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1.2 *Reflections on the expectations and experiences of first time hearing aid users in Denmark*

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«I feel like a chameleon on a tartan blanket. I just don't know whether to enjoy or dislike being a hearing aid user!»
(Experience of a first time hearing aid user)

The Construction and Deconstruction of the Right to Hear

The policy pursued in connection with the distribution of hearing aids can be seen as an example of the ability and willingness of a society to rehabilitate its citizens and provide equal conditions for all. In Denmark, the policy reflects a new trend in the administration of hearing health care. The public sector may still provide high quality rehabilitation of the hard of hearing seen in an international comparison. However, cuts in public funding have led to lack of status attached to the profession of medical audiologist and thus a severe scarcity of staff. Moreover, long waiting lists to obtain a hearing aid have paved the way for a private sector subsidised by public funds.

Societal attitudes toward the hard of hearing and to hearing aids are an example of how society treats difference.

> «When people use, develop, test and manage hearing aids, they are simultaneously using, developing, testing and managing notions of hearing loss and categories of human difference. Sometimes hearing aids are inconsequential – that is, they 'don't matter' to people who wear, see, or manufacture them. But more often hearing aids are consequential, marked and remarkable, serving as artefacts of the various ways in which humans have organized physical and social difference through culture and technology» (Stratton A. 1999: 65).

This paper is based on research carried out for a thesis on the first time users' expectations and experiences of hearing aids in Denmark. The field-

work started early 2003 and the research is still in progress. To this end, the various factors and agents influencing the process of acquiring a hearing aid are examined. The first part of the paper examines the changing conditions of the welfare state in administering care; the second part utilizes notions of embodiment (SCHEPER-HUGHES N. 1994) in connection with hearing impaired persons and their rehabilitation. The focal point is the reaction of the inexperienced users to the various experts and technology and their set up to include them in the hearing world. The users are adults with an acquired, gradual hearing loss. Deaf people are not included in the study. The Deaf[1] represent a strong and independent culture that can be viewed in a historic and social context. The opposite applies to adults with an acquired, gradual hearing loss. They are in danger of losing or lessening the ties to their social group. Self-help groups exist, but the nature of the impairment can complicate communication with fellow-sufferers, just as the hard of hearing tend to minimise the problem and tend not to identify themselves with other hard-of-hearing people.

Even if society does not pay much attention to hearing impairment, the problem is so common that almost everyone knows someone who is hard of hearing. The number of informants is consequently high, and I have recorded their attitudes and thoughts in a field diary. Moreover, to identify interview partners (in this text: respondents), I approached public and private hearing aid clinics. The Danish hearing health care is characterised by a public sector accounting for about 85% of the prescribed hearing aids and a rapidly expanding private sector (15%). The public clinics were very open and helpful. They invited patients from their waiting list to participate in the study. For a number of reasons, gaining access to the private hearing aid clinics was more complicated. I see part of the problem as the different power relations between the private provider and customer as compared to the relations between the medical staff and patients of the public clinics. The existence of the private provider depends on the satisfied customer, while for the public sector the relationship to their patients is based on science and the institutionalised provision of care. Consequently, the private first time customer, despite lack of experience, is to some extent more in control of the situation than the patient of the public clinic. Also, the users that acquire their hearing aids through the private sector may think of themselves as customers and not – like in the public sector – as recipients of a social benefit and thus more compliant to an invitation to participate in a scientific study. As a result, I had to rely on a positive private provider as well as advertise for respondents in order to get in touch with this group. The 38 respondents are between 42 and 92 years old with

an equal distribution of women and men. The distribution is based on coincidence as I accepted almost all who volunteered to participate. I excluded one person at the very beginning of the study because she was too frail to participate. 22 of the respondents are retired and 16 still work. For the latter group, the motivation to acquire a hearing aid was connected to their occupation. For the great majority, the group of retired people represents a highly active group with a wish and need to participate in the activities of their networks. The respondents are all Danish, and their occupations include office staff, shopkeepers, medical staff, teachers, managers, an officer (military), a professor of economy, a lawyer, a bus driver, a social worker, an artisan and a technician. The study is asymmetrical in as much as the degree of contact to the users varies. In some cases, I conducted the first qualitative interviews with the users before they acquired their hearing aids – in others just after the acquisition. Subsequently, I contact the users to learn about their experiences with their hearing aids. When possible, I accompany them to the various institutions where the hearing aids are adjusted and carry out participant observation.

