Approaches: An Interdisciplinary Journal of Music Therapy
**First View (Advance Online Publication)**

ISSN: 2459-3338 | www.approaches.gr

ARTICLE

# 'It's just a different dimension': Music therapists' experiences of hearing loss

**Sara Cole**
Richmond Music Trust; MusicSpace, UK

**Catherine Warner**
University of the West of England, UK

## ABSTRACT

This study explores the lived experiences of qualified music therapists who identify as having hearing loss. The risk of hearing loss for professional musicians is widely acknowledged in literature, with one study demonstrating an increased risk of hearing loss for music therapists. No current literature, however, explores the experiences of hearing loss from the perspective of the music therapist, in a profession in which hearing and listening could be seen as central to the work. For this study, qualitative research methods were employed, involving semi-structured interviews with six music therapists experiencing different levels of hearing loss. Verbatim transcripts were then analysed, using interpretative phenomenological analysis (IPA), resulting in the identification of three principal themes across the data set: 1) Listening is exhausting: Identity as a music therapist with hearing loss; 2) Impatient or intrigued? Stigma versus support; and 3) How I manage: Strategies for coping. These themes are discussed in-depth, in light of existing theory and implications for practice. The analysis supports existing research demonstrating that acquired hearing loss does not impede musical ability. Barriers to proficiency arise from other areas. Implications are discussed, including recommendations for hearing-protection training within music therapy training programmes.

## KEYWORDS

hearing loss,
music therapy,
identity,
stigma,
hearing protection,
musicians' health

**Publication history:**
Submitted 9 Jul 2019
Accepted 10 Sept 2020
First published 5 Oct 2020

## AUTHOR BIOGRAPHIES

**Sara Cole** is a music therapist working at Richmond Music Trust in London and MusicSpace in Bristol. Prior to her training Sara worked for 18 years in the care sector. During this time, she completed an MSc in Deaf Studies and subsequently worked with deaf young adults in community settings. In addition to her role at Richmond Music Trust, Sara works as a visiting musician at the Bristol Royal Hospital for Children. Sara is a pianist and a percussionist; she teaches piano and is an accompanist for a visually impaired choir. [saracole95@yahoo.com] **Dr Catherine Warner** is senior lecturer and programme leader for the MA Music Therapy at University of the West of England. Her research interests include PAR approaches with a focus on empowerment of co-researchers. Projects include researching with non-verbal people with learning disabilities and children affected by adverse life events. She is currently involved in STALWART, an ERASMUS+ project. She has been a music therapist for over 26 years and has also worked as a professional cellist. [catherine.warner@uwe.co.uk]

## INTRODUCTION

The aim of this study is to open up a currently under-researched topic and give music therapists an opportunity to explore the impact of hearing loss in a profession in which listening and hearing could

be considered fundamental within the clinical context. This project is not focused on deafness per se, the Deaf community or deaf identity. Rather, the aim is to explore the perspectives of music therapists who identify as having hearing loss (which may include profound deafness) and their personal experiences of this, as therapists. It is hoped the study will provide a greater understanding of the potential impact of hearing loss and explore the need for more research in this area.

The paper begins with a literature review, moving from a brief summary of where the main focus of research around hearing loss lies, through to the growing recognition of the prevalence of hearing loss in musicians and, more recently, an acknowledgment of the risk of hearing loss for music therapists. The design, methodology and data analysis of the study are detailed, followed by a results section in which verbatim extracts are presented and analysed through three identified principal themes. The final discussion introduces some new relevant literature and includes the limitations of the study, leading to the conclusion and final recommendations.

## LITERATURE REVIEW

According to the World Health Organisation, approximately one third of people over 65 become affected by disabling hearing loss (WHO, 2020). Unsurprisingly, therefore, most studies exploring the physiological aspects and personal experiences of hearing loss are focused on acquired hearing loss in older adults, due to the prevalence of this particular sensory impairment in the older population (Baldridge & Kulkarni, 2017; Simmons, 2005). People with hearing loss may be considered hard of hearing, deaf or Deaf. The capital D denotes personal identification with the Deaf community and with Deaf culture. Members of the Deaf community are often born deaf and, largely due to the use of sign language, consider their deafness to be an intrinsic part of their identity and culture, rather than something that needs to be treated, managed or adjusted to (Darrow, 2006; Ladd, 2003). The majority of people with hearing loss, however, acquire it during their lifetime, having to adjust to the change and loss over time (Dalebout, 2009; Simmons, 2005).

Significantly, a growing number of studies are showing an increase in the prevalence of acquired hearing loss in people of all ages, due in part to a recognition of the alarming increase in noise-induced hearing loss (Jennings et al., 2013). Many studies explore the psychosocial experiences of hearing loss, including the effects on communication, a lack of appropriate hearing aids or assistive technologies and the widely acknowledged stigma of hearing loss (Lysons, 1996; Wallhagen, 2009). Significantly, research has shown that many people feel unable to face or address problems in hearing, which has led to what has been described as an 'epidemic' of untreated hearing loss (Foss, 2014).

### Hearing loss in musicians

For musicians, whose livelihood may depend on their ability to hear, the impact of hearing loss may be multiplied. Many studies have shown an increased risk of hearing loss for musicians (Chasin, 2009) and for people working in the music industry, due to the level of noise exposure and the intensity of the music they experience (Berg et al., 2016; Di Stadio, 2017; Jenson et al., 2009). One study concluded that professional musicians could be almost four times more likely to develop

hearing loss than the general public (Schink et al., 2014). Music-induced hearing loss appears to be becoming a widespread and yet little acknowledged or accepted phenomenon (Khatter, 2011).

Some studies emphasise that music-induced hearing loss is also prevalent within the context of music education and music tuition (Beach & Gilliver, 2015; Chesky, 2008; Hayes, 2013). The findings in Beach and Gulliver's study (2015) which looked at noise exposure for instrumental music teachers showed that despite many teachers considering themselves to be at low risk from their music-related noise exposure, audiograms showed hearing loss in nearly half the participants. Significantly, many of the music teachers in the study downplayed the risk of noise damage from their musical activities. This could indicate a lack of awareness of the risk but may also be due to internal conflict manifesting in the denial of the risk in the presence of knowledge. Indeed, the invisibility of hearing loss makes it less likely to be acknowledged openly or accepted internally, leading to a strong possibility of denial (Sebastian et al., 2015). Reasons for little recognition or acknowledgment of hearing damage within these contexts could be linked with lingering stigma around deafness and hearing loss but could also reflect a lack of understanding of its potential severity (Dalebout, 2009; Wallhagen, 2009).

As clearly demonstrated by the profoundly deaf percussionist Evelyn Glennie, among many other deaf musicians, hearing loss is not in itself a barrier to music-making or attaining a highly professional level of musicianship (Darrow, 2006). Indeed, a successful and growing UK charity, Music and the Deaf, founded by a profoundly deaf pianist, shows, unequivocally, that hearing loss itself need not be a barrier to making and enjoying music (Music and the Deaf, 2020). Furthermore, an observational study on the effects of hearing impairments on verbal and non-verbal communication during collaborative musical performance showed little evidence of hearing loss affecting social interaction (Fulford & Ginsborg, 2014). However, in order for deaf musicians (or musicians with any level of hearing loss) to perform and interact musically, there are factors which may present challenges, for example with regard to the differing ways in which people process and understand sounds (Bathurst, 2017). Significantly, for people wearing hearing aids or who have cochlear implants, there is the potential deficit in the discernment of pitch and sound quality, which may affect connection and enjoyment (Beck, 2014). Visual communication is of paramount importance, so the position of people in the performance space needs to be carefully considered (Fulford & Ginsborg, 2014). Potential psychological effects of hearing loss should also be acknowledged, such as loss of confidence or feelings of isolation, which may in turn affect levels and quality of musical connection (Manchaiah & Danermark, 2016; Simmons, 2005).

