Fair." "But in our families, we were the ones who were the go-gos."
Stage 2	"I knew what I could have, I knew that I could not overspend . . . but, why would I want to, his success is my success." "I had more responsibility when I got married, yeah, because the cooking, the buying, and everything was mine."	ist at TVA--and very, very intelligent, very private person. . . Everybody says he was a brain--well, I don't think he was much of a brain [laughs] but he was--when I met him he was--he had just finished his junior year in college and I met him."	"My husband, he had to make all the decisions . . . . some of the wives succumbed to it. I never did . . . . I just went on and did what I wanted to do." "I could see Sharon going to UNA[b] and I wanted to live near enough . . . but my husband and ____, and another friend bought this property and developed it . . ."	"And I would play bridge with this girl across the street, and then we'd go home just as hard as we could to fix dinner by 5 o'clock." "We played bridge, we went to Circle, went to Sunday School and church."

Table 7 (Continued)

	Responsible	Struggle With Self-Concept	Assertiveness Versus Nonassertiveness	Go-Gos
Stage 2 (Cont'd)		"I changed after I married because, uh, [pause], well, it was kinda nice here--when we came here, there were all young people and we had been in the depression, and the high tech people came to work for TVA and we got together and played bridge."		"And my husband would fish and then we would get together with a couple and play bridge at night."
Stage 3	A person who realized she could not hear sent a person to her home to make a hearing test and she let the test be made.	"For a long time I didn't do that--which was stupid on my part. I didn't know it was flashed up there [prices on cash register]."	"I just went on and did what I wanted to. He said we'll go over to the Independent Methodist Church . . . I said . . . I'm not going to join that church, you can if you want to but I'm not going to do it." "Three days before he had his stroke, a situation came up and I said, 'Frank, I think it's time you were telling me more about your business.' And he says, 'I don't want anybody to know anything about my business.'"	Got hearing aids; activities continued.

Table 7 (Continued)

	Responsible	Struggle With Self-Concept	Assertiveness Versus Nonassertiveness	Go-Gos
Stage 3 (Cont'd)			Concerning the person who arranged her first hearing test: "To this day, who did it, I don't know. They never told me. She never told me. I never asked."	
Stage 4	"They were real sweet to me at the nursing home. Of course, I stayed out there all the time. It becomes your life, but somehow you live through it." "Well, I had to do it, do you know? When he had that stroke and went into the nursing home, I had never stayed by myself in my life. I had to do it."	"Finally I let them put the tube in his side when they could no longer put the tube in his throat. I don't know why they even asked me to do that because they knew he couldn't get well."	"Dr. ___ did not talk to me about it. I was there everyday and sometimes would go back to catch him but--you know--he never did talk to me about it."	"And went to the nursing home. I would sleep--and then I'd get up early the next morning and go back out there and stay until--"
Stage 5	"I had to see about the car, I had to see about this and that and I just had it all to tend to."	"So I got all these [picks up ads from many investment companies] stock. I told someone that the only way I knew how the stock	"I have grown a lot--I'm more independent--uh, now my hearing loss was not, I don't believe, that bad 6 years ago but yes, well I had to do everything . . ."	"Say like we go to ___ ___ . . . , play bridge, go to Sunday School, out to eat with friends."

Table 7 (Continued)

	Responsible	Struggle With Self-Concept	Assertiveness Versus Nonassertiveness	Go-Gos
Stage 6 (Cont'd)		"You are handicapped." "When I wanted to play dolls, I was sitting there trying to play [bridge]--and I still can't play bridge."		

[a] MYF = Methodist Youth Fellowship
[b] UNA = University of North Alabama

Participant 2. Azalee (The Designer)

Two health patterns are explored related to Azalee. These patterns are (a) the pattern of pride and (b) the pattern of designer of life. These patterns can be demonstrated in Azalee's pattern of being at every life stage.

Stage 1--Azalee grew up in a family of 11 people. The family had a 14-room house on a farm in northwest Alabama. Azalee describes her growing up years as happy and states that the family had fun together. Her father had a good job that afforded the family many material advantages. The parents were leaders in the community, which helped to mold Azalee's self-concept. Although strict in disciplining the children, the parents disagreed on methods of discipline. Nevertheless, Azalee as an adult feels that the discipline in the home was "good." The children were expected to work around the farm and were given assignments to complete.

Azalee remembers feeling special as a child because she had an identical twin sister. She was close to all of her sisters but especially to her twin.

Azalee learned about plants and wild flowers from her parents, who took her into the woods to play. This childhood activity became a central influence over Azalee's later interests and activities in life.

Azalee felt pride and had high self-esteem in childhood related to her membership in a good and privileged family. Often, she and her siblings made their own fun: a precursor of her future pattern of designer of life.

Azalee finished college and began teaching school. She maintained strict discipline in her classroom, following the example her parents had set for her.

Stage 2--Azalee married a man who owned a flower shop and after 3 years of marriage quit teaching and traveled with him while he was in the Navy. When her husband's tour of duty was completed, the couple returned to northwest Alabama. Azalee's husband sold his flower shop and took a job at TVA. He never wanted her to return to teaching so she channeled her creative and cognitive energies into being the garden club president, learning about creative design, attending church, playing bridge, and involving herself with a variety of artistic pursuits. Azalee volunteered her time to decorate for special community events. She and her husband traveled extensively on vacations and often took Azalee's twin sister with them. The couple had no children but considered one of her husband's nephews to be their own. Azalee's attachment to her family of origin, especially her twin, remained strong, and Azalee continued to enjoy being with her siblings and her mother when she could.

Azalee designed a life for herself that rechanneled the creative energies formerly consumed by her job as a teacher. She took pride in her accomplishments and in having married well.

Stage 3--Eighteen years ago, Azalee was diagnosed with leukemia and treated with chemotherapy. Azalee followed the treatment regimens prescribed and responded well to treatment. She was later able to continue with her club activities and so forth and to travel with her husband. Azalee's attachment to her family of origin remained strong. There were both denial and recognition of her hearing loss during these years. Although diagnosed with leukemia, Azalee proudly relates that she redesigned her life in such a way that she could both take care of physical needs and also meet her need for creative activity.

Stage 4--Azalee's husband died at about the same time that she became unable to deny her hearing loss any longer. When she could no longer deny her hearing loss, she overcame her feelings of pride enough to buy and wear hearing aids and made a gradual adjustment to them.

Both Azalee's relationships and her activities began to be affected by the hearing loss. Her active involvement in life continued but in a changed way. After her husband died, Azalee chose to redesign her lifestyle in the direction of daytime--as opposed to nighttime--activities but maintained her participation in various clubs.

Stage 5--Azalee has experienced both a fall and bleeding ulcers within the last 2 months. She has been hospitalized several times and has been forced to let go of some of her club responsibilities. Presently, Azalee is trying to pass her knowledge on to younger members of the clubs to which she belongs. She states that at present, her health is more of a problem to her than her hearing loss. She relies more on a sick friend for emotional support than on her twin because her twin does not seem to have patience with either her hearing loss or her leukemia.

Azalee realizes that she likes to stay home more now than she did in the past. She relates the change of pace to being older, rather than to her hearing loss. She stated that she enjoys "peace and quiet." Azalee continues to be involved in her club activities when she is able and loves to go out to eat with friends. She attends church when she can. She is not driving her car at present but plans to return to this activity soon.

There is no evidence to demonstrate that Azalee's lifelong pattern as a designer of life is changing. However, there is some evidence to indicate that Azalee's designs are taking on new dimensions. As Azalee's health declines, she is redesigning her relationship with younger club members by placing herself in a teaching role. Azalee stated: "I'm trying to teach them a lot of things 'cause I'm going to be through one of these days and I can't keep going on."

Azalee has been a proud person all of her life. However, there is some evidence that she is beginning to let go of her pride related to the issue of wearing hearing aids. While not able to completely abandon her pride related to wearing a hearing aid, she is becoming more creative in maintaining her dignity while wearing the hearing aid. She is also becoming more accepting and less prideful as she evaluates her hearing in relation to friends who refuse to buy needed hearing aids.

Data related to Azalee's health patterns of pride and designer of life are provided in Table 8.

Table 8

Health Patterns--Azalee

	Pride	Designer of Life
Stage 1	"My daddy bought us the first station wagon anybody had--it was a Chrysler."	"We used to go hickory nut hunting and muscadine and my daddy and mother'd go up with us . . ."
	"We had a big house--our house had 14 rooms."	"We learned to pick cotton and make sassafras tea and pick mushrooms and all those good things."
	"He had a hundred men that worked for him."	
Stage 2	"So we sold our half to him [flower shop] and my husband went with TVA, which was the best thing he ever did in his life--did pretty good--got a good retirement."	"They asked me to join the garden club and I was just scared to death . . . . I said I'll be President if you federate."

Table 8 (Continued)

	Pride	Designer of Life
Stage 2 (Cont'd)	"I happened to think well if I did this and put the fountain there, give him part of what he wanted and then put my wild flower garden over here--so we decided well, it would work--I'd have what I wanted, and he'd have what he wanted."	"He got me stopped teaching and he never would let me start again--so I took flower arranging and got in the garden club and I did a lot of volunteer work." "One of my sisters had a beautiful garden with a brick wall all the way around it . . . and we decided to have an art show in her garden one time and so we had seven of us, we put mother's things in too."
Stage 3	"And we wanted to see everything and we traveled the whole United States . . . and stayed in $100.00 motels . . . . my husband'd work hard and we'd go on vacation and he'd act like he's rich."	"Oh, I've had leukemia 18 years . . . At first, I did everything I wanted to do. I worked in the garden and I did everything.
Stage 4	"I have my hair cut short now and it's usually down and they don't ever see those things [hearing aids]." "We never could talk to each other in church 'cause she couldn't hear any better than I can and she never would get help . . . I just remembered she asked more times than I did, what everybody was saying."	"I think about him a lot of times, especially when I'm in the garden." "Twin would get so aggravated with me, that's the reason I got hearing aids in the first place."
Stage 5	"Well, I guess I'm so proud. I feel like people, you know, are seeing me, however, a lot of people in our church won't buy one and can't hear nearly as good as I can." "He [husband] cautioned me on a lot of things to do--insurance and everything--he said don't change nothing 'cause I've got it fixed the best way for you."	"I don't usually wear but one." "I just wear them when I want to."

Participant 3. Susie (The Worker)

The writer has selected three of Susie's health patterns for review. These patterns are (a) hard work, (b) thinking "I can," and (c) assertiveness versus nonassertiveness.

These three patterns have been interlaced in a way that describes these aspects of Susie's pattern of becoming at each life stage.

Stage 1--Susie grew up in a large, poor family and spent her childhood working hard on the family farm. Susie described her parents as good people who were hard workers. The family was close and not only worked together but also played together. Susie was taken to church and sent to school. She learned to value hard work, family, gardening, and food. One of her teachers taught her that she could do anything if she was determined to do it. Although Susie completed high school, she related that one disadvantage of her upbringing was that she had no time to study because of doing chores.

Susie was nonassertive as a child in that she did not request that her parents reduce her duties on the family farm in order that she would have time to do her homework. At the same time, the "I can" principle and the dedication to hard work Susie learned as a child would go with her through life.

Stage 2--Susie married and worked in the telephone office until she had her second child. She chose to stay home with her children for the next 16 years. Susie tried to make sure that her children did well in school. Some of Susie's time was spent caring for her mother's yard and home after her mother became ill with cancer. Susie always had a garden in the summer and canned the food she produced. After the children were older, Susie worked in the school cafeteria.

The new hearing aids proved to be helpful, but they were also disappointing in that the tubing became easily occluded by cerumen.

Susie followed her son's advice about where to buy new hearing aids rather than rely upon her personal preference. Although she was not assertive about where she went to buy the hearing aids, she was assertive with the audiologist when the hearing aids needed adjusting. Susie maintained her pattern of hard work as she resumed her job and other usual activities after her husband died.

Stage 5--After working in the school cafeteria for 15 years and 2 months, Susie retired. Overall, she is very positive about her life accomplishments. These accomplishments include having a good retirement and having two children and several grandchildren of whom she is proud.

Susie attends church regularly and participates in the community's senior citizens' activities. She has traveled with her sisters some on senior citizens' trips and hopes to visit her daughter in Nashville soon. Susie related that she could drive to Nashville; however, after considering that idea for a minute she stated that she probably would not.

Susie continues to enjoy working in her garden and yard. She takes food to people who are sick in the community. Susie stated that she sees church attendance and caring for others as her Christian duties and that she places her hopes in the Lord when personal problems arise.

Susie continues with her usual activities in spite of the fact that she becomes embarrassed and aggravated when she cannot hear. She can hear better in some situations than in others. Susie admits to isolating herself from her family at times.

Table 9

Health Patterns--Susie

	Hard Work	"I Can"	Assertiveness Versus Nonassertiveness
Stage 1	"But we knowed we had to work and knowed what our job was."	"And you know we'd say we can't do this and we can't do that, and she said we're going to write down can't and we're going to go outside and we're going to bury that can't and you can't say it because it's buried."	"You know our daddy and others, we had to do what they said--cause they worked and we had to work."
Stage 2	"Yes, after 16 years I went to the school out here and worked 15 years and 2 months--school cafeteria. Hard work"	"I'd go out and mow her grass, and clean her house, or anything she hadn't done and take her to the store or to the doctor or both of 'um you know -- and stuff like 'at, 'onest a week and I'd stay all day."	"I seen my kids got their grades at school, and kept their clothes--I made a lot of their clothes, their shirts." "Course I had to go see the teacher one time he was--his grades had come down . . . she wanted him to put the answer right under the question; he was just puttin' it anywhere--so that got him straightened out--cause he knowed he'd get a whippin' if he didn't get it . . . his work right."
Stage 3	"He got on that machine there at the last, I had to operate that thing. I had to fix that, he was on that machine and I had to get it and put it on the machine and put it	"And I mean I just had to jerk that out all at once--it was about to get him you know." "He says, you can't hear me, you need to go get you some hearing aids--	"Yes, sir, I didn't know whether I'ze a gonna get it out right or not but I--lordy mercy--but I got it out."

Table 9 (Continued)

	Hard Work	"I Can"	Assertiveness Versus Nonassertiveness
Stage 3 (Cont'd)	where it'd go you know --in him."	he'd tell me that for a week or two I guess before I got 'um"	"Well, it'd just aggravate him 'cause I couldn't hear him, that's the reason he wanted me to go get hearing aids . . . he didn't want to repeat it 'cause he said he didn't feel good."
Stage 4	"I taken a leave--and after he died--well, I went back."	"We went to workshops . . . we learned about food . . . you learned stuff you need to know about food and stuff where you have to serve it at school."	"Dan said--he said I ought to go to the doctor. Dan said you know, it might be better, but I don't think it's no better see I just come an inch of going to Miracle Ear."
Stage 5	"You know shoot, I stay busy doing things, I'm not the type person that can just sit down." "Have to keep that you know, cleaned out [hearing aid tubing]." "It [hearing aid] needs cleaning--that 'un does--I have a brush and I do it." "But I can clean 'um with this here. He told me, you know, get this kinda brush [tooth brush]."	"You can do anything if you make up your mind to do it." "I could drive to Nashville." "Well I carry a battery in my purse." "Everybody has something they have to get used to."	"In everybody else's house when they have it [T.V.] turned down and I wouldn't ask 'um to turn it up." "If somebody was in the house, you know with you well I'd ask over [to repeat things], but it's embarrassing to you know, ask over anybody."

enjoyed popping corn. Margaret remained on the family farm until she married at age 25.

Margaret grew up feeling that she was from a good but poor family. These feelings about her family influenced her self-concept in each life stage. Margaret was dependent on her family for support during this period of her life, and the family was dependent upon her help on the farm. Margaret's interdependence with the family influenced her to quit school after completing the 10th grade.

Stage 2--Margaret and her husband enjoyed a good marriage. She said that they were able to do what they wanted to do. They had three children. They owned a country store for about 10 years, and Margaret worked in the store while she kept her children and her husband worked for an oil company. When the family first began to run the store, they lived in a room behind the store, but later they built a house in back of the store.

Margaret's husband was transferred to another town and the family moved there; however, after 1 year, her husband was again transferred. After two additional moves within a short period of time, the family settled down again.

Margaret and her husband's lifestyle of fidelity and choice not to drink alcohol separated them from his family of origin. Margaret demonstrated having both a positive self-concept and independence as she cared for her three children while managing a country store.

Stage 3--Margaret's husband was diagnosed with a malignant brain tumor. The onset of her husband's illness began a difficult time in Margaret's life. She spent the next 3 years caring for him and going out of town with him when he needed hospitalization.

Margaret demonstrated independence as she went and stayed with her husband for periods of time when he would be hospitalized out of town; however, she felt alone as she did what was necessary and would have liked to have someone on whom to lean.

Stage 4--Margaret's husband died when he was 49 years old. At that time, their son was 13 years old and in the sixth grade. Margaret did everything she could to support herself and her son financially--she baby-sat, made dolls, and sold baked goods. Margaret's husband's family never came around her or helped her after her husband died; however, one man in the community would bring her meat. Margaret used her savings to send her son to college. Fifteen or 16 years ago, Margaret sold her home and moved into a basement apartment in her daughter's house. She lived there 5 or 6 years until her daughter's son needed the apartment and Margaret decided she'd rather live on her own.

Margaret was forced to demonstrate independence after her husband's death as she struggled to provide for herself and her son. Margaret's self-concept/self-esteem was bolstered as she managed her life and later realized the accomplishment of sending her son through college.

Stage 5--Twelve years ago Margaret moved into a low-rent high-rise apartment building but continued to be close to her family. She made friends with another woman resident, and they would go to town and cook together.

Margaret busied herself cooking, cleaning, and quilting. She attended gatherings downstairs during the day. Margaret bought two sets of hearing aids that did not help her. She became unable to hear in church or when attending social functions. As friends in her building died and her hearing loss worsened, she began to stay alone more and

Margaret's self-concept is presently a major factor in her choice of living accommodations. She is unhappy now living in her apartment building. She does not believe that the people moving in the apartment building are well screened. At the same time, Margaret is very upset because her family is encouraging her to move into an assisted living facility. Margaret states that the residents there have not had to work in life like she has and states that she would be very unhappy not having her own kitchen. She says she has told her children that she will not move there.

Margaret struggles to maintain at least partial independence as her hearing loss increases and her health declines. Her hearing loss and declining abilities have led her in the direction of a decreased self-esteem/self-concept. Margaret expresses many negative feelings related to herself around the issue of not being able to hear. However, there is evidence that her self-concept has been somewhat bolstered in the last few months related to buying new hearing aids with which she can hear better. Margaret feels more willing to be around others, go to church, and engage in activities since she can hear better.

The greatest positive factors in Margaret's self-concept center around the fact that she not only survived after her husband died but saw her son graduate from college in spite of the comment by her husband's family when her husband died that her son "would never get another day of schooling in his life." Margaret's self-concept issues are central to her way of relating to life and to her determination to maintain control and have as much independence as possible.

Examples of data obtained related to Margaret's health patterns of (a) self-concept and (b) independence/dependence are provided in Table 10.

Table 10

Health Patterns--Margaret

	Self-Concept	Independence Versus Dependence
Stage 1	"Just had to [quit school] we was poor people. We had to work." "Well, they were good--you know we lived in the country and they gave us everything they could--and they was just good to us and my dad and mama was good, and they didn't drink or cuss and carry on and we just had a good home."	"See they started crops and we didn't have no way to go to school--we walked." "No, not many . . . didn't care about 'um. No, we all got together and had a good time but we didn't just have one boy friend." "I done most of the cooking 'cause Mama was getting old."
Stage 2	"They didn't like me. I didn't let 'um boss me [husband's family]." "Anyway, they didn't live like I lived. His brother and daddy drank, his daddy run around and we didn't do stuff like that."	"He worked at the oil company. I did the store." "He got his youngest brother to help at the store, and then he got a sister to help up there sometimes after his brother quit so I've done everything!" "His daddy had a grocery store." "We moved into his daddy's old house."
Stage 3	"It was rough--way back then, you know he had to stay in the hospital in _____ ."	"When my husband was sick I had to go to _____ with him." "I was staying there by myself. Nobody, none of his people was there or nothing."

Table 10 (Continued)

	Self-Concept	Independence Versus Dependence
Stage 4	"I didn't have much and I just worked. I baby-sat and made dolls, and sold 'um-- and done everything I could to make it you know."	"Daddy said he might ask me, I said you tell him he better not ask me [for a date] 'cause he does he'll be sorry. I didn't have no more trouble with him."
	"Well, his people [husband's] told some of 'um that I wouldn't send Travis to school another day but he went to high school and graduated and then he went to college."	"I had somebody to look out for me--I had a friend in Redrock for awhile, he'd send us meat."
	"I had some savings and I took that and sent him to college."	"I was close to them, but they weren't to me, I didn't let them boss me."
Stage 5	"I worked all my life . . . . I have to have something to do."	"I'll just get me an apartment--I'd rather be by myself anyhow. I lived in their house 4 or 5 years and I just decided I'd rather be by myself."
Stage 6	"I don't spend my money for foolishness."	"I said no, I clean up myself. I have a vacuum cleaner, I'll just run it--so I did."
	"Just sit there and look like a dummy."	"No, they ain't gonna make me move."
		"I said no, I'm not going to take your money."
		"If you're by yourself, you can hear better."

Participant 5, Frances (The Acceptor)

Among the health patterns Frances demonstrated were those of (a) acceptance and (b) trust. These patterns help describe the way Frances has chosen to relate to the world at every stage of life and are revealed in the various life stages as summarized below:

Stage 1--Frances spent her childhood moving. She stated that her father always had a good job but that he would want to move on to something else after 1 or 2 years. As a child, Frances saw the moves as big adventures, enjoyed making new friends, and did not mind leaving the old ones behind. She accepted the constant moves of her family during her childhood as a normal way of life. Frances relates that these moves provided her with a liberal education. She was especially close to her parents, an aunt, and one grandmother during these years and relied on and trusted them. Frances worked at TVA before her marriage.

Stage 2--Frances was ready to settle down after she married and was disappointed when her husband began to receive job transfers. However, she accepted her situation as she found new adventures through these experiences. Also, Frances was able to help her husband accept this kind of life since she had moved all of her life and thought of it as normal. Frances was sick for a period of time during this stage of her life, and she expresses feelings of gratitude towards the perfect strangers who helped her. She relied on her mother and on community people to help her when she became ill. This experience taught her that "people are good wherever you go."

Frances and her husband gave love to and received love from various pets during this time. They never had any children and believed that they should not try to adopt since they were always unsettled. She filled her life with volunteer work, making 60-100 visits per week for the church. She began experiencing a ringing in her ears during these years but did not realize that she was losing her hearing.

Stage 3--Frances's husband retired in 1968, and the couple moved back to the town where her husband had grown up. The couple built the only home that they ever owned. Frances had cataract surgery that same year. She believes that her husband spoke to her more loudly during these years but states that they never talked about or realized that she was hard of hearing. She believes that her husband probably just naturally raised his voice to her to enable her to hear; thus, the couple accepted the hearing loss in an unconscious way.

The couple experienced a settled period of about 7 years past his retirement until her husband developed cancer of the lung and died soon after, in 1975. Frances relied on a hospital chaplain to help her through this period of time.

Stage 4--Frances continued living in her home after her husband died. Two or 3 years later, she began to travel overseas with friends. While on one of those trips, she became conscious of her hearing loss. On subsequent trips, she depended on her traveling companions to be her ears. At the same time, her activities and relationships were more and more affected by the hearing loss, and she began to replace her former activities with others in which she could participate more easily. Frances had her ears tested at this time but was told that hearing aids would not help her. She believed it when the professionals told her that she could not wear hearing aids and, for a long period of time, accepted it as fact.

Stage 5--Frances gave up traveling after 1990 due to (a) increasing airline hijacks, (b) lack of money, and (c) increased health problems. Since that time, she has suffered from several fractures and an automobile accident and has had two eye surgeries. She now states: "It's time to stay home now--home's a pretty good place" and seems at peace in this decision.

Frances went to a new audiologist 2 years ago and hearing aids were prescribed. She regrets the years she needed hearing aids and did not have them. The hearing aids have helped her but do not entirely correct the problem. She tries to stay away from situations where she knows she will not be able to hear. Frances is thankful for each new day, tries to put her trust in God, and states that she does not think about the future. At the same time, Frances states she looks forward to death and sees death as a time that she will be with her husband again. She is beginning to feel burdened by maintaining her home and thinks about her limited options. Frances drives some but opts to ride with others when she can. She gains love from and gives love to her dog.

Frances's hearing and her health have declined. She has begun to rely even more heavily on her friends to compensate for her hearing loss, as well as for transportation.

Frances's patterns of acceptance and trust appear to be becoming stronger as she relies more and more on others to help her hear and to assist her with her mobility. Frances's past experiences with strong support systems have only increased her confidence in the belief that others will be there to help her when she needs them.

Examples of data related to Frances' patterns of (a) acceptance and (b) trust are provided in Table 11.

Table 11

Health Patterns--Frances

	Acceptance	Trust
Stage 1	"No, I don't think there was anything hard about it--it's just something that happened--there's things that come along, part of life."	"You mean besides my parents? They were the most important people in my life besides my husband. Well, my aunt was very important to me. I stayed with her in the summer, she taught me a lot--she helped raise me--she was part of my close family."
Stage 2	"So we found this little house in Andersonville--it wasn't even sealed--you could see from the living room to the bathroom . . . But we just loved it there, we'd have more fun--Andy'd go fishing, he'd come home with a basket full of fish."	Telling about becoming ill after moving to a new town: "All the people there took turns to come in to wait on me. They didn't know me from Adam's house cat but they came in taking turns keeping the fire going and bringing me food . . . people are so good!"
Stage 3	"I moved a lot as a child and I never had a home of my own until I was 65 years old--of my very own."	"They had a chaplain, a colored man, and he was so wonderful. People are nice wherever you go--if you love somebody--they'll love you back."
Stage 4	"You just learn to live with it."	"I traveled with Sarah and Silas, so whenever we got in a crowd or anything one of them was always there with me. I was always with them and they were always with me."
Stage 5	"He's been gone 20 years. It doesn't seem that long. It seems like he's been away a long time and yet it seems like it's just yesterday."	"I was saying this morning, I can't walk up a curb--and there wasn't one [person] in sight, but this man came around the corner, I say, hey you! He looked at me like he thought what's the matter? I said I--would you be so kind as to help me up the curb--he came running as fast as he could run--people are always nice like that."

Max spent her childhood trying to find love and acceptance from her family, as well as from outsiders. Although Max was popular and smart, she had low-self esteem. Max suffered from the loss of her brother and became angry at her mother's inability to adjust to his death.

Stage 2--Max married young and was married for over 30 years. She and her husband settled down in the small town where they had gone to high school. Max had three children who lived and one who died. Max's mother died when Max was 25.

Her husband's parents became ill and lived with Max and her husband for 15 to 20 years. Max and her husband both worked several jobs at once in order to support not only their own family but also the in-laws.

Max's father died when she was 40. Her in-laws also died about this time. Max relates that, while things did not always go smoothly having the in-laws living in the house, her mother-in-law provided her with a different example of motherhood than she had known previously.

Max worked as a secretary and bookkeeper during her working years. She believes that her hearing loss began when she worked in a noisy plant environment. Max states that at first she tried to ignore her hearing loss. However, she did have her ears tested and was told that hearing aids would not help her. As Max began to experience more difficulties hearing on the telephone, special accommodations were made for her at work.

After Max married, her anger at her mother continued. She found a new role model of strength in her mother-in-law. As Max and her husband struggled to control their finances while supporting his parents, as well as their own family, Max continued

The marriage brought grief, lowered self-esteem, and anger. Max was unable to establish a good relationship with her stepdaughters. When she recognized that she could not control this situation, she divorced and moved back to Alabama.

Stage 6--Max has built another new home after divorcing 2 years ago. Her health is good, and she is independent and involved in activities. She is presently seeing her ex-husband again, and both her children and his are upset over the continued relationship.