The aim of the first qualitative interview is to clarify the motivation of acquiring the hearing aid. Why do the respondents find it important to hear? How is their personal acceptance of being hearing impaired and being a hearing aid user? Does the hearing loss affect their identity? How do family and friends react to the hearing impairment? Why is the decision to acquire a hearing aid made at that particular time? By whom are they influenced? What are their expectations and, not least, the source of their expectations? Have they had to redefine their relations to other people due to the hearing loss? Are they engaged in activities that require them to attend meetings and quickly perceive what is going on?

Through the interviews, I also want to find out what motivates the respondents to acquire their hearing aids via the private or the public sector. Unlike most other European countries, Denmark does not have a long tradition for private health care. Even within the medical sector, it is in many cases viewed with suspicion to earn one's salary through private health care (expert interview with Torsten Johnsen, audiologist). Here there is a clear difference between hearing care and optical care. The practise of the welfare state has thus construed eye glasses to be a facilitator that is the responsibility of the individual to acquire and pay for. Only in cases of extreme financial need or very poor eyesight will the state subsidy or pay for eye glasses. It is difficult to say whether the difference in the legality of providing subsidies for eye glasses and hearing aids is connected to the costs of the devices, tradition and/or cultural differences in the perception

of the nature and degree of suffering. It would be an interesting research question how and whether the state policy reflects the difference between the kind of social relationships poor eyesight and hearing imply. The fact is that different European countries legislate differently in this area. The respondents of this study find it quite normal to obtain their glasses from a high street optician without going to an eye specialist, because glasses are not seen as a health service provided by the state. Hearing aids are regarded along very different lines. Most of the respondents going to the public sector feel they have a right to free hearing aids, and it is stupid to pay for something you can get without payment. They feel they have paid sufficient taxes throughout their lifetime to have earned their hearing aids. A motivation to go to the private sector can be negative experiences of others who have obtained their hearing aids through the public sector, the long waiting lists or a general belief in private enterprise as opposed to public services.

The Best Hearing Care System in the World?

In Denmark, an estimated 500,000 out of a population of 5.4 million have a hearing loss that would justify the use of a hearing aid. However, only about 250,000 have actually opted for hearing aids. In Finland, the difference is even more significant, the size of the population is 5.2, but only about 14,000 hearing aids are distributed a year (without payment through the public clinics; no subsidies for the private clinics) whereas the same figure for Denmark is about 90,000 (private and public) (expert interview with Søren Hougaard, Manager of an international hearing aid company, 2003 - http://www.hear-it.org, 2003). There are a number of reasons for this, but one could be the efficiency of the Danish system from a historical viewpoint, another could be that the Danish language is blurred (Bleses D. - Basbøll H. 2003) which complicates communication for the hard of hearing.

There is no precise figure for the use of the 250,000 hearing aids in Denmark. Estimates of hearing aids that are not used vary from 8% (Bispebjerg Hospital, public hearing clinic) to 50% (expert interview with Birgit Johnsen, audiologist and private distributor, 2003). An indication of the trend could be that I have made it at habit of talking about my study to people I meet. They almost all know hearing aid users, and most of them tell me about family members who do not use their hearing aids.