## Music therapists and hearing loss

What, then, of musicians with hearing loss working in a therapeutic context, in situations where interactions are less likely to be controlled and may be hard to predict? In order to respond appropriately to a client's needs, a music therapist needs to be finely attuned to all forms of expression from the client, including the tiniest movement or sound (Bunt & Stige, 2014; Wigram, 2004). As such, listening, hearing and responding could be said to be central to a music therapist's work. The importance of the communicative role of music in this context cannot be overstated (Malloch & Trevarthen, 2009). What impact, then, might hearing loss have on a music therapist's

work and identity?

There is a growing body of literature about deaf musicians (Darrow, 2006) with some studies exploring music therapy work with people with hearing loss (Gfeller, 2007; Robbins & Robbins, 1980; Ward, 2016), and the different ways that people may learn to hear, feel and play music (Abrams, 2011; Bang, 2009; Salmon, 2009). There is a dearth in studies, however, looking specifically at hearing loss in music therapists and their experiences, or the potential for clinical work itself to damage hearing. One study measured the level of noise experienced by a music therapist over the course of two weeks (MacMahon & Page, 2015) and highlighted the risk of hearing loss for people working as music therapists, due to the regular exposure to loud noise at close range. The improvisational nature of much music therapy (Wigram, 2004) adds another risk factor for music therapists, as impulsive sound has been shown to be more damaging to hearing than continuous noise (Clifford & Rogers, 2017; Starck et al., 2003). The study by MacMahon and Page (2015) had limitations, including lack of comparable studies and the variables which made it impossible to say for certain what level of occupational noise that music therapists would be exposed to (and the possible subsequent hearing damage which may occur). However, the findings were important and informative, raising awareness for the first time of the potential for music therapy work to damage hearing.

No current studies, however, look at the experiences of hearing loss from the perspective of the music therapist. This could be due to the relatively small demographic of music therapists, and even smaller demographic with hearing loss. Other reasons for the lack of research in this area could include awareness of the stigma associated with hearing loss and fear of judgment or criticism with regard to professional ability (Foss, 2014; Wallhagen, 2009). Lack of awareness of the potential for music therapy work itself to damage hearing could also be a contributing factor to the gap of literature or research in this area.

# METHOD

## Design and methodology

The qualitative methodology chosen in order to undertake the research was interpretative phenomenological analysis (IPA) (Eatough & Smith, 2006; Freeman, 2008; Hefferon & Gil-Rodriguez, 2011; Reid et al., 2005; Smith & Osborn, 2003; Smith et al., 2009). The diverse nature and manifestations of hearing loss, combined with personal and complex music therapy approaches, meant each participant's narrative would be rich and unique, thus worthy of the in-depth scrutiny that is at the core of IPA.

Prior to recruitment for the research, ethical approval was received from the Health and Applied Sciences Faculty Research Ethics Committee at the University of the West of England (reference number: RG310118SC). Purposive sampling was used for recruitment, identifying participants based upon predetermined selection criteria (Braun & Clarke, 2013; Silverman, 2014; Yardley, 2000). As such, participants were required to be music therapists who identified as having hearing loss. The aim was to recruit a relatively homogenous sample, as is typical of IPA studies (Smith et al., 2009; Smith & Osborn, 2003).

The number of years since qualifying ranged from 4 years to over 30 years. Levels of hearing loss ranged from mild high-frequency hearing loss to severe deafness (Table 1). To ensure anonymity of the participants and due to the potential sensitivity of the subject for some, no further details of participants are given.

| Pseudonym | Level and onset of hearing loss |
|---|---|
| Andy | Bilateral deafness from birth (severe) |
| Bella | Bilateral deafness from birth (severe) |
| Christine | Acquired high-frequency hearing loss in adulthood (mild, undiagnosed) |
| Daisy | Acquired high-frequency hearing loss in adulthood (moderate) |
| Edward | Unilateral deafness from early age (profound in one ear) |
| Florence | Unilateral deafness from early age (profound in one ear) |

**Table 1:** Level and onset of participants' hearing loss

All hearing loss was self-reported during the interviews rather than verified using audiometric data. Data were collected using semi-structured interviews. Three of the six participants wore hearing aids. All participants were able to communicate in spoken English, so no adjustments were required in order to make participation accessible. The interviews were between 50 and 90 minutes in duration. Four interviews took place face-to-face; two took place over Skype. The flexibility of the interview allowed participants to explore their experiences without constraint. As music therapists, not audiologists, neurologists or acousticians, we make no pretence to be experts in the fields of hearing loss or hearing preservation. One of us is a music therapist with severe tinnitus and possible mild hearing loss, which gives an elevated level of researcher subjectivity. The advantages and limitations of this position are acknowledged in a subsection in the discussion.

## Data analysis

The audio data was transcribed verbatim to prepare for analysis. To ensure anonymity, all participants have been given pseudonyms and, aside from levels and onset of hearing loss, all identifying details have been removed. To begin analysis, each interview was read, and then twice reread, in order to feel fully immersed in the narrative (Smith et al., 2009). Initial exploratory comments were then made on the right-hand side of the transcript, pointing to any notable linguistic, conceptual or descriptive elements. Following this, emergent themes that linked significant features of the data were noted on the left-hand side of the transcript. Any significant, relevant quotes were highlighted. Developing from these initial steps, connections were then made between the emergent themes. This was achieved by making a visual representation of the data and drawing out interrelationships within the themes, in order to refine the focus of the analysis. This process resulted in the identification of a small number of higher-level superordinate themes. These steps

were then repeated for each subsequent case.

Following close scrutiny of the superordinate themes across the cases and the connections between them, three principal themes were identified:

Theme one: Listening is exhausting: Identity as a music therapist with hearing loss
Theme 2: Impatient or intrigued? Stigma versus support
Theme 3: How I manage: Strategies for coping

The three themes were scrutinised, with verbatim extracts from each participant, to form the final analysis and ensuing discussion. An additional process of gathering participant feedback from all six participants was carried out in order to validate the authenticity of the data. This involved asking participants to read through the study and note any sections which they felt needed clarification or modification. It was particularly important that the participants agreed to the chosen verbatim extracts presented in the results section. Three of the six participants sent revised transcripts, indicating where they felt the extracts or sections of the manuscript needed clarification.

## RESULTS

The three themes are now presented with the chosen verbatim extracts and analysis. On occasion the results are presented alongside relevant in-text citations pointing the reader to relevant literature.

### Theme one: Listening is exhausting: Identity as a music therapist with hearing loss

The fear of missing something significant within the clinical setting was a recurring concern for participants, and exacerbated by the intensity of a therapeutic relationship and the importance of the communication within it. Two participants acknowledged the anxiety they experienced when their hearing loss caused them to miss something within the clinical context:

> The stress levels go up when you're watching lip patterns carefully and you can't understand it and then they say it again and you still don't know. It's exhausting and demoralising. (Bella)

> It's certainly changed how I work, and I'm definitely conscious of it at all times [...] A few weeks ago I was in a group and somebody mumbled something, it was something significant and I wasn't getting it... I asked three times and I couldn't get it [...] I felt awful. (Daisy)

Both comments accentuate the barrier that hearing loss can create and the resulting rising anxieties that can be experienced when important things are felt to be missed. Daisy's response is a stark example of a negative impact of hearing loss, in which internal feelings of guilt arise (Arnason, 2003).