Max's relationship with her children is strained. She resents her children trying to parent her and desires to develop an adult-adult relationship with them.

Max feels that her children impinge upon her personal space. She related that she becomes very nervous and angry when everyone crowds in on her and proceeds to talk incessantly, using soft voices that she cannot hear.

Max describes herself as a perfectionist. She is at present trying to decrease her compulsion to maintain a perfect body, home, and yard.

Max has a lot of anger surrounding the issue of her children's trying to be in control of her life. She continues to grieve over prior losses and suffers from low self-esteem related to life circumstances, aging issues, and her hearing difficulties. Max believes that her hearing is getting worse.

Examples of data related to Max's patterns of (a) grief, (b) control, (c) anger, and (d) self-esteem are provided in Table 12.

It is interesting to note that neither Azalee nor Susie described great changes in feelings toward themselves. The researcher's opinion is that these two participants have much better hearing than the other participants. This may partially explain why the feelings these participants had about themselves had not changed as much as they had in

Table 12

Health Patterns--Max

	Grief	Control	Anger	Low Self-Esteem
Stage 1	"I have had lots of losses in my life as far as people that I loved dying when I was very young, starting with my brother--and I was 15 and I idolized him and then my grandmother when I was 16."	"So I said to myself, 'I'll not be weak like that.'" "My dad used to say to me, 'Don't do this, you're being too independent--and it can be harmful to you,' I said yes but I have to be, I have to take care of what I'm supposed to take care of."	"And she determined from that time on that she would never be happy again--so she set up a self-destructive lifestyle and destruct she did [looks angry]. I viewed it as a weakness."	"Moving made me stronger in a lot of ways but also made me feel inferior--like I didn't belong."
Stage 2	"And my mother [died] when I was in my 20s, and then my daddy when I was 40, and then my mother-in-law and daddy-in-law; so I lived with them as much as I lived with my own parents plus a child [died]." "I was well aware that this [hearing loss] started at this particular time and got progressively worse."	"My youngest daughter was a cheerleader, precious--cute--they called me up and said they were going to go to Cherokee at night--little bitty people, and I said, 'Just a moment, please, my daughter's not old enough to be going to cheer for public games at night.'"	"So finally I told my husband, I said it's time to stop this, I said either you learn to be quiet and give your daddy some space or you get out of this business relationship or I'm leaving because I'm not going to be in this kind of turmoil, it's not worth it."	"And, of course, I was probably a very strict parent but they all seemed to have survived it at any rate in this chaotic world." Talking about her granddaughter being a cheerleader and her own unwillingness to let own daughter sell things to support cheerleaders: "They'll survive if my daughter won't try to straighten them out. And the reason I know this is

Table 12 (Continued)

	Grief	Control	Anger	Low Self-Esteem
Stage 2 (Cont'd)				because I've been guilty of trying to do the same thing--and you can't do it."
Stage 3	"And then the sad thing that happened to me--my husband developed cancer and died when he was 50." "I'm stretched out across the bed, in the middle of the bed just waiting [voice breaks, tears flow] for him to tell me what to do."	"We chose the Estrogen route and the doctor said that he had never seen a knife do any better than what the Estrogen did."	Max's comments of reflection on her husband's death did not reveal anger during this life stage.	"I read the autopsy, I called him and talked to him. I feel like I've committed murder, that night I said to myself, please, not tonight, I can't, I don't have the strength."
Stage 4	"And I immediately jumped into this work program for survival, and I'm sure I made a bunch of mistakes, but it was survival."	"I needed to work--I needed the money, I needed my sanity so I just tried to put these things in the right perspective." "I learned to do that enough to cope."	"I said but you told me it was in his liver and his autopsy says nothing about cancer in the liver--his remark was well, the liver's real large and they may not have biopsied that part of it. I don't believe that to this day, and it wouldn't have changed anything but maybe I could have forced the issue of going to Birmingham."	"I devastated the whole family when I sold the family home." "And it was making me feel inadequate mentally because I would have to wait for these sounds to go through."

Table 12 (Continued)

	Grief	Control	Anger	Low Self-Esteem
Stage 4 (Cont'd)	"All the family suffered a great loss 'cause he was a neat individual, uh, real good father, good daddy, good husband--but you just carry on I guess." "Yes, they were girls. And I said I could have had six males for stepchildren and it wouldn't have been a problem, but when you draw girls--they just won't let daddy go--he could not stand ground for me."	I've got to make some life changes." "When my husband died, I just didn't think I'd ever make it, but then I looked around at some of the other people and they made it and I determined myself that I could cope."	"I said, 'Golly, I'm dead with old age. I'm going on 60 years old,' and you said I'm going to have to block it all out."	"I told them I was their handicap."
Stage 5	"And I told him, I said, 'There's no way that they could ever, ever like me. No way, I mean if I've given them 10 years, and it's still as bad as it was from day one--it'll never change.'"	"I just sat down and I wrote him a long letter and I told him what hurt me so bad and what I expected, and that I fully realized that he was not capable of even trying--and I told him you'll always have my love and you'll always have my heart but I cannot live like a roller coaster and somebody pulling my strings for the rest of my life."	"And I met this man and married him, and adult children got to us, and that went by the board" [looks angry and voice shakes].	"I'm handicapped."

Table 12 (Continued)

	Grief	Control	Anger	Low Self-Esteem
Stage 6	"And sometimes we try to fix our pain, Lord we make it worse. And then, but again, we have to get deep into pain to get things to work out. But anyway, life is just full of things."	Well, it's not hidden--it's just--uh--he [ex-husband] comes to my house because I could not allow my family to have that much control over me." "Just need for them to know that whatever decision I make it is my decision and I have the right and I will pay a price for whatever decision." "But I'm in charge of me. I guess I make work for myself as a way to stay in control." "I have been practicing more protection than I have been getting out in the firing line."	"My children think they know what I should do about a thing." "Occasionally, I'll ask for an opinion, but what I get is a dissertation of advice on how to live and--I've got one that'll call me up and tell me what I need to do and what not to [voice resentful] and I say now wait just a minute--you have no right to tell me." "But they do not have the right to come to my house and tell me these things--they just don't." "They don't understand enough to know how this hearing loss affects a person."	"As I reflect on it, I'm probably guilty of being a part of the downgrade [of society] [tears up, sniffles]." "I guess I think my generation didn't do such a hot job because we raised these groups of people who think they ought to have everything that Mama and Daddy had at 65, at 35." "And I don't know--but I would just like to be treated like everybody else and that's hard to do since I'm not like everybody else in the fact of this particular sense."

the other participants. Azalee has had less change in feelings about herself than any other participant. The researcher relates this finding not only to her not being as hard of hearing as some of the other participants but also to her lifetime pattern of having a higher self-esteem.

Hearing loss in general caused these participants much suffering and inconvenience. There are many situations in which participants are unable to hear as they did earlier in life. Many sounds are lost. The participants experience these lost sounds in their own way and react to the consequences as individuals in accordance with their own life history.

Methodology of Theme Derivation

A theme, as defined by Lukens (1982), is "the idea that holds the story together, such as a comment about either society, human nature, or the human condition" (p. 101). A theme goes beyond the action and reveals the meaning behind the words (Huck, Hepler, & Hickman, 1987). The life stories of individuals, then, can similarly be expected to manifest themes by which life meaning is revealed.

For purposes of this study, life themes and themes related to hearing loss were first analyzed independently of one another. Life themes and hearing loss themes were later unified through creation of a hypothetical statement that described the life and health patterns of older women with hearing impairment. Figure 2 illustrates the process of theme analyzation.

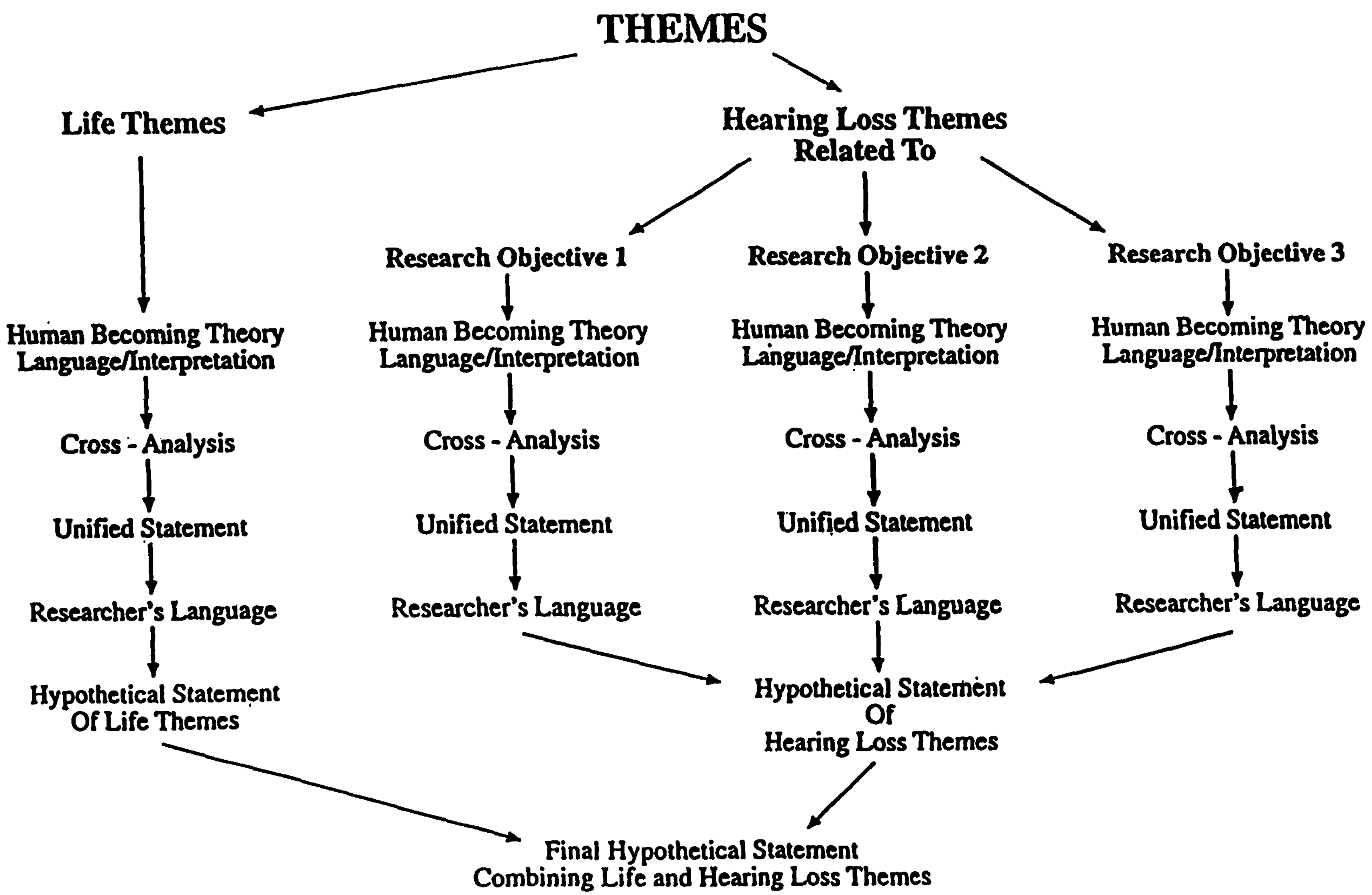


Figure 2. Methodology of theme derivation.

Table 13 (Continued)

Human Becoming Theory Language	Theme Interpretation
She languaged the comfort and help received from pets.	I need love.
Benefiting from a natural zest for life while struggling to walk with joy by denying death, she imaged advantages in her present situation and in controlling negative feelings that arose.	I'll be positive even if it kills me.
She revealed-concealed multidimensional feelings about her marriage as she related both the advantages and disadvantages of this relationship.	Love wants to be blind.
She revealed-concealed feelings of compassion for others who seemingly were in worse situations than herself.	I hate to see others suffer. I'm glad I'm not in their shoes.
Azalee	
She languages how relationships established with family of origin during childhood enriched her middle and later life.	Childhood families provide nourishment through all of life.
She languages the valuing of her mother's influence upon her in regards to learning to stay busy, learning about plants, and learning about sewing as she engages in similar activities and levels of business in later life.	I'm a chip off the old block.
She languages the image of how her mother's and father's earlier influence later shaped her teaching style.	My parents' influence helped me to be a good teacher.
She languages how she has lived life feeling that she was advantaged in many ways while at the same time concealing any felt disadvantages.	I was special.
Her husband, while still being the authority figure in her home, had more of a negotiated authority than her father had in his marriage.	My husband had the title; I had the power.
The sense of belonging she enjoyed as a child influenced her to develop a self-concept that would enable her to be a leader even if in a group of people who were wealthier than she.	Born to lead. Equal to the best.
Languages images of having substituted club work for teaching as a creative outlet.	Create life!
Reveals a generally positive outlook as she remains engaged in life despite concerns.	Too busy to be negative. Attitude!

Table 13 (Continued)

Human Becoming Theory Language	Theme Interpretation
She languages images that her time in the garden club is passing by and uses this insight as an opportunity to pass her knowledge about flower arranging on to others.	I can live on through others.
She dwells with memories of her husband as she putters in her garden area.	He lives!
She powers herself to think multidimensionally as she images her future. She expects to maintain health, help others, continue doing what she's always done but do it better, and go to heaven.	Heaven can wait.
She realizes emotional support from a long-term friend rather than her twin as they cope by engaging in both reminiscence and laughter.	To have is to understand.
She thinks of her mother with awe as she compares her mother's method of discipline to her father's.	A soft answer turns away wrath.
She powers herself to consider herself fortunate when comparing her problems with the problems of others.	I've been rich all my life.
Susie	
Languages the image that she believes people can do anything in life they make up their minds to do and reveals that the origin of this belief lies in the powering of an elementary school teacher.	I can and I will.
Languages the images of life on the farm as being the best days while also revealing-concealing the hardships.	The good life of farming is also hard.
Languages the valuing of cleanliness, education, and a big yield in the garden.	Your worth is measured by what you produce.
Languages the images that she has not had too many disappointments in life and that she powers herself to deal with disappointments by both taking things to the Lord and allowing time to heal.	God and time heal all.
Languages the valuing of caring for others through describing the care she gave to her husband and other family members while they were sick, as well as the care she renders to friends in her community when needed.	I'm a caretaker.
Languages how she chose not to work outside of the home during her children's growing up years in order that she	Education is important.

Table 13 (Continued)

Human Becoming Theory Language	Theme Interpretation
Languages multidimensional feelings towards her growing up years. She experienced enjoyable times while being poor made her feel socially inferior.	People should stay with their own kind.
Languages that learning the work ethic as a child served as a useful background for the hard work required to support her family later on.	Life prepares you one step at a time. Life has been hard.
Powers herself to continue to maintain control over her own life and finances while revealing that she has gradually accumulated multiple health problems and needs some assistance from others.	I'll do it myself. Please help.
Languages evidences of religious upbringing in later decisions that were made in her life.	I play by the rules.
Reveals negativity towards life as it presently is as she is beginning to experience feeling in the way and like she is losing control.	I'm not much use to anybody anymore.
Reveals that her vision of the future is "not much" as she uses bargaining when reviewing her life accomplishments.	The past was good and that's all there is.
Copes by bargaining that she is better off than others around her.	I'm luckier than some.
Languages how cooking is important, gives her something to do, and makes her feel needed.	The cook rules the roost.
Languages regrets that the friends she made in her apartment building have died.	I've lived too long.
Both accepts and denies her present capacities.	I can, but really I can't.
Frances	
Languages images of receiving love and support from family members as a child.	Good families provide security.
Reveals-conceals images of how frequent moving around during her childhood and married life enabled her in some directions and limited her in others.	Life is a mixture of bad and good. It's what you make of it that matters.
Reveals-conceals images of ways that dogs she has had over the years have been both comforts and trouble.	I would be lonely without my dog.
Reveals-conceals how multiple health problems have both enabled and limited her.	Being sick is a learning opportunity.

Table 13 (Continued)

Human Becoming Theory Language	Theme Interpretation
Powers images related to valuing a return to her roots at this time in her life.	Roots are important. As people age they settle down.
Languages images of family members who have died, enabling her to connect with those family members, transcend death, and thus transform death into life.	Precious memories.
Images how friends much younger than herself are dying. Wishes she could die but powering the originating of positive images related to her own life while also revealing that she is enabling self to connect to life by starting a new exercise program in the hope of originating better ability to walk.	Try until I die but I hope I die.
Images how her health problems are no worse than others.	Luckier than some.
Reveals-conceals images of her ability to continue living alone.	She is not what she used to be.
Powers self to originate new ways of being in order to transform self in a positive direction.	It's attitude.
Reveals-conceals her struggle between relying on God and relying on herself.	God's top advisor.
Languages the concealing of thoughts about the future.	I'll think about the future tomorrow--maybe.
Max	
Low self-esteem related to frequent moves in childhood, not feeling loved by her father, her mother's "weakness," her hearing loss, and her feelings that she is contributing to today's lowering of moral standards.	Wounds of childhood gush.
Lifelong griefs related to continual losses of loved ones.	Life is a tragedy.
The kind of acceptance felt in her first marriage from both her husband and his family were not felt during her growing up years and have not been felt since her husband's death.	Acceptance is a rare treasure.
Struggling to maintain independence as her children try to take over the parent role.	I will be free. Little birdies fly!
Languages ways that her value system and priorities have changed as she has aged; imaging how her children are in one developmental stage emotionally while she is in another.	Older and wiser.

Table 13 (Continued)

Human Becoming Theory Language	Theme Interpretation
Languages how involvement with activities and friends during earlier life became a lifelong pattern but also how she gives out earlier at night than others.	Party animal until 10 p.m.
Powers self to originate new ways of thinking in relation to handicapped people.	Life teaches lessons.
Enables-limits acceptance of present life situations by revealing-concealing how lifelong issues affect her present life and relationships.	Time doesn't heal, but I'll fight to the bitter end.
Reveals-conceals how she copes by making work for herself, then experiences multidimensional feelings towards her activities.	Really working at not being a perfectionist.

Cross-Analysis of Life Themes

The following statements, expressed in the language of the human becoming theory concepts, represent life themes which emerged as common to all the participants in the study. The participants

1. Reveal-conceal images of pleasures mixed with hardships during childhood.
2. Reveal-conceal images related to family relationships.
3. Reveal-conceal how childhood influences prevail in present activity patterns.
4. Language images of spiritual valuing.
5. Language images of met and unmet life goals.
6. Reveal-conceal images of the inevitability of death while connecting-separating with life.
7. Power themselves to image that their situation is not as bad as others with whom they come in contact.

8. Reveal-conceal both acceptance and denial of present and future capabilities.

9. Power themselves to maintain control over their own lives by originating new ways of being.

Unified Statement of Life Themes

Participants in this study language both positive and negative images of family relationships and ways of life as they muster enough self-esteem to power themselves to remain in control through a process of connecting and separating, reviewing whether life's goals were met, and accepting and denying present capabilities while living in both independent and dependent ways that may or may not be in line with their spiritual values as they power themselves to image that they are better off than others around them while imaging both a changed and unchanged future.

Unified Statement in Researcher's Language

Participants remember the past, holding on to the present with thankfulness while imaging an unpredictable future as value systems are and are not lived out.

Hypothetical Statement of Life Themes

Participants language the influence of their own past as they live in the present in accordance with individual needs and image an unpredictable future while considering personal value systems and spiritual issues to varying degrees.

Methodology for Analysis of Data in Relation to the Research Objectives

The purpose of this portion of the paper is to review the results of data obtained specifically to answer the research objectives and interview questions (directional ideas). The research objectives for this study were directly derived from the principles of the human becoming theory. The directional ideas utilized to focus the interviews related directly to those theory principles.

Research Objective 1

The first research objective was to describe the health patterns that occur as older women with hearing loss derive the meaning that the hearing loss has for them. Two directional ideas relate to this research objective.

Directional Idea 1

The first question participants were asked related to the hearing loss follows: What is it like to be hard of hearing? Excerpts related to this question are summarized in Table 14.

Explications of the text indicate that the experience of being hard of hearing was, for all 6 participants, (a) a chronic condition that became unignorable, (b) a condition that initiated a grief process, and (c) a condition that affected the daily life of the individual.

Table 14

What It Is Like to be Hard of Hearing

	What It Is Like to be Hard of Hearing
Liz	Unaware that things are even being said; needs close proximity to answering machine to hear; needs television louder; unable to hear birds, train, owls; unable to hear in groups; can't laugh at stories; left out.
Azalee	The loudness of sounds and voice tones affect the ability to hear, difficult to pick out single sounds from a multiplicity of sound, embarrassed to not hear and to wear a hearing aid, sometimes others not helpful, left out, "the look."
Susie	Sometimes others not helpful, embarrassing, bad, aggravating, "like a broke toe you have to put up with," different world, unable to hear some voice tones, unable to hear in groups or noisy places, hearing aids imperfect, unable to hear unless close to speaker and looking directly at speaker, you lose all you could learn, left out, "the look."
Margaret	Unable to hear knock at door, doesn't know what others are talking about when around them, others do not talk to her, it's bad, loud music and loud talk makes her want to jump over the benches at church, unable to hear in groups, depressing, left out, being a dummy, being an old horse or cow "don't nobody want no more," being in the way, "the look."
Frances	Is not aware of what has been said, hears but does not hear correctly, does not know what is going on, unable to hear in groups, embarrassing, left out, "the look."
Max	Really depressing, takes awhile to decide if you've heard right, embarrassing, unable to hear in groups, silent world, devastating, like a little satellite, left out, "the look."

Unignorable condition. Five of the participants acknowledged experiencing some forewarning related to having a hearing loss. Later, a precipitating incident occurred that caused the participant to become very keenly aware of the presence of the loss. This incident moved the participant towards seeking help related to the loss.

Liz had experienced enough awareness that she was not hearing that she had gone to a hearing specialist in Memphis earlier and had been told that she did not hear words like "this, that, these, and those, and a lot of other words." She stated: "And, of course, I just didn't pay much attention to him. And he said, 'Don't wear hearing aids. It will run you crazy,' so I didn't bother about it, but then this happened."

Liz then related the incident which later caused her to get help.

> Well, let me tell you, do you know why I have my hearing aids to begin with? Now who this person was, I don't know. She told Iris, she worked with _____ [The Beltone representative], she says, I want you to go to Liz and ask her to let you give her a test. They were noticing it long before I was noticing it you see. So Iris came here, and I told her well no, I wasn't interested in that, and she said, "one of your friends thought it might help you." So I said alright, and we sat down and she made the test and when she did it then I realized that I can't hear. . . . And that's why I had my first test.

Azalee related how she compensated for her hearing loss for a long time by getting seats close to the front when she and her husband went to plays: "We had reserve seats that we bought every time but they was about on the third row from the front--'cause he could hear better than I could but he liked it up there too."

It was not until after the death of her husband 6 years ago that Azalee began to wear hearing aids. "It's been, my husband's been gone, it'll be 6 years May 23 was 6 years, and it's been since then." She stated that the precipitating factor that led to her finally getting hearing aids was that her twin would get so aggravated with her when she was unable to hear.

When Susie was asked if there ever was a time before her husband became ill that her hearing loss affected her, she replied, "yeah, sometimes at work." The precipitating event that led to Susie's getting a hearing aid came later. Susie stated:

> See my husband had cancer and he got down--he had to stay in bed for a good while, uh, and he couldn't get up--and, uh, he said I couldn't hear him, you know when he'd want something, or tell me 'bout the medicine or something . . . so that's, and he wanted me to go, that's the reason I went, got some hearing aids

> before he died, he said I couldn't hear him, course he couldn't talk out loud you know.

Frances related that when her husband was alive, neither of them realized that she was hard of hearing but that "well, it started, I didn't know it but it started back in 1965 . . . . Well, I'm sure that's when the hearing loss started." Later, Frances stated: "We weren't either one of us, I didn't know it. I was hard of hearing at the time, but it wasn't something that was spoken about out loud, 'cause I didn't know it and he maybe didn't know it. I guess when he couldn't make me understand, he'd just talk a little louder." Two or 3 years after Frances's husband died, she began to travel overseas with friends, and it was on one of these trips that she became aware of her deafness. Frances stated: "You know how they have movies--they put those things in your ear for you to hear--well, I couldn't no more hear out of that thing than nothing."

Finally, Max characterized the recognition of her hearing loss in this manner:

> When I was in my 30s, I guess, I worked at [company name deleted] they established an IBM department . . . the noise factor was extreme. In the very beginning I thought I had trained myself not to hear these irritating noises, and I sort of ignored the fact that I might have damaged my hearing.

Max later worked in a quieter environment but realized that her hearing was deteriorating. One day she answered the telephone and was unable to hear the person speaking to her, even after asking the person to repeat what she had said several times. Max stated that the person responded by hollering in the phone and saying: "What's wrong with you, can you not hear?" Max related that it took this rebuttal to

> jar me into the fact, hey, I've got to make some life changes, some way or another. Either I've got to get into a position where I'm not responsible for taking the phone calls or I'm going to have to see if I can find some amplification to make it possible.

Max said: "I was devastated, because I knew."

Three of the participants spoke to the fact that the hearing loss progressed over time. Max related: "I could really see my hearing going downhill" and "I feel that it is going downhill." Liz stated: "Now I think my hearing progressively got worse." Frances said: "It just gradually got worse and worse."

Grief process. Many of the statements made by participants about their hearing loss indicated that recognition of the hearing loss began a process of grieving that started with denial and led towards acceptance as the participants tried to deal with having this condition. Max related: "It puts you in a position of knowing I can't buy anything to fix this."

Frances referred to how she felt when she first realized that she had a hearing loss by stating that she thought: "I'm sorry about this, I just can't hear like I want to and I'd like to hear better." She also said: "At first it's frustrating and you get mad at yourself that you can't hear and can't react to what someone has asked you because you just don't hear." Frances related that "there's just something inside of you that you take it as it comes and deal with it as best you can."

Frances also said: "It's just something you learn to adapt to" and "you can't hear --you can't hear--and that's the best you can do so you just accept it and go on from there." Last, Frances related: "Don't just get bitter on the world and give up and just sit there and die but just gradually learn to accept what you do have and appreciate what you do have."

Azalee and Max both framed acceptance in terms of overcoming pride enough to allow others to see their hearing aids. Azalee related:

> When I first got 'um I let my hair grow out right down over my ears, and I just, I looked a lot older, with it down long, and I said well, shoot, I don't care who sees me because they know it's a part of my life and I just started having it cut shorter then--let 'um see it--I decided I didn't care, it didn't matter that much.

Max stated:

> You know how pride--because everybody else--I wore long hair for a long time to cover them up. I wasn't ashamed, I just thought they were not all that attractive. And then I decided to heck with this, I was 50. Grateful that I could hear with them, and that I could financially afford this help.

Max also said: "It's just a fact of life, it's just where I am, it's just what's happened to me."

Liz had lived with her hearing loss for many years. She stated that at first she tried to ignore her hearing loss, but later she felt like "that's the way it is." She also recounted: "I look at this sometimes--the Lord does not put anything on you that you cannot bear with His help." Susie said: "Everybody has something or nother now--in life."

Margaret made no direct statement indicating that acceptance of the hearing loss had occurred. Instead, Margaret manifested being depressed about her hearing loss. She stated: "It's bad I tell you, it's really bad when anybody can't hear." Margaret had recently purchased a new hearing aid and related that she is hearing better. She stated: "I feel better, I got some hearing aids, I can hear a little . . . and I am proud of it."

Four of the participants demonstrated using bargaining as a form of acceptance by stating that they would rather see than hear. Susie said: "But see if you didn't see though, you'd be eating stuff that wasn't right--you couldn't see where to go." She also stated: "I just pray the good Lord don't let me lose my hearing completely." Susie went on to relate: "I believe seem like I'd just rather have my eyes." Liz stated: "If I couldn't see, I couldn't be living here at all, but I manage all right by not hearing." Frances said: "If I had to do without one or the other, I had to, I would prefer--I'd rather see." Max related, "Of the senses, I would rather hear less and see more."