From the early days of the Hearing Health Services, since 1951, the system has made it possible for all Danes in need of hearing aids to have these

provided free of charge. Users visiting the public hearing clinics are provided with good digital hearing aids and free batteries. The hearing aids provided through the public system are not always up to the very latest technological development, but they are certainly quality devices. However, at present, the political context is changing, which opens up for privatisation within the sector. To preserve and modernize the system as required, it would have seemed appropriate to analyse the system, create a debate, and adapt the system to the contemporary needs of the population and the general financial situation. Instead, the government has left the understaffed public sector to fend for itself. At the same time, it has strengthened the private sector by subsidising the acquisition of hearing aids through a private dealer. According to the government, this has been done to shorten waiting lists and to give the users the freedom to choose between the private and the public sectors.

Although there is heated debate in the Danish media about the poor standard of the public health sector, the confidence in the public hearing care system seems to be considerable. 85% of the hearing users see their ear specialist, are referred to the public hearing clinic and obtain their hearing aids there. In the study, some of the respondents said that they would be quite willing to pay something in order to obtain higher quality hearing aids. However, this is not possible in the public sector. Patients can nevertheless influence what they obtain from the public sector, but in order to choose the most suitable device, it is necessary to know what one can choose from. Nor is it given that one is always offered the option of choosing.

Due to the higher salaries paid by the private sector to audiogram technicians and hearing aid specialists, the consequences for the public sector have been a shortage of staff and thus longer waiting lists, which has again strengthened the position of the private sector. This has been especially problematic for those people with more severe hearing loss who have no financial means to acquire a powerful hearing aid privately. In addition, the private sector is not organised to interact with social authorities and with the labour market to find the best solutions for the hard of hearing with the most serious problems. However, this problem is given much less attention by the counties than previously which has deteriorated the situation for the most serious cases of the hard of hearing. Moreover, the shortage of qualified staff remains a problem. The public institutions train the specialists and technicians who measure the audiograms and adjust the hearing aids. On completing their training, these people are often hired by the private sector, leaving a gap to be filled in the public health facilities.

In order to obtain an overview of the Danish Hearing Health services from a professional viewpoint, I have carried out 27 expert interviews with public medical staff, private providers, politicians, and representatives of the pressure groups for the hard-of-hearing. The politicians agree that Denmark in general is moving from a supply-regulated health sector to a demand-regulated sector. They claim the problems in the sector are structural, and that market mechanisms will solve the issue. They also state that the financial resources are decreasing at the same time as the public demand for hearing aids is increasing. If the hearing health service is not to deteriorate further, the only way to bridge the gap seems to be through increased user payments.

The interviews I have carried out with representatives of the private and the public sectors reveal a highly competitive attitude towards each other. In some respects, they even have contrary interests. The private sector argues that they provide better service and at less costs to the public. Moreover, the same person mostly follows the user through the adaptation process, which makes the user feel more secure. Also, the users are invited to return to have their hearing aids readjusted. The private sector has a vested interest in increasing the number of users and thus rely on promoting a good reputation. As stated above, about 250,000 Danes are potential hearing aid users, which is a significant market potential. The public sector, on the other hand, urges the government to discontinue the subsidies to the private sector. Advocates for this sector stress the importance of the non-commercial prescription of hearing aids, noting the commercial interest of the private sector in selling as many hearing aids as possible and implying that people, who do not need hearing aids, receive them anyway. The number of follow-up visits during the adaptation process is limited to a minimum in the public sector. In order to shorten the waiting lists, the public sector has no interest in increasing the number of patients. Otherwise, administrative and political pressure on the clinic will increase.

The above may sound as if I conclude that the private sector is doing a better job than the public one. That is not necessarily the case. It could be argued that the private sector has the better conditions to provide good service, but the human factor plays an important role. In the public sector, some staff members provide excellent service, and it the private sector there are cases of greed that motivates the sale of a hearing aid.