Another notable recurring feeling expressed by the participants was insecurity around professionalism, due in part to the difficulty in discerning sound in groups and sensitivity to

peripheral noise. In addition to problems posed in clinical sessions, it was clear that meetings posed significant problems for participants, as seen in the following extracts:

> Meetings at work when I was missing things... people start talking quickly between the two of them and they're not talking to the whole group, and everyone else is picking it up, except for me. (Daisy)

> My team was at the other end of this big office and the other team were all talking to each other and it just made it impossible. These sorts of things I am really sensitive to and I found myself really craning to hear what was happening. I felt exhausted afterwards. (Christine)

The tiring aspect of listening is prominent within the narratives; something which perhaps may not be appreciated by those who have not experienced hearing loss. Bella expresses this powerfully in the following comment, giving us an insight into both the intensity of trying to listen with a hearing loss and the frustrations that can then extend to others who may not understand:

> My ability to actually listen is very acute so I am absolutely focused and it annoys me when I'm in a meeting and people have missed something because they've only listened with half an ear. You're working really hard to keep up but the hearing can afford not to care when they get it wrong. (Bella)

The implication here is that the styles of auditory attending can vary considerably. Bella's comment suggests those who do not have a hearing loss can sometimes be more complacent in their listening. This could instigate feelings of resentment and highlights again the invisibility of hearing loss and the silent, inner struggles that may be little acknowledged by others (Simmons, 2005; Herbst, 2000).

Whilst all participants did point to the difficulties experienced in group scenarios, the levels of frustration did vary significantly, from deep distress to mild irritation. Indeed, one participant was often humorous in his narrative, which could be seen as a coping mechanism, but could also just be a reflection of his self-efficacy:

> It's just a bit of a hassle sometimes. I sometimes think I'd like to have like an old Victorian ear trumpet that goes under my chin, I could just hold it there, an old brass ear trumpet – it would be quite funny! (Edward)

Another participant was also openly honest and humorous about her deafness, but she did acknowledge some anxieties, including concern that she may be unintentionally seeming to ignore others:

> I have honestly considered having 'I am deaf' tattooed on me at some point because, yeah, I always worry that I'm ignoring people. (Florence)

Significantly, one participant talked openly about reaching a point of such distress that he considered leaving the music therapy profession:

> I just wish sometimes people would give me a chance, you know? [...] At one point I really felt like giving it all up, you know – sod this, I'll do something else! But then I said to myself, 'Well, I'll hang on in there.' (Andy)

This could be seen as a powerful illustration of the internal struggle that has been ongoing for Andy. His strong desire to continue his work as a music therapist is evident, despite relentless barriers and never feeling truly accepted or respected in the field. His resolve to 'hang on in there' is testament to his inner determination during what has clearly been (and continues to be) a complex and difficult journey.

For Bella, struggles have stemmed less from the response from others and more from the intensity of the work and the effort of listening:

> It's very tiring. It really is wearing, mentally, because the processing is constant. Conscious listening is exhausting and being a music therapist is exhausting, even though it is an amazing profession to be in [...] and at the end of the day, you know, you've certainly had enough. (Bella)

For Daisy, her acquired hearing loss has been a challenge in the sense that there has been quite a dramatic shift in the way she has felt able to work:

> It's knocked my confidence to do work. I mean, I've got a lot more inner confidence that I can be with someone and know that it's useful... but then again, I don't know. (Daisy)

Daisy's statement suggests that she is also battling with an internal struggle. Whilst she knows she is a capable and professional music therapist with confidence in her own abilities, she is also acutely aware of the significant change and the enormity of adjustment. She has had to deal not only mentally and emotionally with the loss of hearing but also adjust physically to her hearing aids and the resulting different presentation of sound. Crucially, as well as requiring a physical adjustment, adapting to hearing aids is also a long, complex, ongoing psychological process.

In addition to expressing the struggles, some participants were also keen to emphasise the communicative strength of music and the potential for music therapists to connect with others on a different level, through music, without the need for words:

> It's a real privilege actually, to be able to work as music therapists, I think, and it really helps you to appreciate the power of music and how it can sort of act as a different vehicle... without words... and can transcend things as well. (Christine)

Furthermore, there was acknowledgement of the shared sense of humanity between therapist and client due to the shared experience of living with hearing loss, as is poignantly expressed by

Bella in the following extract:

> People say, 'Gosh, how is it that you're doing what you're doing and you're deaf?' Well, actually it makes sense, doesn't it, because you know what it's like to be isolated, you know what it is to be anxious and different, and you know what music means to you, so you understand the power of actual connection at an intrinsic level. (Bella)

## Theme two: Impatient or intrigued? Stigma versus support

All six participants seemed to have strong feelings about how others perceived them; whether they felt stigmatised due to their hearing loss in such a music-based profession, or, conversely, if the response was a positive, supportive or even intrigued one.

One participant pointed to the stigma he believed was attached to his deafness and the resulting mistrust he felt from the music therapy community:

> So I did a music therapy conference… it was strange because people were a little unsure, you know? They don't know how to deal with you, afraid of talking to you sometimes, because of my deafness [...] Even some of the music therapists were so traditional, straitjacket, they didn't like the idea that there was a disabled person qualified in music therapy. There was a stigma attached to it. (Andy)

Despite being a qualified music therapist, Andy has continued to feel judged and misunderstood within the profession. His shift from past tense to present tense and back to the past tense again could be a reflection of his ongoing struggle over time. Noting his own deafness amidst his general statements about fear and stigma could also highlight the isolation he has felt.

Daisy's anger and frustration are apparent, too, in her personal observations which reflect the widespread negativity around hearing loss:

> You know, people get annoyed, because it's invisible, and people don't make the adjustments. People just think they [people with hearing loss] are stupid and they get impatient. (Daisy)

During the interview she also talked on a more personal level about her own feelings as a music therapist with hearing loss. These included fear of increased hearing loss over time and the frustration she has felt at not being taken seriously in the work place with regard to her hearing loss:

> In fact, hearing aids is the only thing that has made managers engage with me in relation to concerns about hearing loss. Nobody has taken me seriously before. (Daisy)

For Daisy, the move to wearing hearing aids, thus making the impairment a visible one, was a

significant move towards her hearing loss being more recognised and thus more understood by others, with employers taking her need for support more seriously.

For Andy, despite seemingly never feeling fully embraced by the profession, there was a notable shift towards a more accepting place:

> I felt totally rejected by the music therapy community, and I still do! Although I think that's changed now since we went to the conference this year... people were much more open, more aware, I think. So I think there's been a change, somehow, in attitude. (Andy)

This development is less linked with any practical changes he has made but appears to be more a result of a gradual shift in attitude and levels of acceptance of disability and hearing loss in the music therapy community. Significantly, despite this shift, to talk of feeling 'totally rejected' by the music therapy community would suggest that his struggle to be accepted is pervasive and ongoing.

Another participant, Bella, also expressed how she had felt misunderstood by some. In contrast to Andy, however, lack of understanding was more often from outside of the music therapy field, for example from some audiologists who did not appreciate the difference in listening required by musicians. That hearing aids are designed primarily to optimise the intelligibility of speech is a well-researched area (Hearing Aids for Music, 2020) and highlights the problems faced by musicians needing appropriate and satisfactory hearing aids. The complex listening required as an interactive musician, further intensified by being deaf, Bella explained, is rarely understood by audiologists. The following extract highlights her frustration:

> A surprising proportion [audiologists] are only interested in speech and it's insulting. I will explain how my job is, as an interactive musician and they'll just say, 'Well, tough!' and that a standard music programme on the aid will be fine for 'listening to Classic FM!' (Bella)

Whilst she noted that real understanding of her hearing loss was limited, Bella did acknowledge that, in contrast to Andy's experience, people within the music therapy profession were generally positive:

> I think people are sort of astonished but just don't understand it, really. People who are in the field are generally quite respectful; they understand something about it, however limited, and that's fine. (Bella)

This view is echoed by Florence, who also experienced positive reactions from others:

> The main response I get, when I tell people I've got a hearing impairment, is they're like, 'Wow! That's amazing you're a music therapist,' and I feel a bit bashful because I think it doesn't feel relevant. (Florence)

That people are 'astonished' or consider it 'amazing' to be a music therapist with hearing loss is perhaps a reflection of lingering common assumptions around deafness and musical ability. Florence clearly does not feel that her hearing loss should hold any significance with regard to her ability as a music therapist. Interestingly, her later comment reflects her view that not having to adjust to a hearing loss was also a contributing positive factor:

> It would be totally different if I'd acquired the hearing loss after learning music, you know? (Florence)

This could be seen as implying that those with acquired hearing loss may struggle more with regard to musical development and ability than those who have not known any different, but could also purely be an acknowledgement of the complexities inherent in adjusting to hearing loss.