Thus, the process of acceptance of having a hearing loss for these participants generally began with a forewarning that the loss was occurring. After a period of time, an incident occurred that stimulated the participant to obtain help. Participants were in various stages of grief related to the hearing loss, and signs of denial, depression, anger, bargaining, and acceptance were evidenced among them.

Effect on daily life. Embarrassment was a term that 5 of the participants used to answer the following question: What is it like to be hard of hearing? Frances described this aspect of the meaning of having a hearing loss by relating that she felt embarrassed when she was supposed to know what was going on and she did not know. She stated that being embarrassed often kept her from asking people to repeat what they had said. Azalee related feeling embarrassed for others to know that she wore a hearing aid. She stated: "I kindly feel embarrassed, don't want them to know, you know exactly." Frances stated: "It's embarrassing, you want to hear, but you don't want to bother anybody because you can't hear." She also said: "It's just, uh, really embarrassing, that's what you have to live with."

Max revealed: "I become somewhat embarrassed by repeatedly saying, what did you say?" The majority of Max's comments about having the hearing loss implied even deeper feelings related to the hearing loss. Max tended to repeatedly use the term depressing and also referred to being devastated when she learned that she had this hearing loss.

Liz was the only participant who did not use the term embarrassment in describing her hearing loss. Liz had been hearing impaired longer than the other participants and demonstrated a high level of acceptance of the condition. However, Liz did not answer questions related to feelings with direct answers about feelings. Instead, when asked about feelings, she answered "that's the way it is." This was not said in an angry tone, but rather matter-of-factly.

One commonality noted about the participants was that they felt left out of conversations. Descriptions related to this characteristic follow.

Azalee described what it is like for her when she attends socials before garden club meetings. She stated: "Well, I don't--it's--I can't hear what any one particular person's saying, it's just a lot of noise and a lot of times, it's too loud." Susie said: "It's embarrassing--you know being in a class when you can't hear the teacher you're discussing the class and the lesson, but I don't know--I mean it's a lot different world." Liz related: "I never hear anything at the bridge table when it's two tables, uh, and they might say I bid a spade and I may not even hear her say that, may not even hear." She also said:

> Now when I try to go, try to go to church, if he tells something funny it just infuriates me that everybody can laugh and I can't laugh--I don't know what he said, if he said something clever, funny, or tells a story, I don't know what it's all about.

She also described going to a city council meeting with neighbors to protest a business being put in the neighborhood but said "well, you can't hold up your hand if you don't know why you're holding up your hand." Margaret said: "Well, you don't say nothing

Margaret said: "If you ask them what they are talking about they say, 'oh, you can't hear noway,' and they go to tell you about it you know and you don't know this and you don't know that." Margaret further stated: "Well, when I can't hear I ask if they are talking about something I think they're talking about, that I know of, I say could you say it over?" Margaret's family responds to her request by saying: "Mama, you're right here."

Margaret provided more insight into the question of what it is like to be hard of hearing by stating:

> You think well, I'm old, there don't nobody care, I told 'um it's just like an old horse or cow when you get old, don't nobody care. You can't hear what they are talking about--you don't know, you can't never see nothing that you can hear to even talk about . . . . you can't hear things, therefore you don't have nothing to talk about.

Last, Margaret said:

> You can't hear and you think nobody cares. And they really don't, I don't think . . . you know they care but still, nothing they can do about it. That's the way I feel about it, I think don't nobody care. You feel like don't nobody care about you, you know, but you know your kids does--but you've got that feeling and you don't want to be around 'um.

Max related:

> The look that I get and the feeling that I still want to be on top of everything, you put those two together and then you could, you know if you allowed it to, it could become very lethal as far as how you participate, what you participate in, and how you handle the situation.

Frances related: "They're not conscious of looking at you like that, it just flashes in their eyes." She also said:

> Because you can't ask 'um to repeat 'cause you know if you do that look's going to come back and you don't want that look again. . . . A disgusting look--what in the world's wrong with you? You just try to get away--naturally, you try to get away from anything that looks at you like that.

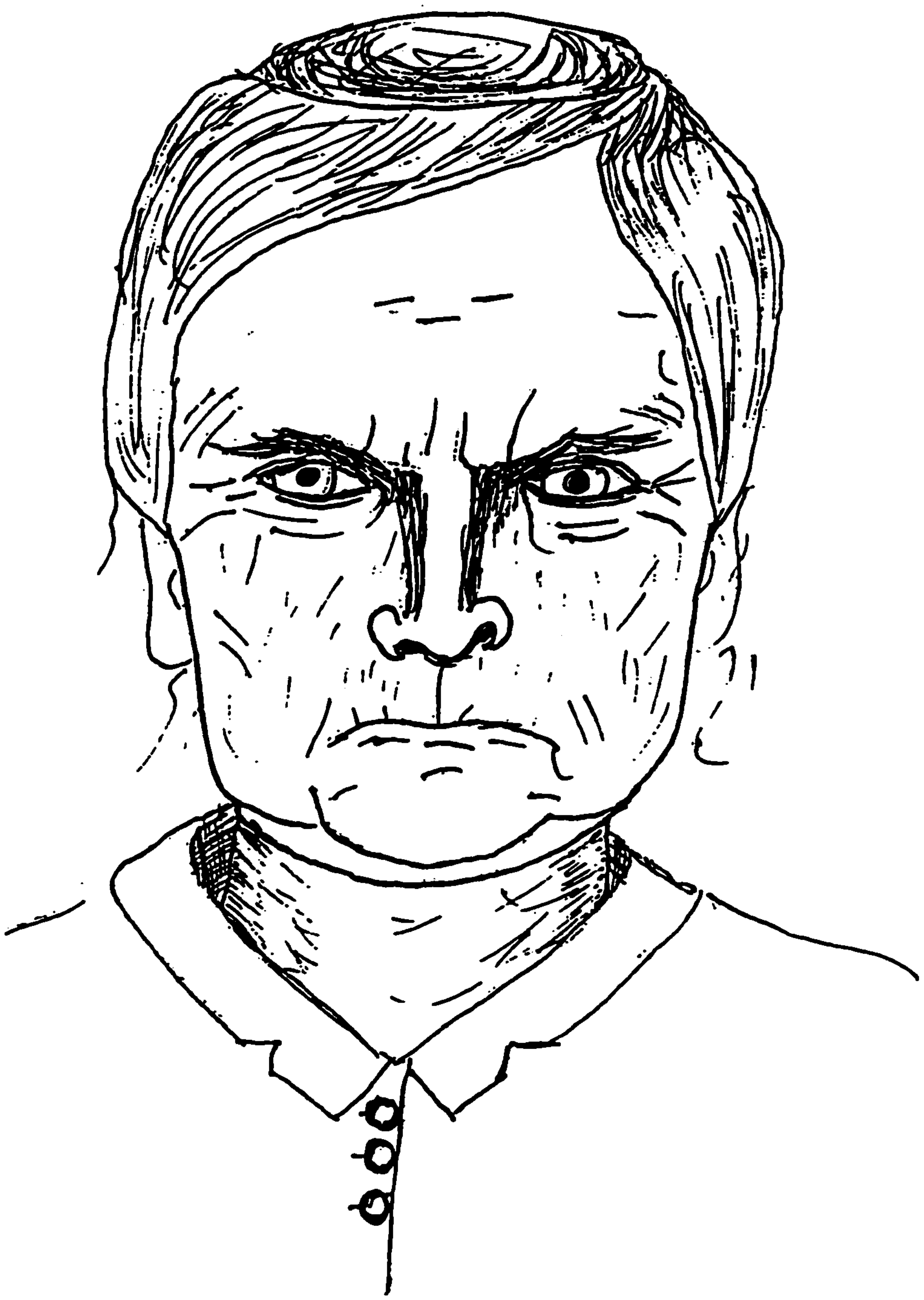


Figure 3. The look participants receive when asking others to repeat.

Table 15
Descriptions of Ways Feelings Changed About Self

Participants	
Liz	Angry at self, decreased self-esteem related to not making clear sentences and giving wrong answers, unwelcome guest?
Azalee	Less capable.
Susie	Less alert, slow.
Margaret	Silly, like I don't know what's going on, not like the same person, don't care about anybody--not even yourself.
Frances	Gets mad at self, irritated at self, more pleasant with others than self.
Max	Handicapped, slow--not quick, inadequate, decreased self-confidence, different, like a modern day Helen Keller, like doesn't have all faculties, like others think her elevator doesn't go all the way to the top, different, dull, losing intellect.

> they would say Anna Rose, there's no use her coming to our Thanksgiving dinner, she won't hear anything they're saying--but Anna Rose wanted to be there. See, you are not completely dead because you can't hear.

Margaret described how she felt "in the way" since she became unable to hear. She also described how she felt towards herself when she pretends to be hearing when she cannot. She said, "It makes you feel silly . . . crazy a lot of times."

Frances said, "but usually I get--I get mad at myself--oh, I get so mad at myself." She further stated:

> If I don't understand something or can't comprehend, or something goes wrong that's not my fault, but it went wrong anyway, and I just got mad at myself because I can't do it right is all--it's a guilt feeling--guilt you bring on yourself. You get mad at yourself that you can't hear.

Max related:

Table 16

Hearing Loss Themes Related to Research Objective 1

Human Becoming Theory Language	Theme Interpretation
Liz	
Languages both the advantages and disadvantages of having a hearing loss.	Every cloud has a silver lining.
Languages images of her friends' responses to others with hearing loss in past years.	They did it to her so they'll do it to me.
Languages ways that others are helpful and nonhelpful related to her hearing loss.	I wish everyone was like those who help me.
Imaging the negative impact that having a hearing loss has on her self-esteem.	I try to be positive but this gets me down.
Languages the self-image that has emerged as she observes how others who have hearing loss look when unable to hear.	Oh, NO--I look blank, too.
Languages images of self-directed anger because of the inability to hear while valuing the image that this anger is irrational.	My feelings are irrational but sure.
Languages images of ways feelings toward self have changed and not changed since becoming hard of hearing.	My self-esteem is lower than ever.
Languages images of both hearing and not hearing all at once.	I hear but I don't hear it right.
Languages images of having experienced denial before any measure of acceptance of the hearing loss.	At first I thought it couldn't be true.
Azalee	
Languages the multidimensional meanings that having a hearing loss has as she relates that it has not and probably will not make a big difference in her life.	It won't affect me--I hope.
Languages what it is like for her when others respond to her hearing loss in helpful and nonhelpful ways.	Sometimes I need help.
Images what it is like to deal with others' impatience with her hearing loss.	I wish others understood.

Table 16 (Continued)

Human Becoming Theory Language	Theme Interpretation
Frances	
Languages images of how her husband spoke louder to her while neither of them realized she had a hearing loss.	We didn't know.
Languages images of the negative effects of not having hearing aids for years after she needed them.	I missed so much!
Languages images of embarrassment when unable to hear.	I'd like to crawl in a hole.
Languages what it is like when others give her "the look" when she asks them to repeat things.	The look of the devil.
Languages image of self-blame related to not hearing.	I blame myself.
Languages images of gradual acceptance of her hearing loss.	Losses must be grieved.
Languages images of fatalism related to her hearing loss.	Nothing can be done so accept it.
Languages images of not being whole.	I'm lost, can you find me?
Max	
Languages images of what it was like the moment that she really realized she could not hear.	Devastated.
Languages both advantages and disadvantages of hearing aids.	It's a love-hate relationship.
Languages the negative effects of having a hearing loss on her self-image.	My self-image is rock bottom now.
Languages image of how others' responses to her hearing loss affect her self-esteem.	Fragile--handle with care.
Languaging images that further deterioration of her hearing loss is occurring.	This is threatening--better go to the beach.
Languages images that she may sometimes feel she cannot hear when she really can.	I'm my own worst enemy.

4. Elderly women with hearing loss experience a variety of negative feelings toward themselves and feel left out of conversations as others talk around them.

Unified statement of hearing loss themes related to Research Objective 1. An ah-ha experience produces an image of a certainty of the presence of a hearing loss, which leads to uncomfortable moments as one experiences changed feelings about self and handles negative feelings that arise out of the experience of the condition as the loss of hearing is grieved.

Unified statement in researcher's language. A burdened heaviness emerges as the was is left behind and the realized and will be surface.

Parse Analyzations Related to Research Objective 1

Research Objective 1 directly relates to Principle 1 of the human becoming theory. Principle 1 reads: "Structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging" (Parse, 1987, p. 69). Examples of analyzations related to the concepts of Principle 1 are provided in Table 17.

These analyzations of data illustrate how the human becoming theory concepts can add new dimensions to the analyzation process by encouraging the researcher to think about the multidimensionality of the experience of hearing loss.

Table 17 (Continued)

	Imaging	Languaging	Valuing	Multidimensionality
Liz (Cont'd)	Hearing but not hearing right. That she both hears and does not hear.	"Oh, I couldn't hear at all. Now, some of my friends I can hear, but I may not hear everything they say." Answering machine: "Sometimes I know what numbers . . . are saying and sometimes I do not." "See I may think I do. You think you are hearing, that's another thing, you think you're hearing, when actually you are not hearing." "Because I'm beginning to see if you can't hear, you're not aware that you don't hear it." "It's right odd too that you can hear a little bit better than others sometimes." In restaurant: "Oh, I would know when you said no or when you said yes, like you carry on a conversation, I might could pick out a word or two." "This is odd, this is very odd to me--like he would [read] part of the Bible that I know . . . I can hear that."	Hearing and hearing correctly	Both hears and does not hear.

Table 17 (Continued)

	Imaging	Languaging	Valuing	Multidimensionality
Liz (Cont'd)		"Well, I have to be careful that I know what they're saying. I have been to auctions where I did not know what they said."		
		"If I should go out in the yard today without my hearing aids, I wouldn't hear the birds."		
		"I can't hear the owls anymore and you should hear our owl concert."		
Azalee	Fussing at her twin when she speaks too loudly to her.	"She said yesterday that I was the only one, she said everybody around Jasper, a lot of her friends was talking about going to see her, she says I don't want anybody to come see me but you."	Twin's closeness People not speaking loudly to her	Azalee feels both closeness to and anger for her twin.
		"If I ask her what she said, well then she'll start screaming, and I said, you don't have to scream if you'll just look at me."		
	Not needing hearing aids all the time.	"But Twin always did, I'd say, 'don't scream at me, I can't stand that.'"		
	That she can hear conversations when it is quiet and one person speaks at a time.	"Some people's voices are different from others--you know Barbara's a good friend of mine and I can never tell what she's saying unless I'm listening carefully. It's the tone of her voice or something that I don't catch."	Hearing with hearing aids on	Azalee both needs and does not need hearing aids.

Table 17 (Continued)

	Imaging	Languaging	Valuing	Multidimensionality
Susie (Cont'd)		"They talk, you know, I can hear them, ah, they talk 'bout like me, you know."		
		"And then one night he got up--and he cut out the microphone and I couldn't hear a word he said."	Hearing	
		"They ought to just talk one at a time you know, but you know when they get to talking though they talk on this side and maybe the teacher up 'aire, she's talking."		
		"So you just have to forget it or ask what they said."		
		"Now my sisters, they always just talk like I do. . . . Like with Adam, they talk like I'm talking now and I can hear them."		
		"Usually they don't turn it [TV] off when I go over there. They just keep it going."		
		"Well, I just have to have it [TV] turned up a little, then uh [son] will come in and say, 'Oh, how loud'--I turn it off."		

Table 17 (Continued)

	Imaging	Languaging	Valuing	Multidimensionality
Margaret	Hearing better with new hearing aids.	"I got tickled the other morning, I was here, and I'd washed, and I decided to iron, so I ironed my clothes, I sat them over there on the chair, had the television on, and they said they knocked but I don't know whether they did or not, they might have. . . . They couldn't hear me in here and they came walking in--I thought they come to eat." "But I can hear now pretty good." "I just sat there because I couldn't hear anything and he said when I went back, 'My land, you sure do do better. You look better.' [laughs] Said, 'you couldn't hear nothing?' I said, 'No, I couldn't.'" "He said I can tell by the way you talk that you can hear now."	Having a family that checks on her New hearing aids Hearing better	Can hear and not hear even with new hearing aids.
	That others don't care about her or about the fact that she cannot hear.	"I wouldn't take nothing for 'um--I hadn't heard anything on TV, just saw the picture, in 10 years."	Relationships with family and friends	That others do and do not care that she cannot hear.
	That family and friends don't know how best to communicate with her.	"Yeah, you do, you're around everybody and you don't know what they're talking about."	Knowing what's going on	
		"Well, I think they don't care."		

Table 17 (Continued)

	Imaging	Languaging	Valuing	Multidimensionality
Margaret (Cont'd)		"That I ought to be somewhere by myself." "I got 11 grandchildren and 1 great-grandchild. . . . But they all love me." "I said, I'm not going to say which one, I love you all." "I don't think they do. You know, they care but still, nothing, nothing they can do about it." "That's the way I feel about it, I think don't nobody care about you, you know, but you know your kids does." When children say to her, "Mama, you're not hearing," she responds by feeling that "it makes you mad, it hurts your feelings. [Feels like children don't talk to her; when she confronts them, they say]. Mama, we do talk to you but you don't hear!"		
Frances	The look people give you when they realize you are not hearing.	"Upsets you because you know you are trying your level best to hear 'um and you get that look in their eyes that tells you you're not hearing what I say--I don't know, you just want to get away from that person as soon as you can."	Friendship with someone who tries to keep her informed of what she needs to know	People are helpful and nonhelpful in relation to her hearing loss.

Table 17 (Continued)

	Imaging	Languaging	Valuing	Multidimensionality
Frances (Cont'd)	People who try to keep her informed of what is going on. That Connie is willing to help her. People are good. "People are nice like that. Sure they are." "But everybody's nice to you in the whole wide world if you'll just be--nice to them--most everybody."	"You'd choose somebody like Connie who's willing to help. . . . When I go out with her for meetings or something like that I just depend on her to listen." "And she'll say, 'went to a meeting today and there's going to be a meeting Thursday,' and she forgot to tell me and I don't even know they are having a meeting." "It's not your fault, it's not anybody's fault, it's just something that you have, you can't help it, but you get kinda irritated because you try so hard to hear what they're saying and you just can't hear. And you know somebody's going to ask you about it and you just kindly subconsciously prepare yourself for their onslaught." "A chaplain--a colored man, and he was so wonderful. People are nice wherever you go." "Why in the world is she bothering me like that? So if you don't hear it the second time, and you don't get it, you don't ask a third time."	When others are willing to help her	People are good but at the same time aren't always helpful.

Table 17 (Continued)

	Imaging	Languaging	Valuing	Multidimensionality
Frances (Cont'd)	People are not always helpful.	"If I'm going to a doctor there's always a nurse I always make a point of having somebody with me that can interpret . . . nobody's ever minded." "But most people don't have that much concern because, they would, I'm sure they would if they thought it would help you [tell you what's being said] but it's just something that won't cross your mind." "And if you don't hear what they're saying and you go and ask your question along the same line when you really don't understand what they are talking about, you really do get a look." "Connie always makes a point of telling me but sometimes she forgets. You know, she takes it for granted everybody hears. She usually tells me." "It's a bother, so you just don't do it anymore [ask over], you just do without."		
Max	Using hearing loss to her advantage when needing to concentrate.	"Well, as a tool of concentration you can. If you really want to zero in on something and there's distractions and whatever, you can. You know, to really think something through,	Being on top of things	Having a hearing loss has both advantages and disadvantages.

Table 17 (Continued)

	Imaging	Languaging	Valuing	Multidimensionality
Max (Cont'd)	The peacefulness that the hearing loss can afford. The disadvantages of having a hearing loss.	you can use it to your advantage that way, because you really isolate yourself in the midst of whatever it is that you are trying to think through." "We do live somewhat in a quiet world." "But there are times when you feel like it's just me and this old world--and it is a good feeling. . . . But like I said, it's also a bad feeling. . . . But it does, it gives you that quiet." "I adjusted as well as I possibly could, and kept my job, but I did retire a little bit early because I felt like I just wasn't getting it all. I felt slow, not quick, and I'd always been quick." "I run a boat, and with that and cars and all I have to watch out for what might go wrong that I would normally hear. Like a bump on the tire, that sort of thing, I wouldn't hear it unless the hearing aids overamplified somehow. So you visually try to keep your tires checked. . . . You wouldn't hear it so you make sure these things are done."	Being known as quick to catch on; smart Spirituality Reliance on God	

Research Objective 2

The second research objective was to describe the health patterns that occur as older women with hearing loss relate to the world. Two of the directional ideas presented to participants related to this research objective.

Directional Idea 1

The first question related to Research Objective 2 follows: How have you tried or not tried to live as usual since your hearing impairment began?

The participants' lives have been impacted by their hearing loss in varying degrees. Participants tended first to state that their lives had not changed and then later to describe ways that they no longer lived life as usual. Susie and Azalee were less affected in their quest to live life as usual than were the other participants. Susie admitted to not trying to watch television while in the presence of others, but otherwise her activities remained the same as before the hearing loss began. Susie stated: "I, I go, I try you know, I go on--I don't never, sometimes get aggravated sometimes 'cause you can't--you have to wear these. . . . I just get aggravated at myself 'cause I can't hear. I do the things I always did."

Azalee remarked, "I don't think it's made that much difference in my life. . . . I haven't gotten out of any clubs." She also said, "But being with people and all in the garden club and other clubs I go to, it doesn't make any difference." However, Azalee does admit to choosing quieter restaurants where she can hear. She compared two restaurants in the following ways:

> Their music's too loud--and their laughing and talking is too loud--and their drinking too much . . . but I like C&C over on the other corner--the music is

Margaret described living life as usual as "I just go on--if I have something to do I got a quilt I'm working on." Even though unable to hear, Margaret had continued to attend Sunday School before she broke her hip. However, she stated that she only went because her family wanted her to go. She had lately returned to Sunday School wearing her new hearing aids, and she stated: "I could understand them. I can understand with these."

Margaret's life has contracted in the last few years. She stays in her apartment more than in the past. Probable causes of this contracting lifestyle include (a) declining health, (b) poorer hearing, and (c) the deaths of most of her friends.

Max continues to have an active lifestyle, enjoying dining out with friends, line dancing, going to the ballet, and attending church. However, she did describe two ways that she does not push herself to engage in normal activities. These include (a) not attending movies routinely and (b) not watching television when with other people. She stated:

> I don't go to the movie much because of the volume--by the time they amplify it for this generation, and that wraparound sound, I tell you, when those cars go flying down the street and squeal their tires and crash and carry on, well then I'm turning down these hearing aids, because that's so offensive that by the time they get back into the dialogue again, here I am turning them back up. So I really don't get a big rush out of the movies.

Thus, each participant's life has changed in some ways. Some lives have been more radically changed than others. It is the researcher's opinion that those participants with less severe hearing losses, like Susie and Azalee, have been able to continue their life as usual much better than those participants who have more severe losses. The researcher has not seen audiogram reports; this assessment is based upon communication difficulties experienced when interviewing the clients. It should also be noted that participants' health patterns evolve simultaneously with other health and personal problems that arise.

Directional Idea 2

The second question related to Research Objective 2 was as follows: What changes have occurred in your relationships with others since your hearing loss began?

Each participant described ways in which her health patterns had changed in regard to relationships with others since the hearing loss began. Family relationships, friendships, and business relationships were all negatively affected by the hearing loss. Participants described these changed relationships with a great deal of feeling, particularly as the changes related to family members.

Azalee described how her identical twin does not understand or have any patience with her hearing loss. At times, the tension builds between them to the point that they take time outs. This relationship problem between Azalee and her twin can be visualized through the following examples. Azalee said: "Once in awhile when she'll talk too loud to me well we'll just pitch a fit to each other then it'll be back calm and all." Azalee also said: "Oh, sometimes she just says I won't talk and she'll just go away and we'll be all right, we won't speak for 10 minutes and then we forget what's happened and start all over again." Azalee both reveals and conceals the relationship problem when she states:

> I don't think it has too much effect on our closeness. I can just, when I get mad at her it don't last long enough to really--[hesitates]--but a reason I think she's impatient with me and you know doesn't have much to say or help do is because she never has been sick.

Azalee described how she had quit confiding in her twin. Part of the reason for this was that her twin does not understand Azalee's leukemia condition, but part of the reason is that "I don't want her to raise her voice at me, fuss on me." Thus, the rhythm of the pattern of relating to her twin has changed as, instead of confiding in her twin, she now confides in a friend who also has health problems. Azalee also had this to say in relation to her twin: "Oh--I just want to hit her sometime. Oh--I told her one time, I wish for 2 minutes that you'd be so you can't hear like I can't, just 2 minutes." In the end, it appears that Azalee fusses at her twin about talking loudly to her because she feels secure in the relationship. The following two statements demonstrate this security: (a) "She said it's funny to me that you don't ever fuss on somebody else and I'm not even talking as loudly as they are," and (b) "But I guess I'm at liberty to say anything to her I want to." Thus, although there is tension in this relationship and although her twin is not her primary confidante at this time of life, Azalee sees the relationship as being secure. She described her relationship with her twin when they were children in this way: "I loved all my other sisters, but she and I were a lot closer than the rest of 'um."

Susie related how her husband reacted: "Well, it'd just aggravate him 'cause I couldn't hear him. . . . He didn't want to repeat it 'cause he said he didn't feel good." Liz described how she would become so angry at her husband "because he knew I couldn't hear--and he would walk off and keep talking." She related: "Now I always wanted to just go over and just hit him." Liz stated the following in relation to how the hearing loss affected her relationships with her family: "I don't see them that often, I really don't know how they feel about it. Mary Ann does not talk. She's like her father."

Liz went on to describe times when she was with her family but was left out of the conversation. Her voice tone reflected some anger and bitterness around this topic as she said: "They talk--they're getting where they talk to each other, they don't talk to

Frances stated that one time she reacted to her friends "in an ugly way" when she couldn't hear. Fortunately, the friends responded by joking and laughing about the incident. Frances has no close family with whom her hearing loss might interfere.

Max described how her relationships with her son, daughter, and grandchildren are affected by the hearing loss. She stated:

> But now I have a son that puts me over the edge because he talks one step above a whisper, and he mumbles. He does not look at you, he'll go across the kitchen, start talking to me in that low voice. . . . I think he needs to go home, he is upsetting me terribly. . . . I am a nervous wreck when I get through trying to fool with him or he clatters so incessantly that I'd like to strangle him because he makes me so nervous.

Max referred to having some difficulties in her relationship with her daughter related to her hearing loss. Max is unable to hear this out-of-town daughter well on the telephone. She stated:

> She'll call and I think gosh, I can't, I can't cope with much more telephone conversation out of her because I am really working hard and I'll say I didn't understand that, run that by me again, and she'll say, "Don't you have your hearing aids in?"

When Max's children come to visit, she relates that "I become very nervous and the slightest little noise that hits across my eardrums that are extremely clangy--and they need to go home [voice shaky] and it's bad--but it's how I feel."

Max described difficulties in relationships with her grandchildren that have arisen when she is unable to hear what they say. She stated that the grandchildren get very frustrated with her when she cannot hear, and they end up saying: "Just forget it." She related: "I really try not to push them too hard because they begin to reject me. Hadn't got time for you Max--just to keep on and on." Max described one incident that occurred when she did ask a grandchild to repeat one too many times. She said:

> So after awhile I just quit pushing it because she was getting angry by then, and I became embarrassed and it hurt my feelings--because I couldn't understand my grandchild and she was trying to talk to me--so I mean we were at the level of having our emotions crop up there--I mean she was angry and frustrated and I was frustrated and embarrassed, and hurt.

Last, both Liz and Max related ways that having a hearing loss impacts business relationships. Liz was unable to hear what cashiers said in the grocery store. She had to be careful in her other business relations as well in that she had to make certain that she had heard things correctly. She described one telephone conversation with a clerk dealing with her medications. Liz stated: "So I called and they du-du-du-du [talked really quickly], and I said, now wait just a minute, please ma'am, I said I can't hear well, you have to talk to me very slowly and plainly."

Max provided an account of a conversation that she had with a worker when she was building her house.