The power struggle between the public and the private sector is only natural. But the policy pursued by the government seems to tip the scales in favour of the private sector. For instance, the Minister of Health recently attended the opening of a new outlet of a hearing aid chain store, whereas

it is difficult for the public clinics to attract governmental attention when they celebrate an achievement.

The Mindful Body and Hearing Impairment

Having described the changing context of Danish hearing health care, the following pages offer an overview of the kind of impairment from which the hard of hearing suffer. To this end, I find it helpful to draw on the concepts of Nancy Scheper-Hughes:

> «The hypothesized "body" of which I speak – *mindful, nervous, consuming, commoditized, fetishized, labouring, anguished* or *disciplined* – is for critical medical anthropologists both unquestioningly real and existentially given, even though its very giveness is always historically and culturally produced» (Scheper-Hughes N. 1994: 230).

The term '*mindful body*', is in itself a powerful declaration in opposition to the «radically materialist thinking, characteristic of clinical biomedicine» (Scheper-Hughes N. - Lock M.M. 1987: 8) which tends towards a separation of mind and body. For people with a gradual, acquired hearing loss that can be treated with a hearing aid, a simplification of the problem would typically be adapting a hearing aid based on the audiogram, without regard to other factors.

The gradual, acquired hearing loss is a bodily impairment, but it has no physical expression that can be perceived by other people. It does not cause physical pain, and it can rarely be cured. Its representation is social and existential, as it hinders communication, the exchange of ideas and knowledge and the identification of sound, e.g. danger signals.

The International Classification of Functioning (Icf) of the World Health Organisation avoids isolating the physical impairment from its social and cultural consequences. 'Functioning' is an umbrella term encompassing all body functions, activities and participation; similarly, disability serves as an umbrella term for impairments, activity limitations or participation restrictions. The Icf describes domains from the perspective of the body, the individual and society, and it is thus in the interaction of the individual and society that an impairment takes on significance. Hearing impairment entails restrictions on social participation, and the domains involved are learning and applying knowledge, communication, interpersonal interactions and relationships, major life areas, community, social and civic life (Who 2001: 14, domains listed in Icf applying to hearing impairment, the choice of domains is undertaken by me).

A study of the origins, consequences and rehabilitation of hearing impairment requires the inclusion of technological, physical, medical, psychological, cultural and societal aspects. Prescribing hearing devices is not something that easily remedies a physical defect. Hearing aids may be accepted, rejected, generate stress, become an object of family strife, be seen as helpful or as a nuisance, as degrading and shameful or as something that symbolizes new and greater technology and thus an object used to negotiate social status.

A hearing impairment as such cannot be defined as an illness. Thus, it is not quite compatible with the concept of illness as a form of body praxis (SCHEPER-HUGHES N. 1994: 232) referring to the reaction of the *'mindful body'* to environmental stress factors. In that kind of reaction, establishing a relation between cause and effect requires an analysis of the societal power relations and their representation in the form of the illness. For the hearing impaired person, the link between cause and effect is more direct. Hearing impairment can be caused by hereditary factors, by excessive noise, by serious ear infections, medicine or by other causes. The various causes may interact. People who for hereditary reasons have ears susceptible to hearing impairment, have suffered from ear infections and work in a noisy environment have a high probability of acquiring hearing impairment. In other words, society leaves its mark on the hearing ability of the individual.

The Body as Starting Point

Maurice Merleau-Ponty (2000) sees the body as the starting point for our apprehension and construction of the world. Our sense organs are body parts that we use to perceive the world around us. Whatever we see, hear, feel, smell or taste of the world around us, our body is the indispensable vehicle to enable us to interact with the world. As a case in point, Merleau-Ponty describes various behaviour patterns of a group of people gradually losing their eyesight. Their behaviour falls into two groups. One group behaves as if it still can see. They do not adapt to the loss of eyesight, but they bump into things and seem to ignore the fact that they are getting blind. The other group adapt to the new situation, acquire a blind stick, find their way around without using their eyes although they still may have some eyesight left.