Surprisingly, one participant, who also talked about experiencing positive reactions from others, suggests that stigma could be seen as something self-created and that it is one's personal responsibility to present something positively in order that it may be positively received:

> In my experience, it's how you present something kind of dictates whether it becomes a stigma with other people […] If anything, people are more intrigued… (Edward)

This strong view reflects Edward's robust attitude and his personal confidence in his abilities as a music therapist with hearing loss. The suggestion that the existence of stigma is dependent on how individuals present themselves is interesting. One reading could be that this is a reflection of some level of internalised ableism, whereby the stigmatised narrative surrounding deafness has in some way been absorbed. Alternatively, Edward may be presenting a conscious challenge to those who may choose to project their own attitudes about his experience on to him.

Another participant, Christine, suggested that musicians may in fact be particularly understanding about deafness and hearing loss, due to the growing awareness of the prevalence of acquired hearing loss amongst musicians:

> Because it's an occupational hazard for musicians, I think that reduces the stigma, because we know there are musicians struggling with it [...] I've never felt stigmatised. Maybe young people would be less patient? (Christine)

Whilst Christine does not feel personally stigmatised in any way, she recognises that hearing loss could instigate feelings of frustration in others, thus opening up the potential for stigma. This acknowledgement that hearing loss may incite impatience in others is echoed by Florence when she talks of having to ask people to say things again or to move positions (in meetings, for example) in order that she may be able to hear better:

> Sometimes it feels like people might get frustrated, if they're having to repeat stuff. [...] I still worry that others may feel annoyed about the act of having to move seats, you know? (Florence)

Without giving any actual examples of impatient responses to her deafness, this could be seen as an example of internalised stigma, in which negative responses to deafness in society have been absorbed and applied to her own experience.

## Theme three: How I manage: Strategies for coping

The need and desire to maintain professionalism and proficiency in the workplace was a prominent theme in the participants' narratives. The strategies employed by the music therapists, however, were strikingly diverse. Factors influencing their different approaches included: levels of hearing loss, use of hearing protection, choice of client group, means of musical communication and concerns for the future.

One participant was no longer able to work as a therapist within the clinical setting due both to the growing severity of his impairment and to additional significant personal physical needs. However, he talked positively about how he had been able to utilise and spread his music therapy knowledge and experience through a different medium:

> I've written some academic articles now, which have been a big help. That for me was my milestone for getting over this hurdle. (Andy)

Andy's use of the word 'hurdle' could be seen as an attempt to make the enormity of his struggle feel more manageable in his mind.

For two of the participants, strategies for coping with their hearing losses within clinical sessions were practical in the main. They considered their hearing impairments to be inherent to their beings and did not talk of any notable detrimental effects to their clinical work:

> You know, that's just how it is. It's just one of those things you adapt to so I don't consider it a disability [...] I always have my client on the right, just because of a much more subtle level of hearing I can get from that. (Edward)

> I have done more individual work than group work (..) I guess my deafness is kind of intrinsic to my experience of music and therefore doesn't affect my practice as a therapist, I guess? Hearing loss is just kind of there, as part of me. (Florence)

Bella, too, was clear about the work that she would avoid, noting that, because of her deafness and her need for intense focus, difficulties would arise from too much movement or too many words:

> I wouldn't want to put myself in a position where I was working with someone who really needed to use words. Because people don't keep their voice levels up, and if you're saying something emotional the chances are your voice drops. So I might miss the key word [...] and I would also not be able to work with someone who is verbal and running around the room; it wouldn't be fair on them or professional. (Bella)

Significantly, Bella was the only participant whose narrative focused almost exclusively on the significance of the musical interactions and need for finely tuning her musical skills as a strategy for working successfully.

> Music in deafness has to be stripped down, you have to really understand what you're working with, what your music is and how you're presenting your sound. When you work with special needs it's very different because then you use the whole spectrum of music […] A major point is that you have to keep reinforcing your listening and checking that your personal knowledge of sound in music is accurate. (Bella)

This is a powerful demonstration of client-focused work and a deep knowledge of different ways that people may not only hear sound but also interpret and understand it (Ward, 2009; Sacks, 2007; Headlam, 2006; Levitin, 2006).

The focus on client need was paramount within the interviews, alongside an understanding of the importance of self-care as music therapists. Protection of remaining hearing was expressed by participants as an important element of self-care. One participant explained that she needed to seek protection for her hearing; a daunting prospect as she feared that it may knock her confidence:

> I don't want it to get worse [...] If I was going to be doing things with my hearing, it would probably make me feel a bit less confident again, just till I'd adjusted. (Christine)

Alongside the fear of hearing loss worsening and having to face the adjustment process, which would be psychological as well as physical, there was a recognition here of the importance of wellbeing as a therapist, including having the self-awareness to know if you are physically and emotionally capable of working at a professional level (Gro, 2016; Skovholt, 2012).

> That self-scrutiny you have to have as a music therapist, I think always has to be at that quite high level so that you are aware of...are you able to work or not? (Christine)

There were notable differences in the levels of openness that the participants showed towards clients about their hearing loss. Some did not see any relevance in telling clients, some actively hid their impairment during clinical sessions and others were more open:

> I'm a very open person, I'm not ashamed to talk about it and I think it's something that people need to understand. (Andy)

> I've never told a client. It's never felt necessary to do so. I have moulded earplugs so having them has made a big difference, and also you can slip them in kind of subtly, which is good, as I don't want clients to feel like they've done something wrong. (Florence)

> I don't think, 'Oh, this is my hearing problem,' I just think, 'I've got to optimise this environment for the patient and me.' (Christine)

All participants were notably and consistently sensitive to their clients' needs. Importantly, however, there is the danger that this sensitivity may override personal need and potentially lead to more hearing damage:

> I'm sort of always thinking, 'Well, is this too loud – should I be stopping it?' And almost always, it never feels like the most important thing, because you're with this person and finally got them to a place where they really need to be and the one thing you don't want to do is stop them. As a therapist you don't want to stop them. (Daisy)

Significantly, Daisy also acknowledges the importance of protecting not only her own hearing but that of her clients. Alongside her increasing personal anxiety about her hearing loss there has developed a growing assertiveness with regard to managing her own clinical space:

> I'm probably more assertive now about how to manage it than I used to be. I don't put the cymbal out [...] Thinking about how to protect your clients is no bad thing, and sometimes you need to stop being loud in order to start thinking. (Daisy)

This comment could be seen as an alternative and positive slant on something that might instinctively be seen in a negative way. Bringing awareness into the clinical setting of the need to protect hearing of both client and therapist could potentially result not just in minimising the risk of hearing damage but also in making space for therapeutic development. Furthermore, it could be said that the experience of hearing loss simply brings a new perspective into the clinical context:

> I am just bringing this thing that a lot of music therapists aren't; an added element in relation to the parameters and boundaries we work within. It's just a different dimension. (Daisy)

## DISCUSSION

This study was an exploration into the experiences of six music therapists with hearing loss. There was substantial disparity between the levels, onset and types of hearing loss experienced by the participants and, of course, between their personal journeys as music therapists; this rich diversity was immediately present in their narratives. The three principal themes identified across the six cases explored issues connected with: personal challenges around extended listening, levels of awareness and understanding from others and, lastly, personal and social coping strategies. The analysis brought to the fore some of the participants' most significant experiences as music therapists with hearing loss, creating avenues for continued research in this area and, importantly, indicating areas of practice and training that may benefit from education and change.