> The air conditioning man was there. He was downstairs working and I was upstairs. He called upstairs and said, I thought, "Do you have a Coke?" And I said, "Don't have a Coke, have a Pepsi"--and he looked at me and just fell over--and I said, "What's so funny?" He said, "I didn't ask you that--I said, 'Is it cold up there.'"--then he went on to say, "I will take something to drink though, since you offered."

Hearing Loss Themes Related to Research Objective 2

The following themes are derived from the data relating to Research Objective 2--to describe the health patterns that occur as older women with hearing loss relate to the world (see Table 18).

Table 18

Hearing Loss Themes Related to Research Objective 2

Human Becoming Theory Language	Theme Interpretation
Liz	
Reveals-conceals the impact-nonimpact of the hearing loss on relationships.	I recognize it but can't admit it.
Limits positive expectations of others accepting her in spite of her hearing loss by remembering her friends' past responses to others with hearing loss.	It makes me suspicious of them.
Reveals-conceals images of the responsibility she places on others to help her hear.	I know they aren't responsible, but I need them to be.
Reveals-conceals how relationship, control, and hearing problems surface in issues surrounding the television.	Generational clash rises to the surface!
Connects-separates from others and from enjoyable activities as she deals with the multiple impacts of aging and hearing loss and begins to find solace in being at home.	I may be slowing down and that's O.K.
Azalee	
Connects with hearing impaired friend at church and thereby enables self to draw support from someone who understands.	I need you near me.
Reveals-conceals images of how relationships are affected when others respond to her hearing loss in helpful and nonhelpful ways.	I confide more in those who understand.
Enables self to feel confident that her relationship with her twin is strong enough to survive the frustration of Twin's not understanding her hearing loss.	Ties can never be broken.
Reveals-conceals images of ways her activities have and have not changed because of her hearing loss.	There are some things I no longer do but I don't dwell on that.
Susie	
Reveals-conceals images of living with increased hearing loss in the future.	I hope my hearing doesn't get worse, but I'm not sure it won't.
Reveals how she does what the men in her family recommend regarding her hearing, regardless of personal desires.	I want to please the men in my life, but maybe they don't give the best advice.

Table 18 (Continued)

Human Becoming Theory Language	Theme Interpretation
Reveals continuing to connect with usual activities in spite of her hearing loss.	I try to go on.
Reveals how her vocal participation in Sunday School changes when she is unable to hear.	I talk when I can hear enough not to sound dumb.
Reveals changed feelings towards those who won't help her hear better.	Some folks won't help anybody.
Reveals how having a hearing loss affected her relationship with her husband.	I didn't want him to suffer because of me.
Reveals images of situations where hearing is made more difficult.	It all depends on the situation.
Margaret	
Reveals-conceals difficulties in relationships related to her hearing loss.	My children just do not understand.
Connects to her children when able to hear but separates when she cannot hear.	It's not fun to watch you talk to each other.
Separates from activities long enjoyed when unable to hear and reconnects when she can hear.	I do what I can.
Frances	
Connects and separates from others according to whether she can hear.	I will if I can hear.
Reveals images related to others' negative reactions to her hearing loss.	I just want to get away.
Reveals images of trying not to inconvenience others because she is hard of hearing.	Others should not suffer because of my problem.
Connects to those who are more willing to help her while separating from those who do not help.	I go where I'm wanted.
Reveals images of what it's like when others do not have a voice pitch which is hearable.	Pitch is everything.
Reveals images that others know when she cannot hear.	Mystical powers.
Reveals images of anger towards others who do not help her hear.	It makes me so mad.

Table 18 (Continued)

Human Becoming Theory Language	Theme Interpretation
Max	
Reveals enabling-limiting activities according to her hearing loss needs.	I do what I can.
Reveals how accommodations were made for her when she was in the work setting.	Others helped me.
Reveals ways that her relationships with others are negatively affected by the hearing loss.	I want to be sociable, but it's hard. Walking gets it out of my system.
Connects and separates from others in accordance with hearing loss needs.	Please don't make me nervous!
Reveals the realization of how her problem affects those around her in negative ways.	It's not fair for others to be penalized because of me.
Reveals strong negative reactions that occur when she tries to communicate with her grown children.	I question their love for me sometimes.

Cross-analysis of hearing loss themes related to Research Objective 2.

1. Elderly women with hearing loss reveal-conceal ways they do and do not live as usual.

2. Elderly women with hearing loss reveal changed and unchanged relationships and activities as they live with hearing loss.

Unified statement of hearing loss themes related to Research Objective 2. Changed and unchanged relationships and activities surface as older women live with hearing loss.

Unified statement in researcher's language. Thoughts of the no longer possible are revealed and concealed, while connections and separations from relationships and activities are enabled and limited.

Parse Analyzations Related to Research Objective 2

Research Objective 2 directly relates to Principle 2 of the human becoming theory. Principle 2 reads: "Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing, enabling-limiting, and connecting-separating" (Parse, 1987, p. 69). Examples of analyzations related to the concepts of Principle 2 are provided in Table 19. These analyzations demonstrate the ebb and flow in relationships as participants live while experiencing a hearing loss.

Research Objective 3

The third research objective was to describe the health patterns that occur as new ways of living and/or viewing familiar concepts evolve as a result of living with hearing loss. Three of the directional ideas presented to the participants related to this research objective.

Directional Idea 1

The first question related to Research Objective 3 follows: What new insights have you had since your hearing loss began?

Each participant described how having a disability herself had made her more aware of the meaning that having a disability has for others. Azalee described how the

Table 19 (Continued)

	Revealing-Concealing	Enabling-Limiting	Connecting-Separating	Rhythmical Patterns of Relating
Liz (Cont'd)	"I miss all the conversation." "I don't know any television all the time they are here." "A lot of times when I don't know what they've said, and I smile--and I laugh too--I don't know whether it's funny or not." "It changes my life, yes."	much as so I can see but it's to hear." "And uh another thing that you can be selfish is, when you go somewhere to eat." "I'll say, 'Say that again. I don't hear well.'" "I do not ever play the radio when I ride in a car--and if I am in the car with anyone and it's on, I'll ask 'um if they will turn it off." "They talked and they talked and I don't know what they said."	don't hear, and this girl who came down there from another class comes and sits in my seat. And I said, 'You're in my seat. . . . I want it.'" "Yesterday I was talking to one of the girls I was playing with and she said, Lynn can't play this coming Monday and I said well I was with her this morning and she didn't tell me that--she said well she told us while we were playing bridge, you just didn't hear it. So I'm beginning to see that I don't hear things I should hear actually. I don't even know it's been said. So I called her to verify and she said, yes, I'm going to have company. So I didn't hear a bit of that [sounds upset, voice low]."	connection to her hearing loss.

Table 19 (Continued)

	Revealing-Concealing	Enabling-Limiting	Connecting-Separating	Rhythmical Patterns of Relating
Azalee (Cont'd)	"I've always been that way to a certain extent [liked quietness], but it [hearing loss] has more to do with it now."		and have a good time with them."	
Susie	"It embarrasses you--you can't hear if you have to ask over, somebody over, oh you hate to ask over, and have 'um repeat, you know, and uh, you just hate to, but you just have to if you can't hear."	"Well, you maybe ask somebody what's said if you want to hear it."	"I don't reckon she's got no hearing aids, but she can't hear too good, and on Wednesday night if I sit by her, she wants me to find what he said, you know, Scripture he's reading, she can't hear it. I know she wouldn't ask me if she could hear him."	Receives help from and gives help to others with hearing impairment.
Margaret	"You just don't care about nobody [when unable to hear]--not even yourself." "I don't care to be around nobody and nothing else."	"I know they talk about things and I don't know what they are talking about, or if you ask them what they are talking about they say oh, you can't hear noway and they go to tell you about it and you don't know that. But I say well, I won't never ask 'um no more." "And that was bad--it was just like you shut out . . . you didn't know what you	"You don't like to go buy nothing 'cause you can't understand what they are talking about." "Since I can hear--yeah, there are a lot of advantages, I can go places and hear things; they can call me on the telephone and I can hear better." "You don't feel like you ought to--but I know I ought not to quit 'cause I ought to	Enjoys being with others when she can hear but not when she cannot hear. Willingness to be around others is dependent upon whether she can hear.

Table 19 (Continued)

	Revealing-Concealing	Enabling-Limiting	Connecting-Separating	Rhythmical Patterns of Relating
Margaret (Cont'd)	"You don't know what they are talking about--because you don't know what they are talking about." "I wished I hadn't come. 'Cause I can't hear what they're saying--and I want to go home and they won't take me. Say, 'no, Mother, you're not going home and stay by yourself.'"	were doing or--that's the way I felt." "[When unable to hear feels like] I ought to be somewhere else by myself. Ought not to be around 'um." When unable to hear: "When you get around anybody you feel like I'm in the way--and you are." "I got these now, I can hear better with these." "Yeah--they can see when I get mad." "'Cause I don't say nothing to 'um. I won't eat, I won't do nothing. I come home and I get in a good humor." "I went Sunday and I could hear [since got new hearing aid]."	go to Sunday School and church."	

Table 19 (Continued)

	Revealing-Concealing	Enabling-Limiting	Connecting-Separating	Rhythmical Patterns of Relating
Margaret (Cont'd)		"Want to be around people and I can hear 'um--I can talk with 'um and I can go to church and I can hear good--and just everything--so I just feel better."		
Frances	"I think that's the thing that made me more conscious of the hearing loss was not being able to participate or hear a play or something like that, and the thing that kinda gets you, or . . . is you ask somebody, 'what did you say?' and maybe they'll repeat it [turn their head away]."	"It's enjoyable--it's peace and quiet, the quietness of the Sunday School Room." When traveling: "It matters about hearing but you don't understand their language."	"I didn't want to quit going to church. I just couldn't hear, had to strain so hard to hear. So--I go to the hospital on Sundays and volunteer. That's my way of worshipping God."	Able to enjoy some activities but not others because of her hearing loss.
	"You're supposed to know about a meeting that's gonna be next week . . . and you don't know what's going on--and you don't have the slightest idea."	"That's not much of a problem when you're traveling, when you can't understand the language anyway."		
	"Like Mr. Bugg, when he teaches, I can *hear him.*"			
	"I still, for certain teachers I can't hear what they say, but the others, it's funny how people's voices are different like that . . . it's not me all the time, it's that voice."			

Table 19 (Continued)

	Revealing-Concealing	Enabling-Limiting	Connecting-Separating	Rhythmical Patterns of Relating
Frances (Cont'd)	"She's such a wonderful teacher and I love hearing her but she just, and it makes me nervous when I go and I can't hear her."			
Max	"Now I have one daughter who talks so soft on the phone. Now when I'm with her, it's not as bad--and she gets frustrated. Mother do you have your hearing aids in. Well, yeah--she gets provoked with me." "It isn't going to happen anymore. . . . I still don't need my territory invaded to the point that a visit makes me terribly frustrated to the point I think, I gotta get out and walk 2 miles to get this out of my system."	"So I really try to avoid those situations and sometimes it's even very difficult for me to converse with the person right next to me because of the noise of--around me--and I have made some blunders." "I enjoy being out and being in the conversation and whatever, but in order to keep myself from being a victim of a stupid answer--and when I say stupid, I mean just completely off the wall--maybe stupid isn't the right word--just a really far out answer because what they said and what I hear are so foreign." "But to watch television with a group is impossible to	"And I have a luncheon group that I meet with regularly and have lunch with friends, I go out a couple of nights with a group for dinner. I play bridge, I have company, particularly in the summertime." "I don't like to go to the malls and look around." "I've even learned to do this line dancing." "I get frustrated with making small talk." "I love to go to Florida and to go see my children." "I'm fixing to get involved in the reunion--the classes of	Enjoys-does not enjoy social situations.

Table 19 (Continued)

	Revealing-Concealing	Enabling-Limiting	Connecting-Separating	Rhythmical Patterns of Relating
Max (Cont'd)		I turned my hearing aids down, I would have been out of it . . . really as far as knowing what was going on with the little group I was with."		

play, The Miracle Worker, has made her think about what life is like for those who are totally deaf. Liz demonstrated having feelings of compassion for several people whom she knew who had impairments. Examples of these include (a) a woman she knew whom no one would ask back for a visit because "she can't hear anything and you have to

Each of the participants in this study wore at least one hearing aid. The hearing aids have a special significance in the lives of these participants, serving as vehicles by repeat it to her," (b) the man who did her yard work while coping with multiple sclerosis, and (c) a friend who is not being invited to play bridge because of senility. Liz stated that she related to the woman who had the hearing loss and can imagine her own friends saying in relation to her: "Let's don't have her 'cause she can't hear anything." Liz further stated: "You just have to be compassionate to people who have handicaps, you've got to be patient with them more than kind." Margaret related that she now feels more compassion for others who are unable to hear. She said: "Feel sorry for 'um and think about how bad it is that they can't hear and don't know what's going on." Margaret revealed: "I never had that before." Frances stated: "I think I'm more conscious of somebody else's situation of not hurting them." She went on to say: "I guess that's part of the way you live--because you're so conscious of being hurt yourself that you don't want to inflict the same hurt on somebody else." Last, she stated:

> I think being deaf makes you more conscious of other people's disabilities. You know, I mean, want to consider them in a kinder way than you used to. Used to just say well, she's crippled and that's too bad, you walk off--and now you think about what that crippleness means and you just be a little bit more tolerant--it's more than tolerance, it's more kindness I guess.

Max related:

> I have more empathy for 'um because I know that they've had to make adjustments and I know they're missing out on the full faculties of life--and they may have been that way all their lives and not known what they've missed.

Max further stated: "Those really young people that are impaired, my heart really goes out to them." Finally, Max related that she has developed compassion towards rude store clerks. She said:

> What do I know about what's going on with these people? And I know that for whatever problems they might be having, this might be making them awfully nervous and not very congenial today, because it does me that way . . . I mean we've got a world of people who are emotionally handicapped that function every day but it's difficult to deal with them, and it's difficult for them to deal with it, and we become so self-centered and so uppity in our ways that we lose contact with the fact that their world might not be going so well. Lose sight of what somebody else is going through.

Thus, all participants except Susie related how their health patterns had changed in a direction towards feeling more compassionate for others since their hearing loss began. It should be noted, however, that Susie demonstrated compassion for others through her accounts of visiting and taking food to the sick, taking older people where they needed to go, and so forth.

Liz, Susie, Azalee, and Max reported other insights that they had had since becoming hearing impaired. Liz described an insight she had while noticing a hearing impaired friend. She said: "By my noticing her, makes me realize how I look to other people. . . . It's not a bewildered look, it's more of a blank look."

Susie stated how she had realized that "you're just losing all that you could learn, you could learn it, what I said, whether you ever know what it said, see?" Azalee related: "I've learned that some people don't have as much patience with you as others do."

Max reported several insights that occurred as a result of having the hearing loss. First, she reported sometimes enjoying having the hearing loss "'cause a lot of little talk at times frustrates me--small talk--it [the hearing loss] can be enjoyable--you can use it as an excuse--if you want honesty." Second, Max reported having the realization that "I can live in my little silent world pretty well." Third, Max related that changes that occur because of having a hearing loss "sorta evolve." She further stated: "Well, this is a learning tool for the hearing impaired and you just have to sorta work into it, and move along as the stages and ages progress." Fourth, Max said: "It's kinda nice in a way when, like the scripture says, be still and know that I am God--well, you're in a be still world and it is, it's quite strengthening at times--at other times it's just maddening."

Directional Idea 2

The second question related to Research Objective 3 was as follows: What changes have you made in your life because of your hearing loss?

Each of the participants' health patterns had changed in some way since their hearing loss began. Seven such ways are discussed and examples of each are provided. These are (a) wearing hearing aids, (b) isolating, (c) faking hearing, (d) depending upon others to help compensate for the hearing loss, (e) becoming more assertive, (f) enjoying activities in a changed way, and (g) taking care of others.

Hearing aids. Buying and using hearing aids represented a major change in the lives of these participants. Each participant admitted to experiencing both advantages and disadvantages related to hearing aid use. The advantages and disadvantages are described in Table 20.

Each of the participants in this study wore at least one hearing aid. The hearing aids have a special significnce in the lives of these participants, serving as vehicles by which the participant can connect to life. Participants seemed unable to describe their hearing loss without describing the advantages and disadvantages of hearing aids. The

Table 20

Advantages and Disadvantages of Hearing Aids

	Advantages	Disadvantages
Liz	● Enables hearing others ● Enables her to hear own voice ● Enables hearing sounds of animals, clocks, and thunderstorms	● Unable to wear while sleeping ● Becomes uncomfortable ● Feels like foreign object in ear ● Does not provide the same sound as normal hearing ● Have to be cleaned ● Batteries die ● Pick up extraneous noises ● Whistles when turned up too loud ● Whistles if touch face with hand ● Unable to wear around water or if perspiring ● Are not pretty ● Make ears poke out
Azalee	● Enables better hearing	● Expensive ● Loud sounds hurt ears ● Unable to block out extraneous sounds in crowds ● Embarrassing to have to reach up to adjust ● Difficult to put on ● Ear mold sometimes uncomfortable

Table 20 (Continued)

	Advantages	Disadvantages
Susie	• Can hear better with them	• Become dependent on them • Tubing easily stopped up with earwax which prevents hearing • Must be cleaned frequently • Picks up extraneous noises • Bothersome • Whistles • Battery dies • Expensive
Margaret	• Can hear and understand better • Can adjust using remote control • Can block out extraneous noises • Can hear television	• Expensive • Batteries last 2 weeks • Batteries expensive • Difficult to put on • Unable to wear at beauty shop
Frances	• Can hear better	• Not like natural hearing • Gets tiring • Unable to wear at beauty shop
Max	• Enables better hearing	• Distorts sounds • Unable to work in yard or when sweating • Unable to use it when on telephone • Extraneous noises loud • Does not completely correct the problem

researcher, therefore, came to realize that in the eyes of the participants these two topics were not separate entities but were each a part of the other. The participants in this study were all glad that they had hearing aids. They did, however, talk not only about the advantages but also about the disadvantages.

Liz expressed some negativity towards wearing hearing aids. She stated:

> Sometimes you feel like you have a foreign object in your ear, and other times, you're not aware they're in your ears. But about two or three times a month I

> wish I could just take them out and not have them in there because they are bothering me.

But on the positive side she said:

> Listen, listen, there was a time that you sat with a trumpet--it's great! Listen, if I took these hearing aids out, I would not hear my voice, nor would I hear yours. They are wonderful and ugly.

Azalee related that she does not wear her hearing aid when at home alone and also that she can hear some people without the hearing aid. She never wears both of her hearing aids because (a) one does not feel good in her ear and (b) she does not feel that she hears better with two. Azalee stated: "I'll tell you, if I was to lose 'um, I'd be frantic, because there's times that I need 'um--super need 'um."

Margaret spoke about her old hearing aids and compared them to the new by saying: "Them others, they never done nothin' but whistle." She then said: "I can hear out of these. . . . I can go places and hear things."

Frances related:

> And you've got not to hear the same out of both ears. Sometimes you just get tired of it and you go in there and take 'um off and don't hear anything--that is the way it is with 'um, I don't know about other people but I don't think anybody enjoys wearing hearing aids but it certainly is a godsend.

Susie repeatedly made negative remarks about wearing hearing aids and focused on the fact that they "are just more work and stuff." She said,

> Yeah, it's better with 'um--but I mean they're aggravating--you've got to clean 'um, you've got to put 'um in, and then you've got to . . . see, that wax in your ear sometimes you have to get it out.

Last, Max related the advantages and disadvantages of hearing aids in this way:

> Yes, it was bad, but it's still better than trying to operate with a 50% loss, 54 in one ear and 50 something in the other. But this is better, the hearing aids are better.

when she was with people. Margaret reported that she would stay home rather than put herself in this situation.

This feeling of not wanting to be where she cannot hear is exemplified in a statement made about attending Sunday School. Margaret said: "I felt kinda bad and I told my friend I'm not going back any more. Hear better at home." Margaret claims to be more willing to be around others since she bought new hearing aids.

Frances also provided accounts of isolating behaviors. She stated: "I know something has been said that I didn't hear and I just dread for somebody to ask me what it was. . . . It keeps me from going to meetings. . . . I can't hear so I just don't go." Frances also described isolating in this manner:

> If you can't hear 'um and you can't understand 'um you have a tendency to get away from 'um so they won't have to talk. . . . I've been in situations like that and I just try to move--go somewhere else. That's all I know to do.

Last, Frances described her tendency not to go to Sunday School since the class moved into a room where she cannot hear as well. She stated: "I catch myself not going as much as I used to . . . If I don't feel good, I don't make that special effort."

Max provided accounts of ways she isolates herself when her family is around. She said: "And when you're in a room with everybody talking--I just think, I'll just draw up in my little shell here and protect myself, and let them go to it." She also related:

> Then when the whole family gets there, sometimes it just almost puts me over the edge. I have to become a little withdrawn, a little reclusive, because it works on my nervous system. It's either that or turn them down, and either way I don't know what's going on.

Max also described isolating herself when her family watches television. She stated: "I just go to bed with a book [sounds hurt], because they can't stand to listen to it where I need it to be . . . and most of the time, I'll still miss the punch line." She later described another way she handles this situation by saying: "There's always a deck of cards there and I get my cards and play solitaire--it doesn't bother them, but I'm with them physically but I'm not into the program."

Max related that she has isolating behaviors when she is out in public. She stated:

> When I'm out, I try not to engage in too much conversation if I'm in a real noisy situation, uh, because I do just about half the time make a fool of myself with my replies--and then when people engage me and I keep missing what they're saying rather than appear dull, and rather than put them on the spot, I'll just excuse myself from the conversation by pointing to my ears and just back out--because it's the kindest thing for me and them.

Faking hearing. Several participants mentioned how they relate to others by pretending to be hearing when they really are not. Susie described how she sometimes acts like she is hearing in Sunday School when she isn't hearing. She said: "you know you don't want to ask her over after she's going on teaching the lesson you know to repeat again when you can't hear so I just let it ride, you know."

Margaret described how she fakes hearing in Sunday School. She stated: "Well, you don't say nothing. You just sit there. . . . I go along with them you know." Next, Margaret described faking hearing in family situations by saying: "They'll be a-talking and laughing and all and you'll do the same way--just do like they do." Margaret went on to say: "Well, they'll be talking about something and you make like you--they wonder if you hear and you say, yeah I heard--I made like I could hear--but I didn't let them know it." When Margaret was asked why she would tell her family she heard when she did not, she replied: "I don't know [laughs] why, you do so much when you don't hear. I'll tell you."

Frances stated:

> If somebody was to come in today and sit down and talk and I couldn't hear what they said, but you could hear it, then I'd let that conversation just flow naturally and it would come to me to interrupt when it was necessary.

She related: "Well, I just go and . . . listen. . . . I mean ah, pretend I'm hearing it all." Last, Frances stated: "If I don't know what's going on and lots of times I don't know what's going on--I just sit there and smile."

Max described how she fakes hearing by saying: "I just sort of sit and watch and look--and hopefully can participate enough that I'm at least sociable." Max also described pretending to hear when she went to a restaurant with friends by saying: "I'd just grin when I'd think I'm supposed to or laugh or shake my head someway to acknowledge that I heard something but I don't know what in the heck it was I heard."

Depending upon others. All participants described ways that they depend upon others to assist them when they are unable to hear. It was interesting to note how participants viewed others' responses to their dependency.

Azalee related how the president of the Garden Club arranges for her to sit in a certain seat so that she can hear. Azalee said the president would say: "'I saved you a seat right here,' and I turn that up and she don't have to talk loud to me to tell me anything or ask me anything." Azalee also described relying on a friend to call her on mornings when she needs to get up early.

Susie described how she depends on a particular person in her Sunday School class to help her hear. She stated: "I sits by her most of the time, but I'll ask who is it they said, you know who was sick or something and I can't hear. I'll ask her you know, about who it was, but I don't like to do that at all."

Liz described ways that others were and were not helpful to her as she related accounts of experiences she had had related to the hearing loss. She described how the grocery clerks were helpful when she did not hear them tell her the amount due. Liz stated: "I find that people, they don't resent that." However, she went on to say: "People don't want to take up all that much time with people who don't hear. They say, oh, you know, she can't hear--we don't want her to come down here. She can't hear anything." Liz then described how her accountant was good to say to her, "Did you understand this?"

Liz described not being able to hear when her nieces came to visit. One niece tried to help her by stating: "We aren't saying anything that means anything--if we do, I'll tell you." Liz related telling her family: "If you want me to know something, you be sure that I heard you. You say, did you understand that?"

She also described relying upon friends to ask for directions when she was traveling with a group of people. She stated: "I'd say now, somebody else'll have to go get the directions, I may not hear it."

Last, Liz described how she hoped that people she had known long term would help her out when she stated: "I think that if you had known someone and well, I hope it's that way, that they are sensitive to your problem, and that they would be compassionate and try to make you understand."

Margaret described how she lets her children order for her in restaurants. She said: "I always let my kids do my ordering and everything--I tell them, I can't hear so y'all just go ahead and order me anything you want to." Next, Margaret stated: "I choose--they read it off to me and tell me what they got and I tell them what I want and they ask for it."

Frances also places a great deal of responsibility on others related to her hearing loss. She said: "I think anyone who loves you is concerned and cares for you, well they know when you can't hear." Frances described how a neighbor helps her know what goes on in meetings when she said, "but when I do go out with her, for meetings or something like that I just depend on her to listen--so if there's anything I ask her--she'll tell me . . . sometimes she doesn't tell me." Frances further related: "I do know that I just depend on Connie and Velma when I'm in a crowd to keep me up-to-date on what's going on."

Frances depends on an office nurse who told her what the doctor said. She reported saying: "'April, you've got to go because you know I don't understand what he says' . . . so she interprets."

Max described how she had received support from people at work related to her hearing loss. She stated: "They put me in a little cubicle and they knew not to bother me if I was really zeroed in." There have been times when she relied upon her son to tell her if her car sounded all right, but at present she states she does not do that. Instead, she states: "I ask my friend, and he'll tell me, if he can't tell me, I go to the car dealer and find out for myself." Last, Max related that she depends on a neighbor to help her related to safety issues and stated: "If I was there and they heard something or saw something, they'd be sure to let me know."

Becoming more assertive. Azalee, Liz, Frances, and Max described ways they have become assertive about getting their hearing needs met. Azalee said that she responds to not being able to hear by stating: "You'll have to speak up a little. There's other people present that can't hear much better than I can." She also described a situation that occurred with a nurse who cared for her while she was hospitalized. Azalee related saying the following to the nurse: "I can't hear what you're saying. . . . I told her one day you're going to have to talk loud to me every time." Another way Azalee related to others assertively while hospitalized is shown by her statement: "Now wait a minute and I'll get my pencil and paper and write down things for sure." Azalee stated she tells the person who comes to help bathe her: "You turn around here and talk to me if you want me to hear."

Liz described several situations where she was assertive related to her hearing loss. She described how she always asked for the back booth at a favorite restaurant. Liz stated that if she sat in the back booth, there would be no one sitting behind her and she could hear better. Other situations where Liz described becoming assertive related to getting a front seat in Sunday School and at auctions in order to enhance her hearing. She related learning to speak up at the bridge table when unable to hear bids by saying: "What did you say--did you say that?" Liz also described how she learned to tell her broker: "You have to talk to me--and you know that I understand what you say."

Frances related how, if she was in a situation where she felt it was important to hear correctly, she would keep on asking questions. She stated: "If I don't understand something and somebody said something to me and I know I should know what he said, then I don't mind keeping on asking that person."

where the cute folks go, dressed up and everything, I have to turn my hearing aids off, I cannot stand all that noise!" She continued: "I just don't have a conversation. Just eat--just look around at people."

Last, Liz related how she enjoyed being with her family whether she could hear the conversation or not. She stated: "I'd rather have 'um here--whether you can hear what they are saying or not--just to see them."

Frances also related ways that she has learned to enjoy her usual activities in changed ways. She said:

> And uh, I read the lesson 'fore I go and just sometimes think about that and sometimes 'bout something that's really pressing on my mind. I think about that, you know, how I can work it out--and it's just uh--even now I don't understand all that goes on so I just sit and listen--absorb the atmosphere you might say.

Frances further stated: "Just to go to church and be with other people and I just love going . . . being alone like that--it's a real treat to go and be with people. And I enjoy it." Last, she said:

> No it was not, it's not boring. You would love to know what's going on and you'd love to hear what they are saying but you can accept anything that you have to and you just sit there and enjoy what you have.

Susie expressed that when she eats in restaurants she will "sit there and eat . . . look at 'um." Susie was unable to verbalize other ways that she enjoyed usual activities in a changed way.

Max spoke about how she can enjoy the ballet in spite of her hearing loss. She stated:

> What you don't hear, your sight will pick up and help you enjoy it. . . . I can turn the hearing aids down and still get the beat of the music so that I see that they are flowing with it or whatever.

Taking care of others. Three participants expressed that they had come to realize a need to take care of others and not let others suffer because of their hearing loss. Frances stated:

> If anybody looked at me for a response or something like that, and I could answer them without them feeling embarrassed that they had said something that I couldn't hear--'cause it's embarrassing to somebody to talk to you and they know you didn't hear 'um . . . and you gotta make it as easy on them as a person as you possibly can.

Max stated: "I wouldn't want you to pay a price in a conversation or business dealing or whatever with me because I'm handicapped with my inability to hear."

Max related how she backs out of conversations "rather than putting them on the spot, I'll just excuse myself from the conversation by pointing to my ears." She also stated that she feels the need to

> really explain to the grandchildren that they don't have a problem, that they don't have to be upset if I tell them I did not understand--to take that burden away from them you know, just trying and frustrating themselves and feeling inadequate because they do not get it across to me.

Last, Max related:

> I'm trying to comfort all these people when in reality I'm trying to say to them, it's me, it's my handicap and I don't want you to be hurt or feel anything is wrong with your ability to communicate--it's mine and I recognize it . . . . I don't want somebody else to be hurt because of what's wrong with my hearing. And so I try to protect 'um I guess.

While Liz tried to get a front row seat at auctions and a certain table at a favorite restaurant so that she could hear better, she then reported feeling guilty that she was taking these places from others or preventing others in her party from sitting where they would like. She related: "Maybe someone else wants to sit--let's don't sit there . . . you know." The researcher suggested that perhaps Liz had a good reason for requesting special seats, to which she replied: "Yes, but they think they have a good reason too." Last, Liz related: "It's my problem--not their problem."

Directional Idea 3

The third directional idea related to Research Objective 3 was this: Describe your vision of the future.

Azalee, Susie, Liz, and Max spoke about their hearing loss in relation to the future. Azalee related: "I don't think it's going to make a lot of difference in my hearing unless I go completely deaf." Susie said: "That's what I dread about getting older, you know but you know 'bout hear, I hope it don't get no worse than what it is, but I don't know." Liz's first response when asked about the future was to say: "You know I don't dwell on that, that is not my business. It's what the Lord has, his plans." Liz then related her thoughts about the importance of the hearing loss in her future. She said:

> Oh, honey, I don't know. Well, my hearing is not as much as, well it could be a bigger factor than I ever think it is. . . . I could say if my hearing aids get any worse, I can't drive a car.

Max stated: "I just hope and pray that I can keep what I've got. But there again, I'm not as sure that that's going to happen and I think that's another thing that happens along the way." Last, Max said: "You know it would be bad--I would just hate it if I went to the gulf or the coast and I couldn't hear the roar of the ocean . . . so I think I better go to the coast all I could."

Participants made further comments about the future that were unrelated to having a hearing loss. Azalee described her further hopes for the future by saying: "I hope I stay healthy and I'm going to keep doing a lot of things I do as long as I'm physically able."

She also spoke about "expecting to go to heaven" and wanting to help others when she is able to.

Susie stated:

> Well, I guess the same thing, going to church and have my health and still work, uh, but I mean I mow my grass, and you know we got, I hadn't worked in the garden this year but uh, Don and them's done it, but I always work in the garden, can stuff, and I pray that I can keep my health and do my grass and do the things, just keep--till I pass away--do for myself--I don't want to be no burden to nobody.

Once Liz began to speak about the future, many concerns were expressed. Liz said: "But my future is what am I going to do with this big yard? How am I going to drive a car when I have to go to town?" Liz further related: "But right now I can't think about any like, the men today said to me you need to have this house stained." Last, Liz stated:

> People they say we're not supposed to worry about our finances and everything, you do have to. So I guess that I am concerned as to what I can spend and what I can't spend because you don't know how long it has to last.

Liz died 5 weeks later.

Max stated: "According to the Good Book, I only have 3 years you know but I plan to live to be 90--that's a projection I have." She reported feeling that her adult children invade her territory and she wants to stop that from happening. Max stated: "I'm not going to be tormented like this for another 13-23 years--if it should be that way."

Frances said:

> How can you say future, you just live one day at a time, and just be grateful for what you can do. . . . No you can't see that far ahead when you get as old as I am because you're too busy preserving the day you've got. Because today is a big important day--you're living it.

Frances further related: "Today's my birthday, I'm 85. . . . I hope I'm not living 5 years from now all by myself." Last, Frances said: "I just want it to come to me, not me go to it. That's all I can handle. That's enough."

Margaret, the oldest of the participants stated: "Not much! Well, I tell you, I've lived a good life, my kids is good to me, all of 'um."

Hearing Loss Themes Related to Research Objective 3

Hearing loss themes related to Research Objective 3 are described in Table 21.

Table 21

Hearing Loss Themes Related to Research Objective 3

Human Becoming Theory Language	Theme Interpretation
Liz	
Powering herself to walk with joy in spite of her hearing loss.	It's attitude.
Powering self not to be crotchety and testy while recognizing the impact of age on her attitudes and tolerance of her hearing loss and hearing aids.	I won't give in to negativity.
Originating ideas about what her future holds in light of her hearing becoming worse.	It upsets me to think about it.
Powering self to originate changes in her life in order to cope with her hearing loss.	I have found ways to cope.
Powering self to feel compassion for others with disabilities.	I know what it's like.
Powering self to feel that the hearing loss has some advantages.	It's what you make of things.
Azalee	
Powering self to maintain a generally positive outlook and remain engaged in life despite health and hearing concerns.	My activities help me survive.

Table 21 (Continued)

Human Becoming Theory Language	Theme Interpretation
Powering self to originate coping mechanisms to help manage having a hearing loss.	I invent ways to overcome things.
Powering self to feel that having a hearing loss has not negatively affected her life.	Thinking positively makes life good.
Originating images of how other health problems have more of a detrimental effect on her life than the hearing loss does.	Hearing loss is the least of my problems.
Originating images of compassion for those who are totally deaf.	I relate to Helen Keller.
Powering self to originate new feelings about others knowing that she wears hearing aids.	Maybe it doesn't matter if they know. Letting go of pride.
Powering self to feel comfort in the fact that others her age have similar hearing problems.	I'm no different from my friends.
Powering self to originate feelings of being better off than friends without hearing aids.	I can hear better than them.
Powering self to use her disability to her advantage when she does not desire to talk with staff when hospitalized.	I choose whom I relate to.
Powering self to feel that others are willing to help her hear.	I have friends. They will help me.
Susie	
Powering self to feel that hearing aids are beneficial in spite of their many disadvantages.	I guess it's worth the work.
Powering herself to place her hopes in the Lord related to her future hearing problems.	The Lord will look after me, I hope.
Powering self to feel all right about her circumstance by saying, "Everyone has something or another."	I'm no different from anyone else.
Powering self to feel some advantage to her hearing loss in that she doesn't have to hear things that are not good.	If I think hard, I can say it has advantages.
Imaging how she copes by faking hearing when out in public.	I do what causes me less embarrassment.

Table 21 (Continued)

Human Becoming Theory Language	Theme Interpretation
Powering self to hear by selecting a seat closer to the front in church.	I want to hear.
Powering self to enjoy activities in a changed way when unable to hear in restaurants.	I want to be with you.
Powering self to put hearing loss in more positive terms by imaging that blindness is worse.	It could be worse.
Margaret	
Powering self to originate positive feelings toward her electronic hearing aid.	It's a whole new world.
Powering self to originate empathetic feelings towards others with disabilities.	To have is to understand.
Powering self to manage around others by faking hearing.	They'll never know.
Relying on her children to help her order in restaurants.	I need your help.
Powering self to find solace in isolation when unable to hear.	I retreat to safety.
Powering self to use her hearing loss to her advantage when it becomes convenient.	I'll outfox you.
Frances	
Powering self to originate a new way to worship God when no longer able to hear in church.	Worship through service.
Powering self to originate positive images of wearing hearing aids.	At least I have a chance of hearing.
Powering self to originate new ways to enjoy old activities although unable to hear.	Creating own world view.
Powering self to prefer hearing loss over blindness.	I could be worse.
Powering self to cope by faking hearing.	Pretending makes me more acceptable to others.
Powering self to get her hearing needs met by depending on others.	I need you.

Table 21 (Continued)

Human Becoming Theory Language	Theme Interpretation
Powering self to realize that there are advantages in her disability.	Spiritual renewal comes with silence.
Powering self to use her other senses to overcome her hearing loss.	Use what you have.

Cross-analysis of hearing loss themes related to Research Objective 3. Older women with hearing loss do the following:

1. Originate a particular compassion for others with disabilities.
2. Reveal expanded consciousness as images of positive aspects of the hearing loss arise.
3. Begin to power themselves to originate new ways to be in the presence of others.
4. Reveal increased dependency on others as they live their daily lives.
5. Power themselves to get their hearing needs met.

Unified statement of hearing loss themes related to Research Objective 3. Older women with hearing loss empower themselves to originate new ways of being in the presence of others while developing ways to get their needs met by others and at the same time deriving some positive meaning from their experience by developing compassion for others with disabilities.

Unified statement in researcher's language. Older women with hearing loss empower themselves to originate new ways of being in the presence of others that transform levels of consideration for others to a higher dimension while benefiting the personal self and assigning new meanings to their experiences.

Hypothetical Statement of Hearing Loss Themes

From Research Objective 1. A burdened heaviness emerges as the was is left behind and the realized and will be surface.

From Research Objective 2. Thoughts of the no longer possible are revealed and concealed, while connections and separations from relationships and activities are enabled and limited.

From Research Objective 3. Older women with hearing loss empower themselves to originate new ways of being in the presence of others that transform levels of consideration for others to a higher dimension while benefiting the personal self in assigning new meanings to their experiences.

Hypothetical statement. The burdened heaviness of first discovery of the hearing loss passes as new meanings are assigned to the hearing loss and thoughts of the no longer possible enable-limit connections and separations from relationships and activities while empowering new ways of being in the presence of others that both benefit the personal self and transform levels of considerations for others to a higher dimension.

Final Hypothetical Statement
Combining Life and Hearing Loss Themes

The burdened heaviness of first discovery of the hearing loss passes as new meanings are assigned to the hearing loss and thoughts of the no longer possible enable-limit connections and separations from relationships and activities while empowering new ways of being in the presence of others that benefit the personal self and transform levels of considerations for others to a higher dimension. Influenced by past experiences but living in the present, the individual meets her own needs as consideration is given to personal value systems and spiritual issues in varying degrees.

Parse Analyzations Related to Research Objective 3

Research Objective 3 directly relates to Principle 3 of the human becoming theory. Principle 3 reads: "Cotranscending with the possibles is powering unique ways of originating in the process of transforming" (Parse, 1987, p. 69).

The data indicated that 4 of the participants had reached the level of cotranscendence as this concept related to some aspect of having a hearing loss. Neither Susie nor Margaret gave evidence of having a health pattern related to hearing loss that demonstrated cotranscendence. Examples of analyzations related to the concepts of Principle 3 are provided in Table 22.

Analysis of Data in Relation to Parse's Theoretical Structures

The data obtained from participants were applied not only to the human becoming theory principles but also to the theoretical structures. Results obtained (a) further

Table 22

Parse Analyzations Related to Principle 3--Cotranscending With the Possibles

	Powering	Originating	Transforming	Cotranscending
Liz	With a slower paced lifestyle. "I don't have to be see I was home yesterday and the day before and I was perfectly contented."	To stay home more now. "For instance, I don't care whether I go to a movie at night or not." "I'm not interested in going in a group of people." "It doesn't change my attitude about things--of course, it changes your attitude about hearing, but anything else it doesn't. You still have the same wants, desires, and, of course, as one grows older those desires are not as great."	Self to live a slowed life in which the desire to go is not as great.	The desire to go and replacing it with the peacefulness and security of home.
Azalee	Self to accept wearing a hearing aid without embarrassment.	Feelings of acceptance towards her hearing aid. "When I first got 'um, I let my hair grow out right down	From embarrassment over hearing aids to advocacy of hearing aids.	The embarrassment of wearing hearing aids in order to have a more normal lifestyle.

Table 22 (Continued)

	Powering	Originating	Transforming	Cotranscending
Azalee (Cont'd)		over my ears and it just, I looked a lot older, with it down long, and I said well, shoot, I don't care who sees me because they know it's just part of life and I just started having it cut shorter and let 'um see it."	"I have a friend that can't hear any better than I can, but she's a whole lot younger--about 10 years younger--than I am, and she always sat by me at church . . . We never could talk to each other 'cause she couldn't hear any better than I can and she never would get any ear helps and so she still--she was here the other day and I just remembered, she asked more times than I did what everybody was saying."	
Frances	Self to accept her hearing loss and enjoy what she does have. A process of day to day acceptance.	"Because I know it's gradually having to adapt to it, so it's just a growing process. You never learn completely." "We're so grateful for the next minute."	Transforming self to accept life as it is. "You gradually learn to adapt to whatever your present capabilities even as a crippled person or	The power of her hearing loss by powering herself to originate a level of acceptance of whatever comes her way.

Table 22 (Continued)

	Powering	Originating	Transforming	Cotranscending
Frances (Cont'd)		"But every situation that comes up you first let it--take it as it comes and deal with it and do the best you can."	somebody that lost a leg, don't you think so, gradually learn to?"	
Max	Self to find something good about having a hearing loss. "Sometimes you're better off not hearing, and not getting involved in it." "Sometimes I use it to--just to protect myself for whatever reason." "Mostly it involves disputes in my family circle, there's somebody that knows everything or they're gonna get all the kinks worked out--just over a heated family--not an argument--but I mean well so-n-so ought to do such-n-such--some members	Ways to use hearing loss creatively to avoid unwelcome conversation. "And I know for a fact when situations are where I don't want to get involved, I'll say I didn't hear that." "My goodness, if you don't learn something in the growing up process, it's kinda bad. And you're not going to change anybody's opinion. They're going to hear and receive exactly what they want to, and all other is just wasted words."	Self to turn a disadvantage into an advantage. "It's their life--it's their choice--so I think it's sorta a waste of time so I'll just cop out here and say, 'Hey, I didn't hear that,' and I don't get in it. I used to but I don't anymore."	The disadvantages of the hearing loss by learning to use it to her advantage.

Table 22 (Continued)

	Powering	Originating	Transforming	Cotranscending
Max (Cont'd)	saying the other members when talking about what they ought to do and ought not to do--and I thought --this is so ridiculous, just wait till they grow up." Self to know what's going on without hearing what is going on.	New ways to know through other senses. "Plus, just well, just observing mother nature, I have to rely on my eyes to compensate and see the beauty of mother nature when I can't hear it all. I don't always hear the birds, the frogs, and the crickets, I don't always hear all of that now, so I have to use my eyes and other senses--you know touch the flower, 'course that flower doesn't make any noise, but by the same token, you are using your other senses to compensate for the loss of--tremendous loss--in one of them. So I think that in seeing things, you see them differently I guess because you appreciate the fact that	Her way of knowing. "But it's just different ways of doing things I guess and letting your other senses keep you informed."	The disadvantages of not hearing by learning to use the other senses to compensate.

Table 22 (Continued)

	Powering	Originating	Transforming	Cotranscending
Max (Cont'd)		you do have another way of enjoying what's around you."		

Table 23

Theoretical Structure 1. Powering is a Way of Revealing and Concealing Imaging

	Revealing-Concealing	Imaging	Powering
Liz	"I nearly got run over the other day--I was walking. I didn't hear the car and I walked right in front of him. . . . I walk [now] on the side the walker's supposed to walk on. . . . I get in the grass and walk that way."	That she might have been killed when she walked into a car.	Self to be more careful and develop new, safer walking habits.
	"OK--when I walk now, if I cross, I turn around and look because I did not hear that car and I had on my hearing aid."		Self to think and talk positively.
	"Well, I am glad that I at one time heard."	What it was like to hear well.	"Well, there's so much things worse than not being able to hear."
	"It isn't all that bad until you get to talking about it."	The necessity to think positively.	"But you can get bitter about anything and I refuse to get bitter."
			"No, I never have felt sorry for myself. Now I may, but right now I just say, 'Come day, go day, God send Sunday.'"
			"But you know, I'm still the same person."
			"Maybe it's a good thing you can't interfere because you don't know how to interfere. You hadn't heard it."

Table 23 (Continued)

	Revealing-Concealing	Imaging	Powering
Azalee	Concealing [sounds thoughtful, far away, voice quieter, sad]: "So it [hearing loss] doesn't make any difference in other clubs and things, too, parties and things, it don't make any difference."	Self as an active person in the present.	Self to think of health and hearing problems as only minor detriments to her life's activities.
	Revealing: "I'm a member of the Arts Division and I used to go to all of those things over there when ______ was living, but now I don't go because it's at night."		
	"The reason I haven't been to church is because I fell and couldn't walk and couldn't drive my car--'course I had a lot of people say they'd pick me up but . . . I just hate to let people wait and do things for me, but I don't think it's made a lot of difference."		
	Revealing: "I still go to a lot of day things, but not at night."		
	Revealing: "I still have a lot of that in store down at the little house. I like to do one of those one day."	Self making dried flower wreaths and all kinds of wreaths and plaques out of nuts and pods and things.	

Table 23 (Continued)

	Revealing-Concealing	Imaging	Powering
Susie (Cont'd)	"Yeah, I'm glad I got 'um--it's just kinda--I mean you can hear better if you got 'um." "Yeah, it kinda bothers you, you know, especially when it, the battery went dead." "If my hearing aid ain't working--if I can't hear, you know, I don't say nothing . . . . If you can't hear there ain't no use saying anything if you can't hear." "I got new batteries and all that, you know it's not stopped up if there's just one talking you know like . . . but it ain't as good as you had your hearing though." "I believe after you get 'um though, it makes it worse."	That her hearing aid has both advantages and disadvantages.	Self to be glad that she has hearing aids in spite of their drawbacks.
Frances	"If they want you to hear they'll--now days--if you want me to hear anything, shout loud enough for me to hear them." "Someway or another, God provides a way for you to know if it's important enough for you to know, God will provide a way for you to know--that's something that's not within yourself."	That those who love you will know when you aren't hearing and will tell you what you need to know.	Self to believe that if she really needs to know something, God will provide a way for her to know it. Self to believe that her friends will tell her what she needs to know.

Table 23 (Continued)

	Revealing-Concealing	Imaging	Powering
Frances (Cont'd)	"Now you just accept it and if they want to--want you to know what they said, they'll tell you." Revealing ways she relies on others. "People are just so good." "But on the whole, people are very good and kind and nice to you to help you." "I was always with them and they were always with me so I didn't have to do without ears because I had theirs--so I didn't suffer from--I didn't get in a tight place."	That others are willing to help her in difficult times.	Self to think in positive terms regarding others' willingness to help out when she's in need. "Everybody in town was on a one or two party line--but they'd hear my voice on the telephone, they'd get off. Mrs. ____ is on the line, everybody got off." "Somebody'll always just be more than glad to tell you what's been said or what's going on." "John'll get it when he can" [change light bulb outside]. "When you get in a tight place, there's always somebody around that can help you."
Margaret	"Yeah--I'm sorry for anybody. You can always find somebody worse than you are. I saw a man at Wal-Mart not long ago--he was pushing a buggy and his feet would go everywhere. I said, 'Well, you look around, you see somebody in worse shape than you are,' and you feel sorry for 'um, you don't know what to do." "I feel sorry for anybody that can't hear and can't talk--I had an aunt and uncle. . . . They adopted two--this boy had married and they had two	Self as healthy when she compares her condition to others.	Self to feel better about her own condition by comparing her health to others.

Table 24

<u>Theoretical Structure 2. Originating Is a Manifestation of Enabling and Limiting Valuing</u>

	Enabling-Limiting	Valuing	Originating
Liz	"I don't know, just like this saying one day at a time--but that's not the way I want to be. Dare to walk with joy. Be joyful that day. And that's the way I have to look at it whether I can hear or not. I can hear. I've got help--so I have to be satisfied with what I can do. I don't know whether I'm looking at it like a do-do or not--but what can I do?"	Planning for the future. Acceptance of her life as it is.	A new way of life--taking one day at a time.
Azalee	Self to go to church and not suffer the embarrassment of turning her hearing aids up in front of others. Limiting opportunity to get used to turning up hearing aids in church. Limiting opportunities to be around music. "Kindly, kindly feel embarrassed, don't want them to know exactly." "But I'd turn 'um completely off for the music 'cause our man that plays the organ, I think he plays too loud." "You know I'm still proud to a certain extent and working those things in the middle of church, I didn't like that."	Privacy in wearing hearing aids. Hearing the preacher. Not having the music hurt her ears.	A plan to enter the church sanctuary after the music is over in order that she does not have to be around the loud music or turn her hearing aids up in front of others.

Table 24 (Continued)

	Enabling-Limiting	Valuing	Originating
Azalee (Cont'd)	Self to have beautiful garden in spite of own limitations related to doing the physical labor. "I guess I owe 'um 50 or 60 dollars for the last 2 days they've been out there so I just pay it and not even think about it." Limited by her health. "I used to keep the garden all by myself until I got to where I couldn't." "I had to stop my yard work because I couldn't do it anymore."	The beauty of her surroundings.	New ideas about how she wants to spend her money. "But I've changed my priorities on a lot of things. I used to spend a lot for clothes and I decided as I'm older that clothes don't mean that much to me--I'd rather my garden would be beautiful and just spend it on it."
Susie	"Yeah, I sit up a little closer." "We've got a new youth director and he'll come Wednesday night and tell, and he won't get by the microphone, and I was going to tell Brother Bill but I never did get a chance." "If you can get in a place where it ain't noisy, you know, you can hear, but you just hafta be a-looking at 'um . . . I mean trying to hear 'um." "Well, I don't know, I just have to look at 'um when they're talking, you know, seems like I can understand 'um better--when I'm looking at 'um and uh, then I would be not looking at them."	One person speaking at a time. Being able to see the person to whom she is speaking.	Ways to increase her hearing ability.

Table 24 (Continued)

	Enabling-Limiting	Valuing	Originating
Margaret	"If you're by yourself you can hear better, but if you're with your kids there's more noise so then you couldn't hear somebody come to the door."	Feeling like she can hear. Independence.	Ways to enable her to feel that she can hear.
	"Well, you feel like you can hear--if anybody comes to the door you can hear them."	Quiet.	A new way to be in the world since buying hearing aids with which she can hear.
	"But now I can hear good. I can hear with it [new hearing aid]."		
	"Well, if I can hear, I can know what's going on, and I can talk more. I couldn't hear enough to talk to nobody or nothing."		
Frances	"I could sit there and enjoy the Sunday School teacher without hearing."	Being with others whether she can hear or not.	A new way of being around others.
	"Just do without your hearing; you just say yeah that's fine, that's right, or say something."	Maintaining her dignity when unable to hear.	
	"You can pick up what's going on by the way others act around you."	Other ways of knowing besides hearing.	
	"Well, I had to depend on others more than I used to."		
	"Usually I just plow on, but I try to listen a little bit more carefully and be sure that I don't blurt out the wrong word."		

Table 24 (Continued)

	Enabling-Limiting	Valuing	Originating
Frances (Cont'd)	"They'll say something and I didn't always understand them and I'll say, 'Yeah, that's right,' and I don't know whether that's the right answer or not. . . . You just have to guess at what they said and hope you're acting right." "I maybe have programmed myself for this protection thing, not the shrillness, the hurt, and also just to protect me from injuring my personality, I don't know. I could have really developed a block there--a mental block--to keep things out--to keep things from embarrassing me--because I did that when all this started to block out the noise. . . . Just talking to you about, you know, I may be developing the same sort of thing which makes me think I don't hear as well as I do at the onset. I can't answer it but you know how we'll protect ourselves?"	Self image	Idea that she is developing ways to protect herself from hurt related to the hearing loss.
Max	"I have to rely on my eyes to compensate and see the beauty of mother nature when I can't hear it all--like uh, I'm conscious of others' facial expressions, their body English, and used to I could hear a person sigh, or sorta grin and chuckle, and I may not hear that now. But I can see it--I can pick up on it." "And people get tensed up and gripe--this sort of thing. You just watch it. Sort of watch for those things where you used to let your hearing and your eyesight pick it up." "It's like you're always doing little precautionary things to cover these tracks--even with my coffee pot--I have to be sure that,	Having other senses that can compensate for her hearing loss.	Other ways to know what she cannot hear.

Table 25

Theoretical Structure 3. Transforming Unfolds in the Languaging of Connecting and Separating

	Connecting-Separating	Languaging	Transforming
Liz	"Now I wouldn't have gotten to know her--we had a nice chat."	"But you know this girl [the driver], I did not know I couldn't hear, but she was watching me. She was noticing that I was just you know [motion that she was moving into the road] and stopped completely and I walked right into the car."	The negative experience of walking into a car that she did not hear coming into a positive experience.
Azalee	"I say sometimes I say to somebody, 'Well, if you live long enough and lose your hearing like I have, you'll know exactly what it does to you--or how you feel--or what happens.' But, uh, it hasn't made that much difference I don't think with me, because when I turn 'um up I can hear as good as, well than some that are talking to me." That her friends "have some of the same symptoms."	That she is becoming more open about her hearing aids. "There's a lot of people that can't hear but they don't want you to know it--this friend said, 'I'm just about ready to quit going to church. I can't ever hear a word the preacher says,' and I said, 'Well, all you need to do is buy you some of those things and you can hear 'um'--but they are too proud to let people know that they can't hear."	Thinking related to others knowing that she is hard of hearing and needs hearing aid. "I decided it didn't matter that much."
Margaret	"Well, you just can't hear and you don't want to go nowhere you don't want to be around nobody, you feel better to stay home and do something."	"Well, when I could hear, I was talking all the time and they was talking to me, you know. But I didn't talk much and they didn't say much."	Life to be more sociable now that she has new hearing aids.

Table 25 (Continued)

	Connecting-Separating	Languaging	Transforming
Margaret (Cont'd)	"Well, one thing, I don't like to be with people, and I don't care to go nowhere, and stuff like that." Since bought new hearing aids: "Want to be around people and I can hear 'um--I can talk with 'um and I can go to church and I can hear good--and just everything--so I just feel better."		
Frances	"I know I can't be what I used to be. I know I can't be, but I keep pushing at it to try to be, to do what I used to do, when I can." "And I don't think I don't know of any of us that I've been talking to lately, think about the future--we just live for the present."	"You learn to be content with whatever you have and you don't do that on the spur of the moment." "It's not a pleasant thing to live with but like everything else, because everybody in the world's got something they've got, and they have to learn to live with it, if it's arthritis, or hearing loss, or something. There's not a perfect old person in this world."	Thought to accepting the things she cannot change.
Max	"I do know there is a supreme being that I can draw strength from to be able to get me through and teach me, reprimand me,	"It's kinda nice in a way when like the Scripture says, 'Be still and know that I am God.' Well, you're in a be still world	Self to draw strength from her hearing loss at least at times.

Analysis of Speech Characteristics and Body Language

Participants manifested individualized speech patterns and body language. Azalee would laugh after telling of a past incident that she found to be amusing. Examples of this characteristic are (a) "so we had company all the time--she never did know how many she was going to have to feed, whether she had to fry two chickens or seven [laughs]," (b) "oh my goodness we have two, four, eight babies--she was learning to count! [laughs]," (c) "I told Twin [laughs], she's a-getting to where she can't hear good too, I said, well I'll rent you this one over here [laughs]."