Analysis of the narratives showed that hearing loss for these music therapists appeared to be experienced as one of the following within the workplace: an obstacle to be overcome, fully integrated, or irrelevant. It was not possible to clearly define these markedly different standpoints in relation to the level or onset of hearing loss experienced by the music therapists. Rather, their lived experiences were largely shaped by social and environmental factors and personal journeys as therapists, which, of course, were unique but also continuously changing and developing over time. Importantly, some common threads in the narratives did emerge.

The adjustment process required when wearing hearing aids or using hearing protection was highlighted, which is a widely researched and recognised area (Dalebout, 2009; Lane & Clark, 2016; Simmons, 2005). These complex adjustments are psychological as well as physical, and have been shown to affect levels of confidence and mental energy. Levels of musicianship of the therapist, however, were not affected. Indeed, there was nothing within the narratives that was indicative of a negative effect that hearing loss had on the music therapists' ability as musicians. This is consistent with a substantial body of research emphasising that hearing loss need not be a barrier to proficiency in musicianship (Darrow, 2006; Fulford & Ginsborg, 2014; Gfeller, 2007). The lack of detrimental effect to musical ability appeared consistent throughout the narratives, whatever the level and onset of hearing loss for the participants and whatever the client group they were working with. This could be a useful finding both for music therapy employers and for musicians with hearing loss who may be considering training as music therapists but who may see their deafness as a barrier to successful work in a music-based profession. It may also potentially counteract some common misconceptions around hearing loss and musical ability or musical connection (Darrow, 2006; Einhorn, 2012; Fulford at al., 2011).

The theory that all humans have an intrinsic predisposition to musicality from infancy (Stern, 1985; Trevarthen, 1997; Trevarthen & Malloch 2000) is now a widely recognised and accepted notion, underpinning much music therapy practice. The subsequent development of personal musical identities is then shaped by social and environmental factors (Hargreaves et al., 2002) but also by the different ways in which music is experienced and understood. For people with hearing loss, constructing and maintaining a musical identity may take a different path due to the different ways of listening, hearing and interpreting music. The need to 'hear' and try to understand what is being communicated, through whatever means, is fundamental to music therapy work. This emerged as a poignant element in the narratives. For the deaf music therapists working with deaf clients, for example, the emphasis was on visual communication, conscious listening, fine-tuning the presentation of sound and being acutely attuned to different ways that individuals process and understand sound and music (Darrow et al., 2000; Darrow & Novak, 2007). Interestingly, Levitin (2006), in his detailed exploration of the ways the brain perceives music, points to what he calls an 'astonishing' discovery that the regions of the brain that were active in following musical structure were the same ones that were activated when deaf people were communicating in sign language. This could be significant and positive when considering the strength of connection involving visual communication for deaf people in musical interaction.

Reflecting the mental effort required for listening, the participants' narratives supported existing literature which emphasises the widely experienced, yet little recognised, exhausting element of listening with a hearing loss (Morata et al., 2005; Nachtegaal et al., 2009). The potential

for cognitive fatigue due the mental exertion required for listening with a hearing loss should not be underestimated. For any therapist, an intense level of listening is required within the clinical context (King et al., 2012; Skovholt, 2012). For music therapists, this is elevated due to the multidimensional aspect of communication in a musical context, and the need to be finely tuned to every form of expression from the client. With a hearing loss, this intensity is exacerbated still. Literature on listening effort with a hearing loss points to the elevated exertion of cognitive resources needed in order to maintain a satisfactory level of listening (Desjardins, 2016; Rudner, 2016). Additionally, the 'capacity to filter and prioritise sound' is compromised (Bathurst, 2017), making it harder to discern sounds, with background noise being a significant barrier to focused listening.

An associated recurrent experience for the participants was the perception of impatience from other people, who, some felt, perhaps did not understand the mental effort required to listen. Impatience has long been acknowledged as a reaction to hearing loss, due in part to the invisibility of the impairment and to the stigma attached to hearing loss (Foss, 2014; Gooday & Sayer, 2017; Harold, 1985; Shohet & Bent, 1998; Simmons, 2005). Significantly, however, none of the participants experienced impatience or judgement from their clients; these negative responses came more from fellow music therapists and colleagues, or from people outside the music therapy profession (such as audiologists). This would indicate that hearing loss need not impede professionalism for music therapists within the clinical setting, but that problems arise, instead, from misunderstanding and judgments from others. Importantly, for those working with deaf clients, the shared experience of hearing loss and the corresponding different way of processing sound may in fact prove valuable in the therapeutic relationship.

The fear of missing something was a common experience in the narratives, inducing feelings of guilt and anxiety in some participants, which could be said to align with existing research on internalised stigma, in which stigma processes may lead to affective responses, such as anxiety and shame (Goffman, 1963; Mendes & Muscatell, 2018, Vogel et al., 2013). Whilst all participants touched on the stigma of hearing loss in their narratives, there were considerable differences in the way that they perceived, experienced and spoke of it. Major et al. (2018), in their exploration into stigma, discrimination and health, point to the contextual nature of stigma, where individuals are believed to possess some attribute that conveys a social identity that is devalued in a particular social context. This would relate to the experiences of one participant who felt judged and 'rejected' by the music therapy community because of his deafness.

The differences in the way some participants felt about or experienced stigma and identity could be congruent with the relational aspect of stigma observed by Jones et al. (1984) in which a condition that may be labelled as deviant by one person may, conversely, be viewed as an intriguing and 'charming eccentricity' by another person. As highlighted in the narratives, some participants felt that people were generally 'intrigued' or 'astonished' by their ability to be a music therapist with a hearing loss, whereas some participants felt devalued and disrespected by others. These are significant findings if we are to consider implications for practice. These opinions, whether positive or not, are still judgements which are likely to come from a place of little understanding. While being thought of as inspirational may not appear to be a negative view, some literature within the disability arena has underlined the contribution of 'inspiration porn' to an erroneous understanding of disabilities, in which 'othering' the disabled person simply accentuates the stigmatisation (Haller &

Preston, 2017). This could correlate with the portrayal and understanding of hearing loss, whereby the focus may often be on the burden of the impairment rather than on societal obstacles faced by the people experiencing hearing loss. As such, disseminating information about the experiences of music therapists with hearing loss, via training, conference presentations or journal articles, could be a valuable and important step towards more acceptance and understanding and could perhaps also be a move towards encouraging more deaf people to consider entering the profession. Input from d/Deaf musicians and music therapists in devising the training should be of paramount importance here.

There were no clear links to be made between participants' confidence levels and the onset of their hearing loss. This does not reflect recent research which concluded that acquired hearing loss in adulthood leads to more psychological trauma than living with hearing loss from the early years of life (Sebastian et al., 2015), although the small sample size in the current study may account for this. It was notable that participants here expressed a broad and complex range of experiences that sometimes did not bear any relation to the onset or severity of their hearing loss. In fact, close analysis of the narratives showed that this diversity in personal confidence with regard to identity appeared to be predominantly linked with the levels at which participants felt accepted and respected by others. This concept is echoed in disability studies literature, which looks at the personal experience of disability and the extent to which experiences are shaped by societal, political and cultural levels of acceptance (Goodley, 2017; Riddell & Watson, 2014).

As an invisible impairment, hearing loss invites a complex dimension: the potential for denial of the impairment (Santuzzi et al., 2015). Whilst none of the participants denied their hearing loss, there were different responses with regard to the level at which they believed or accepted that it was a disability, ranging from not thinking of hearing loss as a disability at all, to talking frankly about being disabled and the need for openness and acceptance. Responses also varied with regard to disclosure of hearing loss to clients. There were no discernible links between disclosure decisions and severity of hearing loss. Some participants did not disclose their hearing loss to clients in the clinical setting. One participant, who openly introduced ear defenders into sessions, was clear and passionate about the need to protect hearing. The different approaches reflect research by Southall et al. (2011), in which factors that influence disclosure of hearing loss in the workplace were explored, including stigma and implications for practice. The primary theme that emerged in the findings was centred on the perceived sense of control, which could be said to echo the responses in this current study.

In order to maintain proficiency in clinical work, some participants spoke of the practical elements they needed to consider, such as: positioning in the room, appropriateness of the clinical space for both client and therapist (Jackson, 2018), choice of client group, methods of musical communication and choice of hearing protection. Distinctions between working with individuals and in groups were also acknowledged, including the barriers to focused listening that may arise in group situations due to the difficulties in discerning layers of sound. Other less tangible barriers to proficiency were also expressed by participants. For example, for two participants who were experiencing a gradual decline in their hearing, there was an added element of concern for the future when considering their personal competence in the profession (Beach & Gilliver, 2015; Chesky, 2008). Other areas of concern expressed in the narratives were: levels of fatigue, fear of missing significant

moments, lack of directional hearing, adjustment processes and confidence levels.

Given the emphasis placed by all six participants on the protection of their remaining hearing, alongside recent research highlighting the potential for music therapy work to cause noise-induced hearing loss (MacMahon, 2015), the issue of hearing protection feels of paramount importance within the music therapy field, and is currently little acknowledged. The improvisational nature of music therapy (Bunt & Stige, 2014; Oldfield, 2006; Wigram, 2004) means that the chance for sudden, impulsive noise within a clinical music therapy session is elevated, giving even more reason to raise awareness of the dangers. Thus, the dissemination of information about hearing loss and the introduction of hearing-protection training could perhaps be recommended as part of music therapy training before entering the profession (O'Brien et al., 2014; Walter, 2017). In addition, education around hearing aids and assistive technologies is needed, especially with regard to the specifics of listening and the different ways that a musician may hear, interpret and understand sounds.

## Limitations

Whilst the participants did not identify with Deaf culture or the Deaf community and all communicated using spoken English, some talked about their experiences of deafness, including reflections on Deaf culture and music. One participant had felt negatively judged due to being born deaf but not embracing Deaf culture; another talked of 'anti-music Deaf signers.' The potential for deeper exploration into this was considerable, especially with regard to exploring views and attitudes held within the Deaf community towards music therapy (Ward, 2016). Unfortunately, this subject was beyond the scope of a study of this size. Future research and analysis could explore this area further.

Having an 'insider status' as a music therapist with tinnitus could be seen as a limitation, in that questions may arise as to whether the interpretation of the analysis reflected personal subjectivity (Corbin-Dwyer & Buckle, 2009). This was particularly relevant when exploring the data of music therapists with tinnitus and high-frequency hearing loss. The heightened level of researcher subjectivity could potentially be seen as detrimental to data analysis. However, being an 'insider' could, conversely, be seen as a positive researcher stance in that it was possible to get closer to some participants' experiences, relate to the feelings expressed, and potentially connect more deeply with the data.

Methodological limitations should also be acknowledged. All hearing loss was self-reported, rather than verified using audiometric data. We also acknowledge that this study lacks transferability due to each music therapist's experience of hearing loss being so unique. However, it is hoped that the identification and presentation of unifying themes across the data has done justice to the rich and diverse experiences of the participants and, as this is currently the only study in this area, that the implications could have some reach.

# CONCLUSION AND FUTURE RECOMMENDATIONS

This study has shown that it is possible to be a professional, proficient music therapist with hearing loss, and that neither congenital nor acquired hearing loss need impede ability to practise in this field. However, there are areas from which barriers to proficiency may arise. These areas include:

levels of awareness and understanding from others, appropriateness of client group, adjustment processes (to loss of hearing, hearing aids, assistive technologies and hearing protection), management of clinical space, and levels of confidence.

Given the potential for sounds created during clinical work to damage hearing for music therapists and the emphasis placed on the protection of remaining hearing by the participants, it is hoped that this study has opened up the potential for more research in the area of music therapy and hearing loss. Crucially, the introduction of hearing-protection training within music therapy programmes is recommended for trainees before entering the music therapy profession.

## REFERENCES


Arnason, C. (2003). Music therapists' listening perspectives in improvisational music therapy. *Nordic Journal of Music Therapy, 12*(2), 124-138. https://doi.org/10.1080/08098130309478083

Abrams, B. (2011). Understanding music as a temporal-aesthetic way of being: Implications for a general theory of music therapy. *The Arts in Psychotherapy 38*(2), 114-119.

Baldridge, D.C., & Kulkarni, M. (2017). The shaping of sustainable careers post hearing loss: Toward greater understanding of adult onset disability, disability identity, and career transitions. *Human Relations*, *70*(10) 1217-1236. https://doi.org/10.1177/0018726716687388

Bang, C. (2009). A world of sound and music: Music therapy for deaf, hearing impaired and multi-handicapped children and adolescents. Multimedia documentation review. *Approaches: Music Therapy and Special Music Education 1*(2), 93-103. http://approaches.gr/wp-content/uploads/2015/09/Approaches_122009_Bang_Review.pdf

Bathurst, Bella. (2017). *Sound: A story of hearing lost and found.* Profile Books Ltd.

Beach, E., & Gilliver, M. (2015). Instrumental music teachers: Music exposure and hearing loss. *Australian Journal of Music Education, 1,* 3-12.

Beck, D. L. (2014). Issues and considerations regarding musicians, music, hearing and listening. *Hearing Review, 21*(8), 14-16.

Berg, A., Ibrahim, H., Sandler, S., & Salbod, S. (2016). Music-induced hearing loss: What do college students know? *Contemporary Issues in Communication Science and Disorders*, *43*, 195-205. http://doi.org/10.1044/cicsd_43_F_195

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Bunt, L., & Hoskyns, S. (Eds.). (2002). *The handbook of music therapy*. Routledge.

Chasin, M. (2009). *Hearing loss in musicians. Prevention and management.* Plural Publishing Inc.

Bunt, L., & Stige, B. (2014). *Music therapy: An art beyond words* (2nd ed.). Routledge.

Chesky, K. (2008) Preventing music-induced hearing loss. *Music Educators Journal, 94*, 36-41. https://doi.org/10.1177/002743210809400308

Clifford, R.E., & Rogers, R. A. (2009). Impulse noise. Theoretical solutions to the quandary of cochlear protection. *Annals of Otology, Rhinology & Laryngology, 118*(6), 417-427. https://doi.org/10.1177/000348940911800604

Corbin-Dwyer, S. and Buckle, J.L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods, 8*(1), 54-63. https://doi.org/10.1177/160940690900800105

Dalebout, S. (2009). *The Praeger guide to hearing and hearing loss. Assessment, treatment and prevention.* Praeger Publishers.

Darrow, A. (2006). The role of music in Deaf culture: Deaf students' perception of emotion in music. *Journal of Music Therapy, 43*(1), 2-15. https://doi.org/10.1093/jmt/43.1.2

Darrow, A.A., Gfeller, K.E., Gorusch, A., and Thomas, K. (2000). Music therapy with children who are deaf and hard-of-hearing. In C.E. Furman (Ed.), *Effectiveness of music therapy procedures: Documentation of research and clinical practice* (3rd ed., pp. 135–157). American Music Therapy Association.