Azalee would also laugh when she felt agitated about a topic she was discussing. One example of this is "It's just a lot of noise and a lot of time, it's too loud [laughs]." Azalee's voice became deeper and sounded warm when she spoke about her mother. She stated: "But Mother never did whip us or anything, she'd just talk to us and tell us what was right--she was a real calm person." She would pause and hesitate before saying anything that was either hard for her to say or was very serious. Examples of this characteristic are (a) "but, uh [hesitates]--another thing too, I was afraid, I've been scary all my life in the dark" and (b) "no [pauses as if to think]--I don't think so---I may like to stay by myself more than I used to."

Susie would grin when she thought the researcher was not from the country like she was. An example would be "you know we had a smokehouse--well, you know what a smokehouse is? [grins]?" Susie's voice would sound proud when she spoke about her family. She said: "She was at home and they come over here and she got to eat with me too." Likewise, her voice would become deeper and softer when she felt sympathetic, as in the statement, "Well, he didn't ever holler or nothing--he just sick--just sick, you know he couldn't eat nothing."

Susie would laugh after saying things which she found to be either amusing or anxiety provoking. An example of this type of event was "some people just don't talk loud--voice don't carry see--don't guess they're used to working in a cotton patch, are they [laughs]?"

On occasion the researcher would relate to Susie ways other people think of things in terms of hearing loss. She would respond to any idea which was new to her with a tone of wonderment. Once the researcher said to Susie: "Some people tell me that when there's a lot of gossip going on around them, they think well I just don't want to hear that, so they choose not to concentrate and then they don't hear it." Susie responded by saying: "Yeah?" Her voice was full of wonderment and she further stated: "I just don't do that--no, I just listen. . . . You know I always just like to hear things, you know."

A few times during the interview, Susie would not hear what was said to her. At times when this occurred, she would get a questioning look on her face and ask the researcher to repeat what had been said.

Liz would also laugh after she said something that she either found amusing or anxiety provoking. Examples of these types of events as they related to Liz are (a) "you know he used to say to me, he'd say well I can hear mice tee-tee in the attic [laughs]," and (b) "I've got a light on my doorbell, and when it flashes if I'm not sitting right here and looking at it, I don't [laughs] know any answer."

Overall, Liz's voice was very expressive. She would use a softer voice tone when she found something to be sad, to express approval, or when speaking very seriously.

Examples related to these concepts are (a) what a nurse said to her immediately after her husband died: "I'll help you--I'll help you [sounds sad]"; (b) "this one's a broker, this one's a math teacher [sounds approving]"; and (c) "blind [serious subject]." Liz could sound very assertive when expressing something like "I wish you'd speak where I can hear you too." Likewise, she would pause and hesitate when expressing negative feelings as indicated by "well [pause] no, that part doesn't make me dumb, it's just that I know I am dumb." Kindness and compassion were noted in Liz's voice tone as she said: "So I came home and I couldn't leave my kitty anyway" and "and he said, listen, I don't talk so good, that's why you don't hear me."

At times, Liz's voice tone would express anger. The researcher noted that angry tones were more likely to become evident when Liz spoke about her husband. One issue the couple never resolved was the issue of Liz's right to work in the garden. Her anger is noted in the following quotation:

> I did nothing out here, I did not know--he would not let me put one thing--that is--his--domain--and I did not have anything to do with it. If I put anything out next thing I know, it was gone [sounds angry, resentful].

When Liz felt fearful or threatened, her voice tone revealed this emotion. An example of a time when the fearfulness and threat were related was when Liz described a deaf woman no one wanted to have visit. Liz said:

> We don't want her to come down here, she can't hear anything and you know that lady may have just needed to come so much emotionally that it may have meant more to her than anything.

Last, at times when Liz did not hear, she would look blank, pause, and say "What?"

Margaret also laughed when she found something she said to be amusing. Relating how a friend speaks too loudly on the telephone when talking with her, Margaret said:

"So I'm about to break her [laughs]." Like other participants, Margaret laughed when she felt anxious, such as when she was describing not being able to hear in church. She said that she thought: "I won't go no more [laughs]."

Last, Margaret laughed after expressing things that depressed her. An example of this was when she described her television watching habits: "Yeah--I watch it more now than I ever did--'course there's nothing else to do over here you see [voice depressed, laughs]."

Especially during the third interview, Margaret either did not understand what the researcher was saying or did not hear. At those times she would say, "What did you say?" or answer incorrectly. Margaret changed her hearing aid battery in the middle of the third interview and was then able to hear better.

Frances would laugh at times she found something to be amusing or anxiety provoking as exemplified by (a) "and got a pin in this leg from a fractured leg and broke my back twice and so--I'm in pretty good shape! [laughs]" and (b) "are you going to do so-in-so? What so-in-so? [laughs]. 'Cause you didn't hear." Likewise, Frances's voice would lower when she expressed serious thoughts like "you're supposed to know what's going on, and you don't know what's going on" or "I'm hearing you, but I'm not hearing you right." Frances's voice would become very wistful when she spoke about loneliness as evidenced by "yes--I need it [hugs] especially. When you live alone--he [her dog] is a big comfort, a joy!" Her voice became high pitched as she described the pain of going barefooted as a child. Frances manifested a mocking tone when she described herself faking hearing. She said: "I just sit there and smile"--but her voice tone said that she felt that was silly of her.

When asked about the future, Frances became extremely pensive and sighed while speaking in very low tones. She said: "And Terry was doing well and the next minute he was practically gone, and he was only 52 years old, so [sighs] I don't [think about the future]."

Max exhibited very strong emotions which correlated with the feelings expressed. She would often become teary eyed, and her voice would get angry and her mouth contorted as she described a life that she has found to be painful. A typical example of Max's depth of feeling is demonstrated in this passage:

> I said, lady, I can only endure so much volume through these [tears in eyes, mouth contorted, voice angry] and when the whole family's around [voice shaky] see living alone I do things that are comfortable with my hearing and my hearing aids.

Max demonstrated bewilderment in her voice as she reacted: "And he did--and I liked it [speaker phone], but no one liked me using it for them, you know, to converse." Like the other participants, Max laughed either when amused or anxious. Examples of this include (a) "And give me a little time and I might outthink you [laughs]" and (b) "if you're an old mean hateful person when you're 30 years old, you're going to be doubly old and mean at 60 [laughs]."

Thus, each of these 6 participants laughed when either anxious or when finding something amusing. Voice tones would lower when sad or serious topics were discussed. Anger was easily detectible through voice tone. At times, tears would express deep heartaches.

Trustworthiness Features

Planned trustworthiness features described in Chapter 3 were carried out. The peer reviewer held a Ph.D. in Nursing from the University of Texas. She teaches both research and psychiatric nursing in a baccalaureate nursing program and has worn a hearing aid for several years. The peer reviewer selected 2 participants to examine after reading parts of the first interviews. The 2 participants selected were Liz and Margaret. The peer reviewer then read the transcripts and Contact Summary Forms and made suggestions as to additional questions during Interview 3. The researcher and peer reviewer discussed initial impressions of the data at that time.

The reviewer studied the materials for logic of codes and accuracy of themes as she perceived them. No changes were made in these codes and themes. As data analyzation progressed, the researcher and peer reviewer discussed the Parse analyzations for those 2 participants and the peer reviewer assessed them for logical thought patterns and content agreement.

Five of the 6 participants were interviewed a fourth time during May and June of 1997. The interviewer read to the participants the descriptions of life stages and themes. Participants were given the opportunity to correct various misinterpretations and also to provide additional information about selected areas of concern. Tapes were made of these sessions and were later reviewed. Final drafts of participants' life stages and themes incorporate the participants' suggestions for change.

9. Imaged how others do and do not understand the effects of this condition on a person.

10. Connected to and separated from others in changed ways.

11. Relied more upon others.

12. Originated new levels of compassion for others with disabilities.

13. Languaged anger toward themselves and others.

14. Both enabled and limited themselves as new health patterns evolved.

15. Connected and separated from activities and people as necessary for comfort.

16. Both revealed and concealed experiences.

17. Made changes in their lives.

18. Powered themselves to hope that further deterioration in hearing would not occur while imaging that it might.

19. Worried about the ability to maintain independence should further hearing loss occur.

20. Sometimes cotranscended the experience and assigned a new meaning to it.

CHAPTER 5

DISCUSSION, CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

The purposes of this chapter are to (a) discuss the relationship of the findings to the literature, (b) describe the researcher's conclusions, (c) review implications, and (d) make recommendations for further research.

Discussion

Mishler (1986) wrote that it is difficult to situate the meaning that a phenomenon holds for an individual into the context of the person's life without multiple interviews. Utilizing a multiple interview method proved to be invaluable to this research in that it enabled (a) the researcher to better understand the meaning that the hearing loss had for individual participants in light of important life events and people, (b) the participants to "relive, reexperience, and savor past experience in the present" (Carlson, 1984, p. 83), and (c) the researcher and participant to form a closer relationship as the researcher spent a significant amount of time in true presence with the participants.

Gardner (1992) wrote that "presence is the physical 'being there' and psychological 'being with'" (p. 191). It is the researcher's belief that being in true presence with participants as they shared their stories promoted a feeling of mutuality between the researcher and participants that enabled the participant to feel important and less like a subject of investigation.

Carlson (1984) wrote that people express verbal and effectual pleasure during times of active reminiscence. This researcher observed that participants experience both pleasure and pain while reminiscing.

Liz stated: "It's fun to reminisce over all those years!" Carlson (1984) wrote that people would "look away from the interviewer at times and seemed to experience more pleasure in recalling certain memories than in sharing them directly" (p. 88). This researcher observed that Liz, Azalee, and Frances would also look away while recalling memories. Last, Carlson related how participants have a tendency to show family pictures and so forth while reminiscing. This researcher noted that Liz and Susie showed family pictures, while Azalee spent time between the first and second interviews writing out further remembrances for the researcher.

Davis and Cannava (1995) wrote that people share those things they treasure--those things that have meaning and demonstrate personal world views. These authors also wrote that people are unable to disclose themselves fully and that disclosure is a rhythmical process that evolves as new images emerge.

Kovach (1991) wrote that people tend to share specific types of events while reminiscing. These events include

1. Activity-centered events such as "work, school, leisure, religion, time periods and travel-relocation" (Kovach, 1991, p. 196).

2. Person-centered events such as descriptions of relationships and acquaintances.

3. Possession-centered events which included both actual possessions and those that had been unattainable.

4. The physical and social contexts of the above types of events are then shared in order to "expand the description of the events which the reminiscer chose to share" (Kovach, 1991, p. 202). Each of the participants in this study shared experiences of the types of events mentioned by Kovach.

Rentz (1995) wrote that reminiscence could be an activity that would help the participants gain knowledge about themselves. This researcher believes that participants developed new self-insights through both the reminiscence and the multiple interview process. Max had related during Interview 1 that she had earlier learned to block out noise at work. In Interview 2 she further stated:

> Just talking with you, about, you know, I may be developing the same sort of thing which makes me think I don't hear as well as I do at the onset. I can't answer it but--you know how we'll protect ourselves?

Frances provided another example of how people learn through participation in an interview process. Frances stated:

> But I guess you get into a, after awhile--you know--maybe I'd better settle this with myself--after awhile when you know that you've decided that that's something you're going to have to live with the rest of your life, and you do things differently, you react differently.

Parse (1997) described the experience of reminiscence as follows: "Living the remembered is recalling a moment through a lingering presence that arises after an immediate engagement" (p. 35). This lingering presence or tendency to dwell with a thought or new insight can occur in both the researcher and the participant. Thus, there is opportunity for both researcher and participant to grasp new insights both during and as a result of the interview process.

Life Patterns

The researcher was able to gain insight into the major life patterns manifested by the 6 participants. Data analyzation revealed that the participants basically relate to their hearing loss in much the same ways that they relate to other aspects of life. Thomas (1987) wrote that "adjustment to hearing loss is a psychological process" (p. 197). Thomas further stated that people who have stable personalities, as well as a support system of friends, tend to adjust better to having a hearing loss. It is important to note, however, that Thomas concluded the discussion of adjustment to hearing loss by writing that "systematic patterning of predisposing factors, either auditory or psychological" (p. 198), has not been identified.

Stone (1987) wrote that any degree of stress that the hearing loss causes an individual is dependent upon the perception, attitudes, and response made to the loss by the hearing impaired individual. Stone continued:

> When a major life crisis is seen as a challenge, coping is within reach. When the same life event is perceived as a crushing blow, helplessness and depression negate effective coping. . . . Once the mind grasps the need for change or readjustment and is open to information on how best to effect such change, there is a good chance for successful handling of the problem involved. (p. 117)

Häggman-Laitila (1997) wrote that a study was conducted in Finland in order "to understand and describe the human being's health as an individual way of existence on the basis of life descriptions" (p. 46). Sixty men and 33 women were interviewed in a freeform manner. Häggman-Laitila reported that study results indicated that "people have in their lives some kind of logic which is exposed in the choices they make" (p. 51).

The basic assumptions of the human becoming theory include that the human, as an open being, has a situated freedom to choose and is responsible for the choices made in the process of becoming (Parse, 1981). The life patterns reflected in the lives of the participants reveal the choices that have been made by those participants. Thus, the openness and freedom of human beings provide opportunities for participants to divert from usual patterns of behavior and derive new patterns of relating as new levels of consciousness are reached. Newman (1989) wrote that old patterns may be noticeably different from new or evolving patterns. There was some evidence that some participants in this study had begun to formulate new patterns of being by "transforming the old and integrating the new" (Reed, 1991, p. 65). Parse (1996d) wrote that people become composers of their own lives as they live out personal value priorities by choosing their own way in life. Each person, therefore, formulates a unique personal history. The personal history of each participant in the present study has been described in detail, and the patterns of relating to the hearing loss have been situated into the total life scheme of each individual.

Meaning of the Hearing Loss

Research findings indicated that the participants in the study entered a time of grief as recognition of the hearing loss occurred. Orlans (1987) wrote that some believe that people who gradually become hard of hearing have a harder and longer adjustment period than those who are faced with sudden deafness. Orlans also related that much adjustment proceeds unconsciously. Max expressed the following point of view:

> No, I think you just sorta evolve into it. It's like a learning tool for a child--well this is a learning tool for the hearing impaired and you just sorta work into it, and move along as the stages and ages progress. Because just the aging process is a change, and change is--we can either use it to our advantage or to our disadvantage.

Ellis and Nowlis (1994) identified five recognizable stages that people generally go through after the onset of a chronic illness. Hearing loss, although not generally thought of as an illness, is like a chronic illness in that it causes permanent damage and leaves the person with a disability. Thus, these stages would apply to persons with hearing loss and include

1. The disbelief and denial stage where people hope that the symptoms will suddenly disappear and not require any further attention or treatment. This stage serves to buffer the person from felt anxiety.

2. The irritability and anger stage produces feelings of anger at one's own body. The person feels outrage that the body is not performing properly.

3. The person develops fears about the condition that stimulate the person to attempt to gain control over the condition by seeking treatment during this stage.

4. Depression arises out of the multiple losses experienced by the person. Both the depth of the ensuing depression and the ways with which the depression is handled are determined by personal factors of the hearing impaired person.

5. Last, the individual becomes empowered to accept the condition and to become actively involved in obtaining all necessary assistance to help combat the condition.

Stone (1987) wrote that people with hearing loss go through a grieving process that begins with shock and proceeds through "stages of denial, anger, guilt, to some level of adjustment" (p. 114). Participants of the present study provided evidences of being in different stages of acceptance and actually verbalized examples of being in multiple stages at once as they described feelings related to the hearing loss, related what it was like to experience a hearing loss, and provided insight into ways their feelings had changed toward themselves since the hearing loss began. Each participant had accepted having a hearing loss to the degree that hearing aids had been purchased and were worn at least part of the time. However, Susie and Azalee repeatedly took the position that they could hear without using the hearing aid and related that they chose to wear hearing aids or not wear them, depending on the situation.

At times, people diagnosed with chronic illnesses will bargain and compare their condition to others. People who lose hearing may relate the following viewpoints:

> I think if I had the choice of deafness or blindness, I think I'd choose to go blind. I think being deaf you're cut off completely. Talking every day is part of life, if you can't communicate with people, that's it. (Jones, 1987, p. 129)

Another participant in Jones's (1987) study expressed an opposite point of view:

> I think blindness is different, worse than deafness. I'd rather be able to see than not hear--even if I can't hear, I can watch T.V. (p. 129)

All participants in the present study except Margaret stated that they would rather see than hear.

Westbrook and Viney (1982) wrote that a patient's reactions to the onset of chronic illnesses were

> related to demographic factors and their perceptions of their handicaps. No relationships were found between patterns of reaction and patient's lifestyles, medical records of their illness, or the types of their disabilities. (p. 899)

Gershon, Byrns, and Dunleavy (1996) also reported the perceived impairment to be more important than the degree of hearing loss and related perceived loss to "emotional, social, and communication dysfunction" (p. 14). Last, Burckhardt, Woods, Schultz, and Ziebarth (1989) wrote that persons with chronic illness must (a) feel independent, (b) be physically active, (c) be able to perform activities of daily living, (d) engage in rewarding relationships with others, and (e) find a sense of security and meaning in life in order to feel that a desirable quality of life has been attained. Several of the participants in the present study demonstrated ways they had adopted new perspectives in order to make the most of life in the present.

Parse (1996e) reported utilizing the human becoming theory conceptual framework and the Parse research method while conducting research on 11 women over 65 years old. The purpose of the research was to derive a structure for the lived experiences of joy-sorrow. Parse wrote that the women in this study reported being able to feel "pleasure amid adversity" (p. 83). This finding is consistent with the findings of the present study on hearing loss in that each participant described experiencing at least some joy in life, in spite of the difficulties arising out of the hearing loss. Participants in Parse's study of joy-sorrow further reported finding contentment in the midst of sorrow as accomplishments were identified and acknowledged. Participants in the present study on hearing loss also reported feelings of contentment in accomplishments despite living with a hearing deficit. Parse further reported that, while both connections and separations from others were described as benevolent by the study participants, in actuality these experiences were a mixture of joy and sorrow. Participants in the present study on hearing loss described both spectrums of this rhythm as being present in relationships. The participants in this study on hearing loss did not always describe benevolence as a characteristic of relationships. Some relationships were strained as participants perceived others' unwillingness to help them know what was being said.

Last, Parse (1996e) described joy-sorrow experiences as being the "ups and downs of everyday" (p. 85) and wrote that these experiences are "transforming as new imagings arise when seeing the familiar and unfamiliar in a new light" (p. 85).

Participants in the present study on hearing loss tended to express feelings that the hearing loss was "just something that happened" to them. The experience of having a hearing loss was one of those downs that occurred in life which led to perceiving the familiar in changed ways. Some participants later became able to feel that there were even some advantages associated with having this condition.

Heidrich and Ryff (1992) studied day-to-day coping patterns of elderly women. The study demonstrated that the concerns of highest priority for aging women were physical health and chronic illness. Women also worried about (a) caring for others, (b) household management, and (c) personal activity limitations. Women in the study reported coping by distraction or calling a friend when feeling unhappy with themselves. The researcher notes that Liz and Azalee particularly demonstrated a health pattern which utilized high levels of socialization. The Heidrich and Ruff study demonstrated that women utilize a variety of coping strategies for hypothetical problems rather than for actual problems. The following findings determined that women were more likely to use

1. Direct action strategies like discussing, communicating, and planning ahead in hypothetical, not actual, situations.

2. Passive cognitive strategies like ignoring, avoidance, and staying busy when actual health problems arose or when describing ways to handle hypothetical friendship problems.

3. Positive cognitive strategies like acceptance and faith in others when actual health problems occurred. Positive cognitive strategies were not utilized when hypothetical health problems were presented.

4. Emotional expressions when presented with hypothetical health and family difficulties. Examples of emotional expressions included worrying, crying, and demonstrating upset behaviors.

The women in the present study demonstrated using both direct action strategies and passive cognitive strategies in relation to their hearing losses. Participants used direct action strategies when they bought and used hearing aids, arranged for others to tell them what was said in meetings, prerecorded movies, and sat in special seats when attending functions in order to maximize the likelihood of hearing. Participants used passive strategies when they dealt with their hearing loss by depending on others and by faking hearing. Likewise, positive cognitive strategies were utilized by participants as they powered themselves to originate new ways of thinking about the hearing loss. All participants in this study demonstrated having ongoing emotional responses to their hearing loss. These emotional responses were present even when participants also demonstrated acceptance of the hearing loss. Therefore, the researcher can deduce that having a hearing loss has multidimensional meanings for those afflicted with the disorder.

What It Is Like

Rye (1990) wrote that people with hearing loss feel that others believe they are plain "daft" (p. 43). Max, participating in the present study, reported feeling like others think her "elevator just doesn't go all the way to the top." Cowie, Stewart, and Douglas-Cowie (1987) quoted from a participant in their study: "People don't adapt to deafness because they're embarrassed, and you carry that embarrassment all the rest of your life"

(p. 149). As previously stated, 5 participants in the present study reported feeling embarrassed in relation to their hearing loss.

Orlans (1987) wrote that persons with a hearing loss experience "discomfort, embarrassment, confusion, and loss of confidence" (p. 100). One person in Orlans's study stated: "'I have lost confidence and social comfort'" (pp. 100-101). Orlans reported that a participant in that study described what it is like to have a hearing loss in the following way: "'It has resulted in a lack of confidence, feelings of inadequacy, and extreme sensitivity" (p. 101). "'Confidence and ease have been replaced with anxiety and apprehension'" (Orlans, 1987, p. 101). Oyer and Oyer (1979) wrote that people with hearing loss experience the following reactions: (a) embarrassment, (b) fatigue, (c) increased irritability, (d) increased tension, (e) avoidance and withdrawal, (f) increased endangerment to bodily safety, (g) boredom, (h) rejection, (i) increased vulnerability to promises of restored health, (j) depression, (k) tendency toward acting upon misinformation, (l) negativism, (m) decreased opportunities to assume leadership roles, and (n) a reduction in the amount of information learned. Participants in the present study also demonstrated each of these characteristics. The findings of the Gershon et al. (1996) study supported previous studies which found "an association between hearing loss and multiple, negative outcomes" (p. 14). Negative outcomes mentioned by Gershon et al. include "depression, loneliness, altered self-esteem, and diminished functional status" (p. 11). Margaret and Max in the present study related feelings of depression. Margaret and Frances both revealed loneliness by the statements made relating to the isolation of hearing impairment, while Liz and Azalee seemed to use involvement in activities to counteract loneliness. All participants had experienced self-esteem alterations as well as decreasing functional abilities related to having a hearing loss.

Luey, Glass, and Elliott (1995) wrote that "the most damaging thing about hearing loss is that it interferes with communication" (p. 178). Persons with hearing loss often only hear parts of the expressed sound. Many of these people then learn to discern the meaning of what is being said by observing body language and lip reading. Rollman and Harrison (1996) compared hearing and nonhearing clients in order to determine if there was a difference in their abilities to read facial expressions accurately. Findings of that study indicated that there was no difference in the abilities of the hearing and the hearing impaired to accurately perceive visual nonverbal information about people. In the present study, both Liz and Max related how they relied on and valued other senses as ways of knowing. Rollman and Harrison wrote that, although some people feel that those who lose one of their senses gain increased abilities to use the remaining senses, empirical data do not validate this viewpoint.

Each participant in the present study reported having a decreased ability to recognize words. Gates, Cooper, Kannel, and Miller (1990) wrote that hearing sensitivity worsens as hearing thresholds elevate with age. Gimsing (1990) concurred that discrimination abilities decrease with advancing age and further related that the amount of discrimination loss is directly related to decibel loss.

Orlans (1987) wrote that it is tiring physically and emotionally for the hearing impaired person to try to interpret "distorted half-heard speech, other sounds, lip movements, and facial expressions" (p. 100). Several participants in the present study reported going places but tiring quickly from the strain of trying to hear.

Noisy environments decrease speech discrimination in older people even "more than their pure tone threshold would predict" (Turrini & Arslan, 1991, p. 136). Turrini and Arslan wrote that the noise of cocktail parties, traffic, and so forth makes hearing more difficult as speech discrimination is lessened. Lindeman and Platenburg-Gits (1991) also wrote that room noise of the type that occurs at meetings, church, and celebrations decreases the ability of the hearing impaired person to hear. Participants in the present study also reported difficulties in hearing when conditions were noisy and preferred one-to-one conversations in quiet settings.

Liz, a participant in the present study, reported that she could understand passages read from the Bible in church if they were familiar. Likewise, Carlisle (1989) wrote about a hard of hearing nursing student who stated: "I can hear those who are closest to me, but not strangers" (p. 66).

Rutman and Boisseau (1995) wrote that, when people become hearing impaired before age 65, they may feel that the hearing loss causes them to miss educational and career opportunities, as well as opportunities to participate in community life. Both Susie and Margaret, participants in the present study, identified with the hearing loss preventing them from having learning opportunities, while Max's career was significantly affected.

Effect on Relationships

Each participant in the present study reported being left out of conversations. Rutman and Boisseau (1995) wrote that all deaf persons feel left out of conversations, but the elderly especially feel this way and relate this feeling not only to being hard of hearing but also to others' belief that their mental capacity has decreased.

Orlans (1987) wrote that people with hearing loss blame their spouse or relatives for such things as mumbling and talking to them while not in the same room. All participants in the present study also blamed others in part for their inability to hear. Participants in Orlans's study related that family members talk to each other and not to them. The hard of hearing person then reports feeling left out during events occurring even within the family circle.

Overall, hearing impaired people do not feel that others understand what it is like to be hard of hearing (Orlans, 1987). Orlans quoted the following participant from that study: "'When choosing friends, I'm very careful. . . . My best friends understand my hearing problems. In a way, I don't want too many friends'" (p. 102). In the present study, Frances related that she chose as friends people who would help her.

Orlans (1987) made the statement that "friends who recognize the hearing problem and show patience in dealing with it are retained, while others are dropped" (p. 101). Each participant in the present study verbalized having negative feelings towards those who do not understand what having a hearing loss is like. Jones (1987) interviewed 123 hearing impaired people and 129 persons who lived with them and reported that one participant said "'I find if you tell people straight out you're deaf, they tend to help you, they make allowances for you'" (p. 132).

However, participants noted that often others become frustrated when they cannot be heard and say things like "'pay attention, listen'" (Jones, 1987, p. 128) or "'you'd never say to a blind man, here, have a look at this, would you'" (p. 128).

Participants in the present study expressed similar difficulties when dealing with others' responses to the hearing loss. Orlans (1987) wrote that one participant said: "'I get angry over the insensitivity of people who don't understand hearing loss'" (p. 101). Another participant said "'most people are not aware I wear an aid. . . . But I am still angry since my loss is not my fault, and I expect consideration for this'" (p. 101). Joensen and Saunders (1984) wrote that others make statements like the following examples about the hearing impaired: "'He lives in a world of his own'" or "'he hears only what he wants to hear'" (p. 39).

Orlans (1987) quoted another participant as saying "'people become annoyed at having to repeat themselves.'" Still another participant in Orlans's study described attempts to relate to others in this way:

> If you ask people to speak up repeatedly and they don't, then you try to move your ear closer to their mouth, they draw away, as if you have a contagious disease, or else they are stymied by my staring at their lips. (p. 100)

Participants in the present study described very vividly difficulties incurred when asking others to repeat things. Likewise, Liz described her own uncomfortable reaction to the necessity of staring at men as they speak to her.

Rutman and Boisseau (1995) wrote that people become angry and embarrassed when constantly having to lip-read and ask others to repeat things. These inwardly directed feelings may cause the hearing impaired person to choose to isolate, thereby making a decision that leads to despair.

Orlans (1987) quoted a participant as saying "'I'm terrified that someone will talk to me and terrified that no one will talk to me'" (p. 100). Margaret and Frances, participants in the present study, also expressed these sentiments, while Max and Frances related how they had learned to walk away from situations when unable to hear. Thus, isolation ensues.