Darrow, A. A., & Tsiris, G. (2013). Music therapy and special music education: Interdisciplinary dialogues. *Approaches: Music Therapy and Special Music Education, 5*(1), 13-17. http://approaches.gr/wp-content/uploads/2015/09/6-Approaches_512013_Darrow-Tsiris_Interview.pdf

Desjardins, J.L. (2016). The effects of hearing aid directional microphone and noise reduction processing on listening effort in older adults with hearing loss. *Journal of the American Academy of Audiology*, 27, 29-41. http://doi.org/10.3766/jaaa.15030

Di Stadio, A. (2017). Which factors to induce hearing loss in professional musicians? Extensive literature review and histopathology findings can answer it. *Hearing, Balance and Communication, 15*(2), 63-71. http://doi/.org/10.1080/21695717.2017.1311505

Eatough, V., & Smith, J. (2010). 'I was like a wild wild person': Understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychiatry, 97*(4), 483-498. http://doi.org/10.1348/000712606X97831

Edwards, J. (2016). *The Oxford handbook of music therapy*. Oxford University Press.

Einhorn, R. (2012). Observations from a musician with hearing loss. *Trends in Amplification, 16*(3), 179-182. http://doi.org/10.1177/1084713812468513

Foss, K. (2014). (De)stigmatizing the silent epidemic: Representations of hearing loss in entertainment television. *Health Communication, 29*, 888-900. http://doi.org/10.1080/10410236.2013.814079

Freeman, M. (2008). Hermeneutics. In L. M. Given (Ed.), *The sage encyclopedia of qualitative research methods* (pp. 385-388). Sage.

Fulford, R, Ginsburg, J., & Golbert, J. (2011). Learning not to listen: The experiences of musicians with hearing impairments. *Music Education Research*, *13*(4), 447-464. https://doi.org/10.1080/14613808.2011.632086

Fulford, R., & Ginsborg, J. (2014). Can you hear me? Effects of hearing impairments on verbal and non-verbal communication during collaborative musical performance. *Psychology of Music*, *42*(6), 846-855. http://doi.org/10.1177/0305735614545196
Gfeller, K. (2007). Music therapy and hearing loss: A 30-year retrospective. *Music Therapy Perspectives, 25*(2), 100-107. http://doi.org/10.1093/mtp/25.2.100
Goffman, E. (1963). *Stigma: Notes on the management of a spoiled identity*. New Jersey: Prentice Hall Inc.
Gooday, G., & Sayer, K. (2017). *Managing the experience of hearing loss in Britain, 1830 - 1930.* Palgrave Pivot.
Goodley, D. (2017). *Disability studies: An interdisciplinary introduction* (2nd ed.). Sage.
Gro, T. (2016). Self-care in music therapy: The art of balancing. In J. Edwards (Ed.), *The Oxford handbook of music therapy* (pp. 936-956). Oxford University Press.
Haller, B., & Preston, J. (2017). Confirming normalcy: 'Inspiration porn' and the construction of the disabled subject? In K. Ellis & M. Kent (Eds.), *Disability and social media: Global perspectives* (pp. 41-56). Routledge.
Hargreaves, R., Macdonald, R., & Miell, D. (2016). Musical identities. In S. Hallam, I. Cross & M. Thaut (Eds.), *The Oxford handbook of music psychology* (2nd ed., pp. 759-774). Oxford University Press.
Harold, O. (1985). *Adjustment to adult hearing loss*. Taylor and Francis.
Hayes, P. (2013). Noise doses of high school band directors. *Journal of Band Research, 49*(1), 54-70.
Headlam, D. (2006). Learning to hear autistically. In N. Lerner, N & J. Straus (Eds.), *Sounding off: Theorizing disability studies in music* (pp. 109-120). Routledge.
Hearing Aids for Music (2020). http://www.musicandhearingaids.org
Hefferon, K., & Gil-Rodriguez, E. (2011). Interpretive phenomenological analysis. *The Psychologist, 24*(10), 756-764.
Herbst, K. G. (2000). Acquired deafness. In P. Hindley & N. Kitson (Eds.), *Mental health and deafness* (pp. 253-284). Whurr Publishers Ltd.
Jackson, D. (2018). Aesthetics and the psychotherapist's office. *Journal of Clinical Psychology, 74*(2), 233-238. https://doi.org/10.1002/jclp.22576
Jennings, M.B., Southall, K., & Gagne, J. (2013). Social identity management strategies used by workers with acquired hearing loss. *Work*, *46*, 169-180. http://doi.org/10.3233/WOR-131760
Jensen, E., Helleman, H., Dreschler, W., & de Laat, J. (2009). Noise induced hearing loss and other hearing complaints among musicians of symphony orchestras. *International Archives of Occupational Environmental Health*, *82,* 153-164. http://doi.org/10.1007/s00420-008-0317-1
Jones, E. F., Farina, A., Hastorf, A. H., Markus, H., Miller, D. T., & Scott, R. A. (1984). *Social stigma: The psychology of marked relationships.* Freeman.
Khatter, K. (2011). Personal music players and hearing loss: Are we deaf to the risks? *Open Med, 5*(3), 137-138.
King, G. A., Servais, M., Bollack, L., Shepherd, T. A., & Willoughby, C. (2012). Development of a measure to assess effective listening and interactive communication skills in the delivery of children's rehabilitation services. *Disability and Rehabilitation, 34*(6), 459-469. https://doi.org/10.3109/09638288.2011.608143
Ladd, P. (2003). *Understanding Deaf culture: In search of deafhood.* Multilingual Matters Ltd.
Lane, K. R., & Clark, M. K. (2016). Assisting older persons with adjusting to hearing aids. *Clinical Nursing Research, 25*(1), 30-34. http://doi.org/10.1177/1054773814563350
Levitin, D. (2006). *This is your brain on music.* Atlantic Books.
Lysons, K. (1996). *Understanding hearing loss.* Jessica Kingsley Publishers.
MacMahon, L., & Page, A. (2015). Noise induced hearing loss in music therapists: A case study. *Journal of Environmental Health Research., 15*(1), 57-70.
Major, B., Dovidio, J. F., & Link, B. G. (Eds.). (2018). *The Oxford handbook of stigma, discrimination and health*. Oxford University Press.
Malloch, S., & Trevarthen, C. (Eds.). (2009). *Communicative musicality: Exploring the basis of human companionship*. Oxford University Press.
Manchaiah, V., & Danermark, B. (2016). *The experience of hearing loss: Journey through aural rehabilitation*. Routledge.
Mendes, W., & Muscatell, K. (2018). Affective reactions as mediators of the relationship between stigma and health. In B. Major, J. F. Dovidio & B. G. Link (Eds.), *The Oxford handbook of stigma, discrimination and health*. Oxford University Press.
Morata, T. C., Themann, C. L., & Randolph, R. F. (2005). Working in noise with a hearing loss: Perceptions from workers, supervisors and hearing conservation program managers. *Ear Hear, 26*, 529 -545. http://doi.org/10.1097/01.aud.0000188148.97046.b8
Music and the Deaf (2020). http://www.matd.org.uk
Nachtegaal, J., Kuik, D. J., & Anema, J. R. (2009). Hearing status, need for recovery after work and psychosocial work characteristics: Results from an internet-based national survey on hearing. *International Journal of Audiology, 48*, 684-691. http://doi.org/10.1080/14992020902962421
O'Brien, I., Driscoll, T., Williams, W., & Ackermann, B. (2014). A clinical trial of active hearing protection for orchestral musicians. *Journal of Occupational and Environmental Hygiene, 11*(7), 450-459. http://doi.org/10.1080/15459624.2013.875187
Oldfield, A. (2006). *Interactive music therapy: A positive approach. Music therapy at a child development centre.* Jessica Kingsley Publishers.
Reid, K., Flowers, P., & Larkin, M. (2005). Exploring the lived experience. *The Psychologist, 18*, 20-23.
Riddell, S., & Watson, N. (Eds.). (2014). *Disability, culture and identity*. Routledge.
Robbins, C., & Robbins, C. (1980). *Music for hearing impaired and other special groups*. Magnamusic-Baton.
Rudner, M. (2016). Cognitive spare capacity as an index of listening effort. *Ear and Hearing: The Official Journal of the American Auditory Society, 37,* 695-765. http://doi.org/10.1097/AUD.0000000000000302
Sacks, O. (2007). *Musicophilia: Tales of music and the brain.* Pan Macmillan Ltd.
Sacks, O. (1989). *Seeing voices*. Macmillan Publishers Ltd.
Salmon, S. (Ed.). (2008). *Hearing, feeling, playing: Music and movement of hard-of-hearing and deaf children*. Reichert Verlag.
Santuzzi, A. M., Waltz, P. R., Finkelstein, L. M., & Rupp, D. E. (2015). Invisible disabilities: Unique challenges for employees and organisations. *Industrial and Organisational Psychology, 7*(2), 204-219. http://doi/org/10.1111.iops.12134
Schink, T., Kreutz, G., Busch, V., Pigeot, I., & Ahrens, W. (2014). Incidence and relative risk of hearing disorders in professional musicians. *Occupational and Environmental Medicine*, *71*, 472-476. http://doi.org/10.1136/oemed-2014-102172