Isolation

Strome and Vernick (1989) wrote that older people choose to limit activities and isolate themselves rather than put themselves in an environment that is out of their control. Ravish (1985) presented four levels of social isolation that can occur as a result of having a hearing loss. These levels are (a) sensory loss for high pitched sounds, (b) sensory isolation that presents itself as passivity or "lack of interest in the environment" (p. 11), (c) social desolation that presents itself as "extremes in behavior ranging from withdrawal to hostility" (p. 12), and (d) anomie or a "complete break with the environment . . . which is seen as disorientation and confusion" (p. 12).

No participant in the present study had reached the anomie stage. However, participants exemplified the other three stages of isolation to various degrees. Liz spoke about not being able to hear the birds when she was outside unless she had her hearing aids on, while Max and Margaret demonstrated more hostility and withdrawal related to not hearing normally.

Participants in the present study ranged in age from 67-90 with the more elderly clients being the most isolated. Age and increased health problems may have influenced isolating tendencies as much as the hearing loss. The researcher had no way to know the amount of decibel loss each participant had.

Cowie et al. (1987) wrote that people who become hard of hearing feel disconnected from the once familiar world. One participant in that study made the following statement:

> When I waken up in the morning I cannot hear water, I cannot hear the kettle, I cannot hear anything. . . . You're just in a glass cage looking out at the world moving about you but you don't know anything about. (p. 147)

Orlans (1987) quoted participants as saying: "'When I had my hearing I was an outgoing person. I don't care to be with people anymore'" (p. 103); "'it's a lonely disease. My love of people and being with them diminishes daily'" (p. 103); "'I tend to enjoy being by myself, because it is easier'" (p. 103); "'I am least alone when I am alone. Most alone at a dinner or cocktail party'" (p. 103). All participants in the present study revealed responding to the hearing loss by isolating themselves in the more comfortable quietness of home.

Faking Hearing

Tolson and Swan (1991) wrote that persons with hearing loss try to cover up for the fact that they are unable to hear. If hurried to answer, the hearing impaired may agree with something with which they really do not agree in order not to frustrate the speaker (Janning, 1991). Hearing impaired people develop ways to appear more normal. Rye (1990) wrote about "one old gentleman who always says, 'yes' when in doubt. He once mistakenly turned down a glass of whisky! Others nod their head sagely and hope to pick up a clue later in the conversation" (p. 44). Vesterager and Salomon (1991) also wrote about people coping by hiding the handicap, guessing, or pretending to understand things they did not understand. Participants would also react by simply ignoring the communication. Each participant in the present study demonstrated the propensity for faking hearing some of the time.

Hearing Aids

People who get hearing aids usually feel more handicapped than nonusers do to begin with. People do not buy hearing aids unless experiencing disruptions in abilities to live life normally (Weinstein, 1991).

Mulrow et al. (1990) wrote that use of hearing aids helped reverse the social, emotional, and communication dysfunctions caused by hearing impairment (p. 191). However, the hearing aid only amplifies the sound; it does not make the sound more understandable for the user. Hearing aid use is disappointing for many people. However, it is interesting to note that less educated people rate the attributes of hearing aids higher than the more educated (Von Wedel, Von Wedel, & Streppel, 1991). This researcher notes that this finding related to education is not applicable to Susie, a participant in the present study who spoke repeatedly of much unhappiness related to hearing aid use.

Orlans (1987) wrote that people experience multidimensional feelings related to having hearing aids. Participants in that study stated that the hearing aid is "'my lifesaver, my dearest possession'" (Orlans, p. 100) but also stated: "'I sometimes fantasize about smashing them on the ground to relieve the frustrations they cause'" (Orlans, p. 106). Each participant in the present study validated both of these points of view.

Positive Outcomes of Acquired Hearing Loss

People who develop hearing loss may realize some positive changes that arise out of the loss. One positive change that might occur is the development of a deepened religious experience. Each participant in the study spoke of having religious values, but Max especially related having a hearing loss lead to opportunities for a more in-depth spirituality.

Reed (1996) wrote that in the human becoming theory "cotranscendence evolves with the relationship of what-is-present and what-is-possible, and between person and person, and person and universe" (p. 2). The process of transformation yields new insights as new experiences are encountered and relationships evolve. Reed wrote that other authors, including herself, define cotranscendence in different ways. One commonality noted by this writer in Reed and Parse's definitions of cotranscendence is that both describe the emergence of new developmental forms of the self as changes towards higher levels of consciousness occur.

Some participants in the Cowie et al. (1987) study reported that having a hearing loss had enhanced their lives by providing opportunities to confront their own and others' human nature as they came to recognize human failings and human virtues. Max, a participant in the present study, revealed having learned much about human nature and had changed her behaviors and responses to others based on that increased knowledge.

Positive Outcomes of Use of the Human Becoming Theory

Cody (1997) wrote that use of the human becoming theory in practice enables nurses to

> - Bear witness to the unfolding reality of the person.
> - Explore the person's universe when invited, as a not-knowing stranger, humbly and sincerely offering personal presence.
> - Coparticipate in a shared moment of personal meaning and cocreate a lived experience of quality of life.
> - Love the person unconditionally.
> - Listen attentively and steadfastly, staying truly present to the person's stories of joy and suffering, loss, fear, struggle, hope, and triumph.
> - Revere the person as a self-interpreting free agent and the expert on her or his life and health.
> - Acknowledge those whom the person relates to as family, regardless of societal norms.
> - Give self over to the flow of the meaning moment in being with the other person.
> - Risk moving with the person beyond the moment to what is not yet, despite not knowing what the outcome may be.
> - Tell the person's story to others, with consent, to relay the reality of the person's universe from her or his own perspective. (p. 66)

This researcher asserts that use of the human becoming theory as a conceptual basis for the present study of hearing loss in older women derived benefits similar to those Cody (1997) derived in a practice setting. Use of the theory provided a paradigm of openness towards and equality with the participant as the research was conducted. Furthermore, use of the human becoming theory as a conceptual framework enabled the researcher to be open towards a belief that the participant's point of view was what was important.

Bunkers (1996a) wrote that "the nurse guided by the human becoming theory believes the person knows the way. There is no judging or labeling" (p. 80). The researcher in the present study on hearing loss sought to keep this important tenet ever in the forefront as data were collected and analyzed.

The literature review has thus provided much validation for the findings of the present study. The examples provided by participants of this study compare favorably with findings from previous studies. The examples provided in the literature offer further rich descriptions of what it is like to experience hearing loss.

Conclusions

Research Question 1

The first research question to be answered by this study was as follows: What are the health patterns of older women with hearing impairment who live alone?

Stone (1987) wrote that "the only known universal stressor is the breakdown of communication and that is what happens when hearing is lost or impaired" (p. 116). Women who encounter late onset hearing loss are beset with grief reactions which are compounded by other griefs already experienced. People who become hard of hearing in later life have more disruption in life than those with early onset hearing loss because of the simultaneous adjustment to the complications of old age.

People experience common problems related to having a hearing loss. However, meanings assigned to that loss may be multidimensional in nature and different people may assign different meanings. Choices of responses made are made according to the assigned meanings, as well as the personal histories and value systems of the individuals concerned.

Participants in this study relied on their usual patterns of coping at the onset of this loss. However, new health patterns became evident as they experienced changed feelings about themselves and others and as new rhythms evolved in the ways they related to the world. Activities were dropped or experienced differently. Participants protected themselves by isolating from others. New ways of being with people emerged as hearing declined. Participants commonly faked hearing to protect themselves from embarrassment.

As time progressed, some participants began to experience changed health patterns as expanded consciousness and cotranscendence occurred. Some health patterns began to change in a direction of more openness towards themselves and others. Several participants felt that having a hearing loss had made them become more compassionate towards others with disabilities. One participant was able to enjoy the quietness that having a hearing loss afforded and to find new closeness to God through that quietness.

Analysis

Participants traveled similar paths as they became conscious of having a hearing loss and grieved for life as it had been previously. The grief process that ensued was consistent with the five recognizable stages of acceptance of a chronic illness as identified by Ellis and Nowlis (1994).

Denial of the hearing loss would be followed by the occurrence of an incident that would make the hearing loss impossible to deny. Psychological reactions to the onset of a chronic illness were consistent with those described by Westbrook and Viney (1982).

Participants experienced varying degrees of anger and depression as they dealt with the hearing loss in conjunction with a multiplicity of other simultaneously occurring challenges. Multidimensional meanings were assigned to the hearing loss in accordance with individual world views, assumptions, values, and life experiences. Evidences of these multidimensional meanings could be easily associated with Principle 1 of the human becoming theory (Parse, 1987) as participants languaged and imaged values.

Lifelong patterns of responding became evident in the individual ways that participants dealt with their hearing loss. Those participants who had (a) better educations, (b) more privileged lives, and (c) broader life experiences were better able to be creative in dealing with having a hearing loss and used more direct action strategies to assertively counteract the negative effects that the hearing loss had on their lives. These direct action strategies are consistent with those described by Heidrich and Ryff (1992). Participants' backgrounds affected their self-concept, self-esteem, and levels of independence and assertiveness to a degree that impacted upon their ability to get personal needs met in relation to the hearing loss.

Participants gradually and sometimes unconsciously formed new relationships with the world as they lived separate yet interdependent lives. Self-protective mechanisms arose out of difficulties encountered in relating to the world around them. Participants developed changed feelings toward themselves in relation to these experiences. Usual activities were experienced in changed ways and were often assigned new meanings as the hearing loss impacted and changed the very essence of the meanings of those activities and relationships. Participants expressed both frustration and comfort with the changes that had arisen out of the experience of hearing loss. Participants gradually developed more dependence on others as a result of having a hearing loss, yet fiercely struggled to maintain as much independence as possible. This constant struggle between the forces of dependence and independence occurred at both conscious and unconscious levels. Participants vacillated between demonstrating the enabling-limiting and connecting-separating behaviors described in Principle 2 of the human becoming theory (Parse, 1981). Thus, rhythmical patterns of relating to others and to the world occurred.

The very nature of having a hearing loss separated the participants from others and created a more silent backdrop for the living of life. The experiences that participants had in relation to others were influenced by both personally assigned interpretations and others' behaviors in relation to the hearing loss.

Participants acknowledged feeling an aloneness in the silence of their world. Cowie et al. (1987) reported similar findings. This aloneness was experienced multidimensionally as both loneliness and a peaceful stillness. Participants felt more control when alone and relating to others was not necessary. For some participants, the quietness of the world and physically being alone became at times like a sanctuary. This finding was synonymous with the findings of Orlans (1987).

Participants in the present study also demonstrated a propensity towards finding joys in the midst of sorrow. These participants were not only experiencing hearing loss but were also coping with a multiplicity of other age and health-related problems. Joys experienced in the presence of hearing loss were sometimes different from the joy others would be expected to realize from that same experience. Joys were experienced in relational situations, as well as in times of solitude. Participants found joy in social interactions in individual ways and to varying degrees. Each participant described at least some elements of joyfulness and love of life, however bad the expressed sorrows. Parse (1996e) described similar findings in a recent study on the concepts of joy-sorrow.

The researcher noted a certain innate desire on the part of all participants for the new life to be as much a facsimile of the old as possible. Participants attempted in the earlier stages of hearing loss to maintain usual routines and activities. Participants reluctantly admitted ways that having a hearing loss had impacted their lives. Participants seemed to have a need to think that life was unchanged by the hearing loss even as changes were consciously and unconsciously expressed.

Some participants demonstrated that they had in some way cotranscended earlier meanings that the hearing loss and use of the hearing aid held for them. Again, participants who had (a) better educations, (b) more privileged lives, and (c) broader life experiences were the ones who demonstrated more cotranscendence. Life experiences, world views, assumptions, and values again impacted individual participants as they were or were not able to cotranscend the experience and reach a higher level of consciousness. New levels of self-development and self-understanding were realized as cotranscendence occurred among some participants. These findings can easily be applied to the concepts of powering, originating, and transforming in the process of transforming as identified in Principle 3 of the human becoming theory (Parse, 1981) and are congruent with Reed's (1996) definition of cotranscendence as a form of self-development occurring as higher levels of consciousness are attained.

Several participants stated that having a hearing loss had led them to be more compassionate towards others with hearing loss and other disabilities. Participants described feeling they had developed new insights and understandings of how disabilities affect others' lives since incurring a disability themselves.

Thus, in the end, participants in the study described (a) the human condition of aloneness in the midst of non-aloneness, (b) the need to both be with others and withdraw from others, (c) the experiencing of simultaneous joy and sorrow, (d) having multidimensional thinking in relation to the experience of adversity, (e) resistance to change in life while recognizing that change is inevitable, and (f) the onset of the grief process when change could not be avoided.

Participants in the study further demonstrated the human capacity to (a) derive new health patterns, (b) experience expanded consciousness, and (c) derive new meanings from the life situation.

In summary, the participants reacted to having a hearing loss in multidimensional ways. Health patterns evolved in individual ways as choices were made within a framework of situated freedom to choose.

Research Question 2

The second research question follows: Is the human becoming theory model appropriate as a conceptual basis for analyzing data related to health patterns of older women with hearing loss?

The human becoming theory model proved to be an excellent conceptual basis for analyzing health patterns of older women with hearing loss. Data seemed to fit naturally with the theory concepts, principles, and structures. The researcher could easily relate the data to the theory assumptions and vice versa. Findings of the research were enhanced by the use of this theory in that the researcher came to visualize the personal meanings that the hearing loss held for participants as people imaged, valued, and languaged the things that were most precious to them. Rhythmical patterns of relating could also be identified as data were categorized according to the concepts of enabling-limiting, connecting-separating, and revealing-concealing. The act of writing down the behaviors that were enabling, as well as the behaviors that were limiting and so on, forced the researcher to consider both aspects of the rhythmical pattern. Likewise, identification of ways participants powered themselves or did not power themselves to originate new ways of being facilitated the ability to think in terms of the participants cotranscending the condition.

Difficulties encountered in use of the theory included the fact that the same block of data could be interpreted in many ways. One example of this would be when the researcher identified that Liz had cotranscended the power the hearing loss had in her life by originating new ways to enjoy her usual activities. The researcher identified that Liz had powered herself to enjoy church in a new way and originated new ways to entertain herself when unable to hear in church while at the same time transforming the ways that activities were enjoyed. However, the same block of data could also be categorized as imaging, languaging, and valuing as meaning was structured multidimensionally. The researcher could see that Liz could not have told about the experiences related to cotranscendence unless she valued that situation, imaged it, and later languaged it. Thus, the more the researcher worked with the concepts, the more evident it became that the concepts themselves are holistic and meant to be intertwined and interwoven.

It became evident after awhile that sometimes the researcher's interpretation of the data and not the actual data themselves was what was needed to go with a code. For instance, the researcher would need to interpret what the images and values were. Much of the time, data would fit with two concepts of a principle but not the third. The researcher determined that data had to fit into all three concepts of a principle before a statement could be made that the participant possessed the characteristics of that principle.

The theory was not easy to use. The language of the concepts is poetic and a great deal of analytic rigor is required to grasp the meanings of those concepts. However, this researcher remains enthusiastic about the theory after studying and working with it. The theory assumptions require a new openness to others on the part of the nurse. It is the researcher's belief that use of this theory by nurses could transform the practice of nursing by enabling nurses to image people in a more holistic way.

Implications

Practice

The present research has a small sample size and so cannot be generalized to a larger population. The research does, however, add validity to research findings from other studies which reported some of the same findings as the present study.

The nurse who utilizes the human becoming theory as a conceptual base practices in collaboration with clients and families, learning from them and helping them learn as information is freely exchanged. The nurse who practices from a human becoming theory perspective would not feel the need to generalize findings in order to share findings. Therefore, this researcher believes that the findings of this research could be presented to populations of hearing impaired persons and their families. The purpose of sharing the information would be to let hearing impaired persons and their families know how the 6 participants in the study responded to hearing loss and to allow opportunities for dialogue.

Findings related to this research could lead practitioners towards more awareness of the meaning that having presbycusis held for these clients and families. Nurses who have increased knowledge and awareness would provide more sensitive care to clients with hearing loss.

Research

This research helps to expand the body of knowledge related to the meaning of presbycusis in elderly women. It also tests the human becoming theory for appropriateness of use as a conceptual framework for a study related to older women with presbycusis. This research adds to the body of knowledge of older women in general.

The research findings indicate that older women are well able to verbalize the frustrations related to experiencing a hearing loss. Planning research around the human becoming theory provides an opportunity for participants to think in terms of the negative aspects of hearing loss, to explore ways of personal adaptation, and also to consider whether there is a positive side to having the condition. Thus, the use of the human becoming theory as a conceptual basis for this study assisted the researcher to gain insight into the (a) multidimensional meanings that the hearing loss held for the participants, (b) the rhythmical patterns of relating, and (c) expressions of cotranscendence.

Multidimensional and rhythmical aspects of hearing loss have heretofore been only minimally reported. Opportunities for exploration of these avenues are opened up with utilization of the human becoming theory as a conceptual framework.

cocreating rhythmical patterns of relating, and cotranscending with the possibles need to be further explored in relation to hearing loss in elderly patients.

Participants in such studies should be grouped by age, living conditions, and the severity of the loss. Findings could then be compared to determine whether hearing loss has a different meaning among various groups.

Additional research that utilizes the human becoming theory is also needed in order to further test the model for appropriateness of philosophy, concepts, principles, and structure. Consideration should be given to the idea of utilization of the Parse methodology of data analyzation for data that are not related to universal human experiences.

Research also should be expanded in the direction of intervention studies to derive a broader knowledge base from which to assist clients and families of clients to deal with the effects of hearing loss.

APPENDIX A

METHOD OF COMMUNICATING WITH HEARING IMPAIRED PERSONS

Compensation for Hearing Impairment

Typical ways hearing impaired persons compensate for hearing loss include (a) avoiding eye contact to discourage conversation, (b) requesting repeats, (c) attempting to lip-read, (d) withdrawing from social situations, (e) pretending to hear, and (f) taking over the conversation to avoid being the listener (Chovaz, 1989; Jinks, 1991).

Communicating With the Hearing Impaired

Communicating with hearing impaired persons can be made easier by (a) decreasing background noise; (b) being sure the hearing impaired person is using any hearing aid or assistive devices owned; (c) warning the person before beginning a conversation by calling the person's name or providing a gentle touch; (d) having the room well lit to make lipreading easier and decrease glares; (e) sitting or standing at the level of the person at a distance of 3-6 ft away; (f) freeing your mouth of food; (g) facing the person as you speak; (h) preventing covering the speaker's mouth in any way; (i) placing bright lipstick on the speaker's mouth to assist the lip-reader; (j) speaking slower and slightly louder than usual; (k) using short, uncomplicated sentences; (l) checking for understanding by having the person repeat what you have said; (m) using visual aids when appropriate; (n) remaining calm and patient and not frustrated (Tolson & Swan, 1991); (o) being natural without exaggerating lip movements and gestures (Carbary, 1988); and (p) rephrasing misunderstood sentences (Palumbo, 1989).

APPENDIX B

PARTICIPANT CONSENT FORM

Participant Consent Form

The Meaning of Living with Hearing Impairment

Lavin Rowe, RN, MSN
Investigator

I have been invited to participate in a study which will explore the meaning of living with hearing loss. This study is being conducted as a part of a doctoral dissertation.

I understand that in order to participate in the study I must:

1. Be at least 65 years old.
2. Have hearing loss that began as I aged.
3. Be able to hear well enough to talk with the interviewer.
4. Live alone.

I will be asked to participate in three tape recorded interviews with Lavin Rowe. Each interview will last from 60-90 minutes. I will be asked to utilize the following directional ideas as I first shared my experiences of having hearing loss.

1. Tell me about the most meaningful persons and events in your life--begin with your childhood" (Newman, 1994, p. 147).
2. What it is like not to be able to hear well.
3. Any ways that my feelings toward myself have changed since I noticed I had a hearing loss.
4. How I have or have not tried to live as usual since my hearing impairment began.
5. Changes in my relationships with others since I became hard of hearing.
6. New ways of looking at things that have developed since my hearing loss began.
7. Changes that I have made in my life since the hearing loss began.
8. My vision of my future.

I understand that another researcher may listen to the tapes in order to validate the investigator's interpretation of data. Transcripts of the discussion will be prepared and quotations from it may be used in the write-up of this study. The name that I made up for myself before the interviews began will be the name used in the write-up of this study. No write-ups of this study will identify me in any way.

Interviews will be arranged at mutually agreed upon times and places. My participation is being granted freely and I am free to withdraw my participation at any time. I understand that there will be no monetary compensation for participation. No specific benefits to participation can be promised; however, some people who have participated in similar interviews have found the experience of thoughtful reflection to be useful in gaining insights into their own situation. If I have any questions about the study at any time, I understand that I can contact Lavin Rowe at [number deleted].

I understand that signing the consent form means that I have consented to participate in the study.

Signature ________________________________ **Date** ______________

Witness ________________________________

APPENDIX C

PARTICIPANT DATA FORM

APPENDIX D

SHORT PORTABLE MENTAL STATUS QUESTIONNAIRE

Short Portable Mental Status Questionnaire

What is the date today? (month/day/year)?
What day of the week is it?
What is the name of this place?
What is your telephone number? (If no telephone, what is your street address?)
How old are you?
When were you born? (month/day/year)?
Who is the current President of the United States?
Who was the President just before him?
What is your mother's maiden name?
Subtract 3 from 20 and keep subtracting each new number you get, all the way down.

Scoring
0-2 errors= intact
3-4 errors= mild intellectual impairment
5-7 errors= moderate intellectual impairment
8-10 errors= severe intellectual impairment

Examples of evidence of mental deterioration include (a) lack of ability to describe situations logically, (b) making up words, (c) not recognizing visitors who drop in, (d) not knowing where they are, and (e) speaking as if it were another time and year (Haber, McMahon, Price-Hoskins, & Sideleau, 1992).

Test-retest reliability better than .8
Test correlated with clinical diagnosis of organic brain syndrome.

Pfeiffer, E. (1975). A short portable mental status questionnaire for the assessment of organic brain deficits in elderly patients. American Geriatrics Today, 23(10), 433-440.

APPENDIX E

CONTACT SUMMARY FORMS

Interview #1
Contact type:
Visit: _____
Phone: _____

Contact Summary Form

Site:

Contact Date:
Today's Date:

1. What were the main issues or themes that struck you in the contact?

2. Summarize the information you got (or failed to get) on each of the target questions. "Tell me about the most meaningful persons and events in your life--beginning with your childhood" (Newman, 1994, p. 147).

3. Is there anything else that struck you as salient, interesting, illuminating, or important in this contact?

4. What new (or remaining) target questions do you have in considering the next contact with this person?

Interview #2 **Contact Summary Form**
Contact type:
Visit: _____
Phone: _____

Site:

Contact Date:
Today's Date:

1. **What were the main issues or themes that struck you in the contact?**

2. **Summarize the information you got (or failed to get) on each of the target questions.**

   a. Tell me what it is like for you not to be able to hear well.

   b. Tell me about your feelings toward yourself now as compared to when you could hear well.

   c. How have or have you not tried to live as usual since your hearing impairment began?

   d. Compare your relationships with others now to how your relationships were before you became hard of hearing.

   e. What new insights have you had since your hearing loss began?

   f. What changes have you made in your life because of your hearing loss?

   g. Describe your vision of the future.

3. **Is there anything else that struck you as salient, interesting, illuminating, or important in this contact?**

4. **What new (or remaining) target questions do you have in considering the next contact with this person?**

APPENDIX F

CODES AND CODE DESCRIPTIONS

Codes and Code Descriptions

Hearing Loss	
HL:Advantages	HL:AD
HL:Disadvantages	HL:DA
HL:Others helpful	HL:OTHLP
HL:Others not helpful	HL:OTHNHLP
HL:Fears	HL:FRS
HL:Assistive Devices Advantages	HL:ASDIA
HL:Assistive Devices Disadvantages	HL:ASDID
HL:Work Accommodations	HL:WKACC
HL:Others manage	HL:OMG
HL:Hearing Impaired Manage	HL:HIMNG
HL:Safety	HL:SAF
HL:Progression	HL:PRO

Hearing Aids	
HA:Management	HA:MNG
HA:Amount of use	HA:USE
HA:Advantages	HA:ADV
HA:Disadvantages	HA:DAV

Life Issues	
LI:Maintaining control	LI:CONT
LI:Grief	LI:GF
LI:Accomplishments	LI:ACCOMP
LI:Guilt related life events	LI:GLT
LI:Outlook	LI:OUTL
LI:Values	LI:V
LI:Vision future	LI:FUT
LI:Faith	LI:FTH
LI:Maintaining Independence	LI:INDE
LI:Self concept/self esteem	LI:SC/SE
LI:Work	LI:WR

Meaningful Events in Life	
CL:Health	CL:HLTH

CL:Stability	CL:STBL
CL:Hardships	CL:HSHP
CL:Lifestyle	CL:STYL
CL:Discipline	CL:DIS
ML:Stability	ML:STBL
ML:Hardship	ML:HSHP
ML:Lifestyle	ML:STYL
ML:Health	ML:HLTH
LL:Stability	LL:STBL
LL:Hardships	LL:HSHP
LL:Health	LL:HLTH
LL:Lifestyle	LL:STYL

Feelings

FE:Living Conditions	FE:LC
FE:TV	FE:TV
FE:Hearing aid	FE:HA
FE:Others helpful HL	FE:OHHL
FE:Hearing loss	FE:RHL
FE:Others not helpful	FE:ONHLP
FE:Others about hearing loss	FE:OAHL
FE:Hearing impaired person about others	FE:HIAOT
FE:Multidimensional	FE: M-D
FE:Feelings of family related to hearing loss	FE:FRHL
FE:About aging	FE:AGE
FE:Ambivalence HL	FE:AMBHL
FE:Ambivalence HA	FE:AMBHA
FE:Compassion for others	FE:CO
FE:When unable to hear	FE:WUH
FE:Blocked feelings	FE:BLK
FE:Lonely	FE:LONE
FE:Feels nonpowerful	FE:NP
FE:Not related to hearing loss	FE:NRHL

COP:HL

COP:Isolating	COP:ISOL
COP:Nonisolating	COP:NISOL
COP:Faking hearing	COP:FAK
COP:Entertain self when can't hear	COP:ENTSLF

COP:Positive self talk	COP:PST
COP:Adapting to HL	COP:AHL
COP:Guilt associated with adaptation	COP:GLTHL
COP:Bargaining	COP:BAR
COP:Blaming others	COP:BLM
COP:Denial	COP:DEN

Relationships

REL:Family origin	REL:CLFO
REL:Childhood life friends	REL:CLF
REL:Middle life husband	REL:MLH
REL:Middle life husband's family	REL:MLHF
REL:Middle life children	REL:MLC
REL:Middle life friends	REL:MLF
REL:Middle life family origin	REL:MLFO
REL:Later life childhood friends	REL:LLCF
REL:Later life family origin	REL:LLFO
REL:Later life friends/significant others	REL:LLF/SO
REL:Long time friend	REL:LTF
REL:Effective ML relationships	REL:HRLF family
REL:Effect HL relationships - others	REL:HRLO
REL:Later life children (good)	REL:LLCG
REL:Later life children (strained)	REL:LLCS
REL: Pets	REL: PETS
REL: Professionals	REL:P

Activities

ACT:Childhood life family origin	ACT:CLFO
ACT:Childhood life friends	ACT:CLF
ACT:Middle life	ACT:ML
ACT:Later life	ACT:LL
ACT:Activity changes related HL	ACT:CHRHRL
ACT:Activity changes related health	ACT:CHRHLTH
ACT:Activity changes related aging	ACT:CHRAG
ACT:Changes in enjoyment	ACT:CHEJY

Advise-P

Acceptance of Hearing Loss

ACCPT:Problem recognition	ACC:PR
ACCPT:Seeking to find acceptable origin HL	ACC:ORIGIN

Directional Ideas

QHL:LIKE	What it's like not to be able to hear
Q.FE:CHSLF	How have feelings changed toward self
Q.LIF:MPE	Meaningful persons events in life
Q.Lif:USU	Trying to live as usual since HL began
Q.REL:CHOHL	Relationship changes with others re: HL
Q.HL:INSITE	New ways of looking at things developed related to HL
Q.LIF.CHGH	Changes made in life re: HL
Q.Lif:VIS	Vision of future

Parse Concepts

P.I	Imaging
P.V	Valuing
P.L	Languaging
P.RC	Revealing - concealing
P.EL	Enabling - limiting
P.CS	Connecting - separating
P.P	Powering
P.O	Originating
P.T	Transforming

__Imaging__ P.I = a way of knowing, assigned meaning that is given something.

__Valuing__ P.V = process of living cherished beliefs while assimilating the new into a personal world view. Process of choosing, owning, prizing.