Sebastian, S., Varghese, A., & Gowri, M. (2015). The impact of hearing loss in the life of adults: A comparison between congenital versus late onset hearing loss. *Indian Journal of Otology, 21*(1), 29-32. http://doi.org/10.4103/0971-7749.152857
Shohet, J. A., & Bent, T. (1998). Hearing loss: The invisible disability. *Postgraduate Medicine*, *104*(3), 81-90. http://doi.org/10.3810/pgm.1998.09.572
Silverman, D. (2014). *Interpreting qualitative data: A guide to the principles of qualitative research.* Sage.
Simmons, M. (2005). *Hearing loss: From stigma to strategy*. Peter Owen Publishers.
Skovholt, T. M. (2012). *Becoming a therapist: On the path to mastery*. John Wiley & Sons Inc.
Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis. Theory, method and research*. Sage.
Smith, J., & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to methods* (pp. 53-80). Sage.
Southall, K., Jennings, M. B., & Gagné, J. P. (2011). Factors that influence disclosure of hearing loss in the workplace. *International Journal of Audiology, 50*(10), 699-707. http://doi.org/10.3109/14992027.2011.588963
Starck, J., Toppila, E., & Pyykko, I. (2003). Impulse noise and risk criteria. *Noise and Health. A Bimonthly Interdisciplinary International Journal*. *5*(20), 63-73.
Stern, D. N. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology.* Ingram Publisher Services.
Sutton, J. P. (2007). The air between two hands: Silence, music and communication. In N. Losseff, & J. Doctor (Eds.), *Silence, music, silent music* (pp. 169-186). Ashgate Publishing Limited.
Trevarthen, C. (1997). Preface. In M. Pavlicevic, *Music therapy in context: Music, meaning and relationship* (pp. ix-xii). Jessica Kingsley Publisher https://doi.org/10.1080/08098130009477996
Trevarthen, C., & Malloch, S. (2000). The dance of wellbeing: Defining the musical therapeutic effect. *Nordic Journal of Music Therapy, 9*, 3-17. http://doi.org/10.1080/08098130009477996
Vogel. D.L., Bitman, R.L., Hammer, J.H., & Wade, N. (2013). Is stigma internalised? The longitude impact of public stigma on self-stigma. *Journal of Counseling Psychology, 60*(2) 311-316. http://doi.org/10.1037/a0031889
Wallhagen, M. (2009). The stigma of hearing loss. *The Gerontologist, 50*(1), 66-75. http://doi.org/10.1093/geront/gnp107
Walter, J. (2017). Earplug usage in preservice music teachers. *National Association for Music Education, 35*(2), 5-14. http://doi.org/10.1177/8755123315603108
Ward, A.J. (2016). Music therapy interventions for Deaf clients with dual diagnosis. *Voices: A World Forum for Music Therapy*, *16*(3), 1-10. https://doi.org/10.15845/voices.v16i3.840
World Health Organisation (WHO) (2020). http://www.who.int/news-room/fact-sheets/detail/deafness-and-hearing-loss
Wigram, T. (2004). *Improvisation: Methods and techniques for music therapy clinicians, educators and students.* Jessica Kingsley Publishers.
Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, *15*(2), 215-228. https://doi.org/10.1080/08870440008400302

Ελληνική περίληψη | Greek abstract

# *'Είναι απλώς μία διαφορετική διάσταση'*: Οι εμπειρίες μουσικοθεραπευτών με απώλεια ακοής

Sara Cole | Catherine Warner

## ΠΕΡΙΛΗΨΗ

Η παρούσα μελέτη διερευνά την ζώσα εμπειρία πιστοποιημένων μουσικοθεραπευτών που αναγνωρίζουν ότι έχουν απώλεια ακοής. Ο κίνδυνος απώλειας της ακοής στους επαγγελματίες μουσικούς είναι ευρέως αναγνωρισμένος στη βιβλιογραφία, και μία μελέτη επικεντρώνεται στον αυξημένο κίνδυνο απώλειας της ακοής των μουσικοθεραπευτών. Όμως, δεν υπάρχουν μελέτες στη βιβλιογραφία που να διερευνούν το βίωμα της απώλειας της ακοής από την οπτική του μουσικοθεραπευτή, σε ένα επάγγελμα που η ακοή και η ακρόαση είναι κομβικής σημασίας για την δουλειά τους. Στη μελέτη αυτή χρησιμοποιήθηκαν ποιοτικές μέθοδοι έρευνας, με τη χρήση ημι-δομημένων συνεντεύξεων με έξι μουσικοθεραπευτές που βιώνουν σε διαφορετικά επίπεδα απώλεια ακοής. Οι μεταγραμμένες συνεντεύξεις αναλύθηκαν μέσω ερμηνευτικής φαινομενολογικής ανάλυσης [Interpretative Phenomenological Analysis, IPA], από όπου προέκυψαν τρεις βασικές θεματικές κατηγορίες: 1) Η ακρόαση είναι εξουθενωτική: η ταυτότητα του μουσικοθεραπευτή με απώλεια ακοής· 2) Ανυπόμονος ή περίεργος; Στίγμα έναντι υποστήριξης· και 3) Πώς το αντιμετωπίζω: στρατηγικές διαχείρισης. Αυτές οι θεματικές αναλύονται σε βάθος, υπό το πρίσμα της υπάρχουσας θεωρίας και των επιπτώσεων στην πράξη. Τα αποτελέσματα υποστηρίζουν τα υπάρχοντα ερευνητικά δεδομένα

ενισχύοντας ότι η επίκτητη απώλεια ακοής δεν παρεμποδίζει τη μουσική ικανότητα. Εμπόδια επαγγελματικής επάρκειας προκύπτουν από άλλους τομείς. Στη συζήτηση των συνεπειών συμπεριλαμβάνονται συστάσεις ως προς την εκπαίδευση για την προστασία της ακοής μέσα στο πλαίσιο των σπουδών μουσικοθεραπείας.

## ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

απώλεια ακοής, μουσικοθεραπεία, ταυτότητα, στίγμα, προστασία ακοής, η υγεία του μουσικού