Languaging P.L = expressing valued images. It is "showing meaning of personal experiences through speaking, moving, gesturing, and being silent." The way meaning is explained.

Reavealing Concealing P.RC = rhythm in pattern of relating to others. Rhythm evidenced by patterns of disclosure - indisclosure (directional movement or chosen focus of life).

Enabling limiting P.EL = a rhythmical pattern of relating. Choice one makes may move one in one direction while limiting movement in other directions.

Connecting Separately P.CS = rhythmical process of moving together with one phenomenon and moving apart with another phenomenon. Moving in a direction closer to or farther away from others.

P Powering P.P = the pushing resisting rhythm of all interrelationships. Conflict enables persons to clarify views previously unexamined.

O Originating P.0 = creating new ways of living. New ways of viewing familiar concepts.

T Transforming P.T = the changes that occur as new perspectives develop.

Code Descriptions

Hearing Loss

HL:AD	Ways the person has learned to use the hearing loss (HL) to her advantage.
HL:ASDIA	Ways that assistive listening devices enable the hearing impaired to hear better.
HL:ASDID	Descriptions of the imperfections of assistive listening devices.
HL:DA	Ways the hearing loss is detrimental to the person's well-being.
HL:FRS	Anticipation of undesired consequences related to the hearing loss.
HL:HIMNG	Ways the hearing impaired person helps herself in relation to her hearing loss.
HL:INSITE	The ability of the hearing impaired person to see others or situations in a new way.
HL:OMG	Ways others become the ears of the hearing impaired person.
HL:OTHLP	Things others do which enable the hearing impaired (HI) person to hear better.
HL:OTHNHLP	Things others do that hinder the hearing/isolate the person and leave the person out of conversations.
HL:PRO	Descriptions of the hearing loss progression from initial recognition to the present time.
HL:SAF	Things the HI person does to increase safety/or descriptions of times the person has felt unsafe in relation to the hearing loss.
HL:WKACC	Ways the hearing loss was accommodated for in the work setting.

Hearing Aids

HA:ADV	Description of how the hearing aid enables the person to hear better.
HA:DAV	Description of imperfections in the hearing aids which decrease the HI person's ability to hear.
HA:MNG	Ways the HI clean, protect, and set the hearing aid according to day-to-day needs.
HA:USE	The amounts of time/incidences in which the person actually wears the hearing aid and times when it is not worn.

Life Issues

ACC:ORIGIN	The belief which participant espouses as the originating cause of the hearing loss.
ACC:PR	Any movement from denial towards acceptance of the hearing loss that is experienced by the participant.
ACT:CHEJY	Changes in enjoyment of activities that have occurred in the participant's life.
ACT:CHRAG	Changes in activities that the participant has made due to aging.
ACT:CHRHLTH	Changes in activities that the participant has made due to health factors.
ACT:CHRHRL	Recreational or other activities changed because of the participant experiencing a hearing loss.

ACT:CLF	Recreational or other activities in which the participant and the participant's childhood life friends took part during the participant's childhood.
ACT:CLFO	Recreational or other activities in which the participant's family of origin took part during the participant's childhood.
ACT:LL	Recreational or other activities in which the participant has taken part since the participant's spouse died.
ACT:ML	Recreational or other activities in which the participant took part during the time the participant was married.
ADVISE:P	The advice that professionals have given the participant related to the hearing loss.
CL:DIS	The modes of punishment used, or the outlook toward punishment that existed in the child's home during the growing up years.
CL:HLTH	An individual's general state of health during the childhood years.
CL:HSHP	Those times that occurred before marriage which are described as difficult.
CL:STBL	The degree to which an individual's life is nonchanging and firmly established during the childhood years.
CL:STYL	The manner or mode of living that the family has during the participant's childhood years.
COP:AHL	To adapt or respond to hearing loss by adjusting.
COP:BAR	To adapt or respond to hearing loss by the participant telling self her situation is better than another's.

COP:BLM	To adapt or respond to having a hearing loss by placing responsibility for their inability to hear in a place outside herself.
COP:DEN	To adapt or respond to having a hearing loss in a way that disavows its presence.
COP:DSOL	To adapt or respond to having a hearing loss in a manner which removes the person from the presence of others.
COP:ENTSLF	To adapt or respond to not hearing in a way which allows the participant to divert attention onto something attainable.
COP:FAK	To adapt or respond to not hearing in a way designed to make others believe that they are heard when they really are not.
COP:GLTHL	The feelings of self-reproach that arise within participants as a result of taking assistive actions to hear better in public situations.
COP:NISOL	To adapt or respond to having a hearing loss in a manner which draws a person towards others.
COP:PST	To adapt or respond to situation in a self-affirming way.
FE:AGE	The participant's emotional response to the aging process.
FE:AMBHA	Simultaneous feelings that occur within the participant related to the hearing aid.
FE:AMBHL	Simultaneous feelings that occur within the participant related to the hearing loss.
FE:Blocked Feelings	Hurt feelings which the participant languages but does not consciously perceive.
FE:CO	An emotional reaction of sympathy regarding another's situation.

FE:TV	Any emotion summoned up that related to television viewing or television programs.
FE:WUH	An emotional reaction that occurs when the participant cannot hear.
LI:ACCOMP	Perceived achievements in one's life.
LI:CONT	Process of being in charge of self rather than allowing others or situations to have direct influence over the decision making process of one's life.
LI:FTH	A system of religious beliefs that the individual espouses.
LI:FUT	The way one envisions the future unfolding.
LI:GF	Losses in one's life that are mourned.
LI:GLT	Guilt felt as a result of one's actions/inaction related to life events.
LI:INDE	The quality of being self-determined.
LI:OUTL	A general attitude towards life's events.
LI:SC/SE	A way of looking at oneself that is either with or without self-satisfaction.
LI:V	Those ways of being or objects which one's life reflects having been assigned great importance.
LI:WK	One's occupation in life, whether or not it reaps monetary rewards.
LL:HLTH	The participant's general state of health during the years after the death of the spouse.

REL:LLCF	The state of affairs that exists between the participant and childhood friends in the years after the death of the participant's husband.
REL:LLCG	Good relationships that the participant has enjoyed with children since the death of the participant's husband.
REL:LLCS	Strained relationships that the participant has had with her children since the participant's husband died.
REL:LLF/SO	The state of affairs that exists between the participant and friends/-significant others after the death of the participant's husband.
REL:LLFO	The state of affairs that exists between the participant and the participant's family of origin in the years after the death of the participant's husband.
REL:LTF	The state of affairs that exists between the participant and long term friends who were not childhood friends.
REL:MLC	The state of affairs that existed between the participant and the participant's children while the husband was alive.
REL:MLF	The state of affairs that existed between the participant and the participant's friends while the participant was married.
REL:MLFO	The state of affairs that existed between the participant and the family of origin during the years that the participant was married.
REL:MLH	The state of affairs that existed between the participant and the participant's husband.

REL:MLHF	The state of affairs that existed between the participant and the participant's husband's family while the husband was alive.
REL:P	The relationship that the participant has had with professionals in the medical field.
REL:PETS	The relationship of the participant to family pets.

LIST OF REFERENCES

Adams, G. R., & Schuaneveldt, J. D. (1991). Understanding research methods (2nd ed.). New York: Longman.

Antai-otong, D. (1995). Therapeutic communication. In D. Antai-otong & G. Kongable (Eds.), Psychiatric nursing, (pp. 96-108). Philadelphia: Saunders.

Armstrong, D., Stoney, P., Hawke, M., & Farkashidy, J. (1992). Presbycusis: Correlations of clinical audiology with morphological changes in the cochlea and the ventral cochlear nucleus. The Journal of Otolaryngology, 21, 343-349.

Banonis, B. C. (1989). The lived experience of recovering from addiction. Nursing Science Quarterly, 2, 37-43.

Bates, B. (1991). A guide to physical examination (5th ed.). Philadelphia: Lippincott.

Baumann, S. L. (1996). Feeling uncomfortable: Children in families with no place of their own. Nursing Science Quarterly, 9, 152-159.

Bess, F. H., Lichtenstein, M. J., & Logan, S. A. (1991). Making hearing impairment functionally relevant: Linkages with hearing disability and handicap. Acta Oto-Laryngologica (Suppl. 476), 226-231.

Bunkers, S. S. (1996a). Thank you Dorothy: Now I know. Nursing Science Quarterly, 9, 79-80.

Bunkers, S. S. (1996b). Storyteller and the tall man. Nursing Science Quarterly, 9, 42-43.

Burckhardt, C. S., Woods, S. L., Schultz, A. A., & Ziebarth, D. M. (1989). Quality of life of adults with chronic illness: A psychometric study. Research in Nursing and Health, 12, 347-354.

Butler, M. J. (1988). Family transformation: Parse's theory in practice. Nursing Science Quarterly, 2, 68-74.

Butler, M. J., & Snodgrass, F. G. (1991). Beyond abuse: Parse's theory in practice. Nursing Science Quarterly, 4, 76-81.

Carbary, L. J. (1988). "What did you say?" Caring for the patient who has a hearing impairment. The Journal of Practical Nursing, 38(3), 36-39.

Carlisle, D. (1989). Deaf but not disabled. Nursing Times, 85(47), 66-67.

Carlson, C. M. (1984). Reminiscing: Toward achieving ego integrity in old age. Social Casework, 65, 81-89.

Chen, H. (1994). Hearing in the elderly--Relation of hearing loss, loneliness, and self-esteem. Journal of Gerontological Nursing, 20(6), 22-27.

Chinn, P., & Kramer, M. (1995). Theory and nursing--A systematic approach (4th ed.). St. Louis, MO: Mosby.

Chovaz, C. (1989). Nursing the hearing impaired patient. The Canadian Nurse, 85(3), 34-36.

Christian, E., Dluhy, N., & O'Neill, R. (1989). Sounds of silence. Journal of Gerontological Nursing, 15(11), 4-9.

Cody, W. K. (1997). Theoretical concerns. The many faces of change: Discomfort with the new. Nursing Science Quarterly, 10, 65-67.

Cody, W. K., & Mitchell, G. J. (1992). Parse's theory as a model for practice: The cutting edge. Advances in Nursing Science, 15(2), 52-64.

Cowie, R., Stewart, P., & Douglas-Cowie, E. (1987). The experience of becoming deaf. In J. G. Kyle (Ed.), Adjustment to acquired hearing loss: Analysis, change, and learning. Bristol, UK: The Centre for Deaf Studies.

Daly, J., Mitchell, G. J., & Jonas-Simpson, C. M. (1996). Quality of life and the human becoming theory. Nursing Science Quarterly, 9, 170-174.

Davis, D. K., & Cannava, E. (1995). The meaning of retirement for community-living retired performing artists. Nursing Science Quarterly, 8, 8-16.

Ellis, J., & Nowlis, E. (1994). Nursing: A human needs approach (5th ed.). Philadelphia: J. B. Lippincott.

Gardner, D L. (1992). Presence. In G. M. Bulechek & J. C. McCloskey (Eds.), Nursing interventions. Philadelphia: W. B. Saunders.

Garner, J., & Mercer, S. (1989). Women as they age: Challenge, opportunity, and triumph. New York: Haworth Press.

Gates, G. A., Cooper, J. C., Kannel, W. B., & Miller, N. J. (1990). Hearing in the elderly: The Framingham cohort, 1983-1985. Ear and Hearing, 11, 247-256.

Gershon, R. M., Byrns, G. E., & Dunleavy, M. L. (1996). 6-year impact of hearing impairment on psychological and physiologic functioning. Nurse Practitioner, 21(9), 11-14.

Gimsing, S. (1990). Word recognition in presbycusis. Scandinavian Audiology, 19, 207-211.

Giorgi, A. (1970). Psychology as a human science. New York: Harper & Row.

Giorgi, A. (1985). Sketch of a psychological phenomenological method. In A. Giorgi (Ed.), Phenomenology and psychological research. Pittsburgh, PA: Duquesne.

Goetz, J. P., & LeCompte, M. D. (1984). Ethnography and qualitative design in educational research. Orlando, FL: Academic Press.

Guba, E. G., & Lincoln, Y. S. (1981). Effective evaluation. San Francisco: Jossey-Bass.

Guba, E. G., & Lincoln, Y. S. (1989). Fourth generation evaluation. Newbury Park, CA: Sage.

Haber, J., McMahon, A. L., Price-Hoskins, P., & Sideleau, B. (1992). Psychiatric Nursing (4th ed.). St. Louis, MO: Mosby-Year Book.

Häggman-Laitila, A. (1997). Health as an individual's way of existence. Journal of Advanced Nursing, 25(1), 45-53.

Heidegger, M. (1977). Basic writings (D. Krell, Trans.). New York: Harper & Row.

Heidrich, S. M., & Ryff, C. D. (1992). How elderly women cope: Concerns and strategies. Public Health Nursing, 9, 200-208.

Hinchcliffe, R. (1991). The age function of hearing-aspects of the epidemiology. Acta Otolaryngologica (Suppl. 476), 7-11.

Huck, C., Hepler, S., & Hickman, J. (1987). Children's literature in the elementary school (4th ed.). New York: Holt, Rinehart, & Winston.

Janning, J. (1991). Reflections on aging. Journal of Emergency Medical Services, 16, 36-44.

Jarvis, C. (1996). Physical examination and health assessment (2nd ed.). Philadelphia: W. B. Saunders.

Jinks, M. (1991). Counseling older adults with hearing impairment. The Journal of Practical Nursing, 61(3), 43-51.

Joensen, J., & Saunders, D. (1984). Psychological correlates of geriatric hearing loss. The Hearing Journal, 37(3), 39-41.

Jones, L. (1987). Living with hearing loss. In J. G. Kyle (Ed.), Adjustment to acquired hearing loss: Analysis, change, and learning. Bristol, UK: The Centre for Deaf Studies.

Kausler, D. H., & Kausler, B. R. (1996). The graying of America. Chicago: University of Illinois Press.

Klotz, R. E., & Kilbane, M. (1962). Hearing in an aging population. The New England Journal of Medicine, 266(6), 277-280.

Kovach, C. R. (1991). Reminiscence: A closer look at content. Issues in Mental Health Nursing, 12, 193-204.

Kryter, K. D. (1983). Presbycusis, sociocusis, and nosocusis. Journal of the Acoustical Society of America, 73, 1897-1916.

Lincoln, Y. S., & Guba, E. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. In D. D. Williams (Ed.), Naturalistic evaluation. San Francisco: Jossey-Bass.

Lindeman, H. E., & Platenburg-Gits, F. A. (1991). Communicative skills of the very old in old people's homes. Acta Oto-Laryngologica (Suppl. 476), 232-238.

Lowell, S. H., & Paparella, M. M. (1977). Presbycusis: What is it? Laryngoscope, 87, 1710-1717.

Luey, H. S., Glass, L., & Elliott, H. (1995). Hard of hearing or deaf; Issues of ears, language, cultures, and identity. National Association of Social Workers, 40, 177-182.

Lukens, R. (1982). A critical handbook of children's literature. Glenview, IL: Scott, Foresman.

Lutman, M. E. (1991). Hearing disability in the elderly. Acta Oto-Laryngologica (Suppl. 476), 239.

Magilvy, J. (1985). Experiencing hearing loss in later life: A comparison of deaf and hearing impaired older women. Research in Nursing and Health, 8, 347-353.

Markovac, M. (1997). From theory to perioperative practice with Parse. Canadian-Operating-Room-Nursing Journal, 15(1), 13-16.

Marshall, C., & Rossman, G. (1995). Designing qualitative research (2nd ed.). Thousand Oaks, CA: Sage.

Merleau-Ponty, M. (1974). Phenomenology of perception. New York: Humanities Press.

Merriam, S. B. (1988). Case study research in education. San Francisco: Jossey-Bass.

Miles, M. B., & Huberman, A. M. (1994). Qualitative data analysis. Thousand Oaks, CA: Sage.

Mishler, E. G. (1986). Research interviewing. Cambridge, MA: Harvard University Press.

Mitchell, G. (1990a). The lived experience of taking life day-by-day in later life: Research guided by Parse's emergent method. Nursing Science Quarterly, 3, 29-36.

Mitchell, G. (1990b). Struggling in change: From the traditional approach to Parse's theory-based practice. Nursing Science Quarterly, 3, 170-176.

Mitchell, G., & Cody, W. (1992). Nursing knowledge and human science: Ontological and epistemological considerations. Nursing Science Quarterly, 5, 54-61.

Mitchell, G. J. (1996). Practice application. A reflective moment with false cheerfulness. Nursing Science Quarterly, 9, 53-54.

Mitchell, G. J., & Heidt, P. (1992). The lived experience of wanting to help another: Research with Parse's method. Nursing Science Quarterly, 7, 119-127.

Mulrow, C. D., Aguilar, C., Endicott, J. E., Tuley, M., Velez, R., Charlip, W., Rhodes, M., Hill, J., & DeNiro, L. (1990). Quality-of-life changes and hearing impairment. Annals of Internal Medicine, 113, 188-193.

Newman, M. (1989). The spirit of nursing. Holistic Nursing Practice, 3(3), 1-6.

Newman, M. (1994). Health as expanding consciousness (2nd ed.). New York: National League for Nursing.

Newman, M. A. (1997). Evaluation of the theory of health as expanded consciousness. Nursing Science Quarterly, 10, 22-25.

Nokes, K. M., & Carver, K. (1991). The meaning of living with AIDS: A study using Parse's theory of man-living-health. Nursing Science Quarterly, 4, 175-179.

Orlans, H. (1987). Sociable and solitary responses to adult hearing loss. In J. G. Kyle (Ed.), Adjustment to acquired hearing loss: Analysis, change, and learning. Bristol, UK: The Centre for Deaf Studies.

O'Rourke, C., Britten, F., Gatschet, C., & Kein, T. (1993). Effectiveness of a hearing screening protocol for the elderly. Geriatric Nursing, 14, 66-69.

Oyer, H. J., & Oyer, E. J. (1979). Social consequences of hearing loss for the elderly. Allied Health and Behavioral Science, 2, 123-138.

Pallikkathayil, L., & Morgan, S. (1991). Phenomenology as a method for conducting clinical research. Applied Nursing Research, 4, 195-199.

Palumbo, M. (1989). Hearing access 2000: Increasing awareness of the hearing impaired. Journal of Gerontological Nursing, 16(9), 26-31.

Paparella, M. M. (1978). Differential diagnosis of hearing loss. The Laryngoscope, 88, 952-959.

Parse, R. (1981). Man-living-health: A theory of nursing. New York: Wiley.

Parse, R. (1987). Nursing science: Major paradigms, theories and critiques. Philadelphia: Saunders.

Parse, R. (1990a). Health: A personal commitment. Nursing Science Quarterly, 3, 136-140.

Parse, R. (1990b). Parse's research methodology with an illustration of the lived experience of hope. Nursing Science Quarterly, 3, 9-17.

Parse, R. (1992). Human becoming: Parse's theory of nursing. Nursing Science Quarterly, 5, 35-42.

Parse, R. (1993). The experience of laughter: A phenomenological study. Nursing Science Quarterly, 6, 39-43.

Parse, R. (1994a). Laughing and health: A study using Parse's research method. Nursing Science Quarterly, 7, 55-64.

Parse, R. (1994b). Quality of life: Sciencing and living the art of human becoming. Nursing Science Quarterly, 7, 18-21.

Parse, R. (Ed.). (1995). Illuminations: The human becoming theory in practice & research (NLN Publication No. 15-2670). New York: National League for Nursing Press.

Parse, R., Coyne, A. B., & Smith, M. J. (1985). Nursing research qualitative methods. Bowie, MD: Brady.

Parse, R. R. (1996a). Quality of life for persons living with Alzheimer's disease: The human becoming perspective. Nursing Science Quarterly, 9, 126-133.

Parse, R. R. (1996b). Building knowledge through qualitative research. Nursing Science Quarterly, 9, 10-16.

Parse, R. R. (1996c). A reflective moment of false cheerfulness. Nursing Science Quarterly, 9, 53-54.

Parse, R. R. (1996d). Reality: A seamless symphony of becoming. Nursing Science Quarterly, 9, 181-183.

Parse, R. R. (1996e). Joy-sorrow: A study using the Parse research method. Nursing Science Quarterly, 10, 80-86.

Parse, R. R. (1997). The human becoming theory: The was, is, and will be. Nursing Science Quarterly, 10, 32-38.

Patton, M. Q. (1980). Qualitative evaluation and research method. Newbury Park, CA: Sage.

Patton, M. Q. (1990). Qualitative evaluation and research method (2nd ed.). Newbury Park, CA: Sage.

Pestalozza, G., & Shore, I. (1955). Clinical evaluation on the basis of different tests of auditory function. The Laryngoscope, 65, 1136-1163.

Pfeiffer, E. (1975). A short portable mental status questionnaire for the assessment of organic brain deficits in elderly patients. American Geriatrics Today, 23(10), 433-440.

Prigogine, F. (1976). Order through fluctuation: Self-organization and social system. In E. Jantsch & C. H. Waddington (Eds.), Evolution and consciousness (pp. 93-133). Reading, MA: Addison-Wesley.

Ravish, T. (1985). Prevent social isolation before it starts. Journal of Gerontological Nursing, 11(10), 10-13.

Reed, P. G. (1991). Toward a nursing theory of self-transcendence: Deductive reformulation using developmental theories. Advances in Nursing Science, 13(4), 64-77.

Reed, P. G. (1996). Transcendence: Formulating nursing perspectives. Nursing Science Quarterly, 9, 2-3.

Rentz, C. A. (1995). Reminiscence. Journal of Psychosocial Nursing, 33(11), 15-20.

Rogers, M. E. (1970). An introduction to the theoretical basis of nursing. Philadelphia: Davis.

Rogers, M. E. (1990). Nursing: Science of unitary, irreducible, human beings: Update 1990. In E. A. M. Barrett (Ed.), Visions of Rogers science-based nursing (NLN Publication No. 15-2285), New York: National League for Nursing Press.

Rollman, S. A., & Harrison, R. D. (1996). A comparison of deaf and hearing subjects in visual nonverbal sensitivity and information processing. American Annals of the Deaf, 141,(1), 37-41.

Roy, C., & Andrews, H. A. (1986). Essentials of the Roy Adaptation Model. Tappen, NJ: Appleton-Century Crofts.

Rutman, D., & Boisseau, B. (1995). Acquired hearing loss: Social and psychological issues and adjustment process. International Journal of Rehabilitation Research, 18, 313-323.

Rye, S. (1990). A confusion of sound. Nursing Times, 86, 43-44.

Sartre, J. P. (1957). Existentialism and human emotions. New York: Philosophical Library.

Sataloff, R. T., & Sataloff, J. (1993). Hearing loss (3rd ed.). New York: Marcel Dekker.

Schuknecht, H. F. (1989). Pathology of presbycusis. In J. C. Goldstein, H. K. Kashima, & C. F. Loopman (Eds.), Geriatric otolaryngology (pp. 40-48). Toronto, Canada: Decker, Inc.

Seidman, I. E. (1991). Interviewing as qualitative research. New York: Teachers College, Columbia University.

Smith, M. C. (1990). Struggling through a difficult time for unemployed persons. Nursing Science Quarterly, 3, 18-28.

Smith, M. C. (1991). Existential-phenomenological foundations in nursing: A discussion of differences. Nursing Science Quarterly, 4, 5-6.

Stone, H. E. (1987). Adjustment to post-lingual hearing loss. In J. G. Kyle (Ed.), Adjustment to acquired hearing loss: Analysis, change, and learning. Bristol, UK: The Centre for Deaf Studies.

Strome, M., & Vernick, D. (1989). Hearing loss and hearing aids. Harvard Medical School Health Letter, 14(6), 5-8.

Taylor, K. S. (1993). Geriatric hearing loss: Management strategies for nurses. Geriatric Nursing, 14, 74-76.

Thomas, A. J. (1987). Knowing the people who have hearing loss. In J. G. Kyle (Ed.), Adjustment to acquired hearing loss: Analysis, change, and learning. Bristol, UK: The Centre for Deaf Studies.

Tolson, D., & Swan, I. (1991). Facing up to deafness. Nursing Times, 87(23), 26-31.

Turrini, S. P., & Arslan, E. (1991). Effects of different noises on speech discrimination by the elderly. Acta Oto-Laryngologica (Suppl. 476), 136-142.

U.S. Bureau of the Census. (1993). Statistical abstract of the United States (113th ed.). Washington, DC: Author.

U.S. Bureau of the Census. (1994). Statistical abstract of the United States (114th ed.). Washington, DC: Author.

U.S. Bureau of the Census. (1996). Statistical abstract of the United States (116th ed.). Washington, DC: Author.

U.S. Department of Health and Human Services. (1981). Health interview survey. In R. Manheimer (Ed.). (1994). Unpublished Older American's Almanac (p. 423). Detroit, MI: Gale Research.

U.S. Department of Health and Human Services. (1996, February). The road to an aging policy for the 21st century (Executive Summary). 1995 White House Conference on Aging. Washington, DC: Author.

van Manen, M. (1990). Researching lived experiences. Albany, NY: The State University of New York Press.

Vesterager, V., & Salomon, G. (1991). Psychosocial aspects of hearing impairment in the elderly. Acta Oto-Laryngologica (Suppl. 476), 215-220.

Von Wedel, H., Von Wedel, U.-CH., & Streppel, M. (1991). Monitoring the efficiency of hearing aid fitting in the aged by the social hearing handicap index. Acta Oto-Laryngologica (Suppl. 476), 270-277.

Watson, J. (1988). Nursing: Human science and human care. New York: National League of Nursing Press.

Weinstein, B. (1991). The quantification of hearing aid benefit in the elderly: The role of self-assessment measures. Acta Oto-Laryngologica (Suppl. 476), 257-261.

Weinstein, B. E. (1989). Geriatric hearing loss: Myths, realities, resources for physicians. Geriatrics, 44(4), 42-58.

Weinstein, B. E., & Ventry, I. M. (1982). Hearing impairment and social isolation in the elderly. Journal of Speech and Hearing Research, 25, 593-599.

Westbrook, M. T., & Viney, L. L. (1982). Psychological reactions to the onset of chronic illness. Social Science Medicine, 16, 899-905.

Willott, J. F. (1991). Aging and the auditory system. San Diego, CA: Singular Publishing Group.

Wolcott, H. (1990). Writing up qualitative research. Newbury Park, CA: Sage.

GRADUATE SCHOOL
UNIVERSITY OF ALABAMA AT BIRMINGHAM
DISSERTATION APPROVAL FORM
DOCTOR OF SCIENCE IN NURSING

Name of Candidate Lavin R. Rowe

Major Subject Community Mental Health Nursing

Title of Dissertation The Experience of Hearing Loss in Older Women: Patterns of Human Becoming

I certify that I have read this document and examined the student regarding its content. In my opinion, this dissertation conforms to acceptable standards of scholarly presentation and is adequate in scope and quality, and the attainments of this student are such that she may be recommended for the degree of Doctor of Science in Nursing.

Dissertation Committee:

Name	**Signature**
Dr. Penelope Paul, **Chair**	Penelope B. Paul
Dr. Pamela Fordham	Pamela N Fordham
Dr. Anne Foote	Ann Foote
Dr. Cecelia Pierce	Cecelia Pierce
Dr. Renitta Goldman	Renitta Goldman

Director of Graduate Program Carol J Dashiff

Dean, UAB Graduate School Joan F Lorden

Date 1/7/98