Both of the above strategies aim at staying in control of one's existence although the strategies are opposing and not equally useful. Merleau-Pon-

ty's example of progressive blindness is comparable to the situation of the hard of hearing. Some people will acknowledge that they have a hearing loss; they will adjust their communication strategies and possibly acquire a hearing aid in order to remain part of their social networks of identification. Other people refuse to admit to their hearing impairment or it takes them several years to acknowledge the problem. Hence, an often heard remark is: 'There is nothing wrong with my hearing, if only I could make my wife speak more clearly.' The group that rejects hearing aids does not necessarily consciously turn their back on their social networks, but they are likely to pretend that they hear, and they may develop communication strategies that are seen as different from other people's. Some of the respondents of the study spoke very loudly prior to getting hearing aids because they could not hear their own voice; some spoke all the time to prevent questions they could not hear. For the same reason, some of the respondents tend to participate physically but not socially in larger social gatherings. In literature about hearing, it is described that some even tend to isolate themselves (e.g. HÉTU R. 1996). Only about four of the respondents of this study can be said to have consciously occupied themselves with the development of their hearing problem and have had their audiogram taken to see if measures were required. To a varying degree, the others have considered the problem as non-existent until its impact on their life could no longer be ignored.

Both strategies, i.e. acknowledging or repressing the hearing loss, can be based on strategies that within a certain dialectic might be useful or detrimental. Acknowledging the hearing loss and acting on it is a useful strategy to remain in control of one's position in one's social networks. If we consider the disadvantages of this strategy, it could be a general tendency to focus on morbidity, such that a hearing loss could be used to establish an identity. It could also indicate a possible lack of independence such that one is constantly seeking facilitators. The latter view is not represented by the respondents in the study.

Denying the existence of a hearing loss could on the one hand be based on a desire to appear healthy and fit, which in a positive sense is helpful. In a negative sense, however, it can lead to negligence of a condition that should have been examined. The individual could also be motivated by vanity or by a fear that the hearing aid would be associated with old age or lack of intelligence – views that often are expressed by the respondents and informants. It could be connected to a kind of body alienation (SCHEPER-HUGHES N. - LOCK M.M. 1987) as expressed in the obsessions, and fetishisms of 'modern' life in the post industrialized world. Some hard of hear-

ing idealize the youthful and perfect body to the extent that the hearing aid becomes a taboo (Arvidsson T. 2000). In their description of the body politic, Lock and Scheper-Hughes (Scheper-Hughes N. - Lock M.M. 1987: 25), quoting Pollitt 1982, claim that the politically correct body is the lean, strong, androgynous, physically fit form. Health is the responsibility of the individual, which makes ill health the individual's failure to live in the prescribed way. This means that persons with physical ailments not only have to live with their weakness, they also have to cope with their own sense of guilt and with society's suspicion that they probably did not take enough care to avoid their condition. For the sense of hearing, this statement is supported by medical tests showing a connection between a good blood circulation and good hearing ability. Exercise improves blood circulation (http://www.hoerelse.info, 30 Nov 03). On this point as well, I find an inherent dialectic. The position at one extreme is the idealization of the youthful and perfect body that depicts a sick society focussing on human difference. The other extreme is the total lack of interest in health and well being. When it comes to hearing aids, a balanced strategy is a point where a hearing aid is seen as the difference between hearing and not hearing and not a negotiable emblem making the user more or less worthy in the eyes of the world. At this point, the individual takes an interest in preventing the noise-induced hearing loss or in keeping fit. Comparing this aspect with the respondents of this study, I find statements that support this view in as much as some respondents tend to look at their hearing loss as self-inflicted.

It could be argued that the hearing aid challenges the integrity of the body. In comparison to glasses, hearing aids seem to penetrate the body, thus transgressing a borderline of privacy. When directly asked in an interview situation, the respondents in this study do not have any problems with earwax. It is something that is taken care of through everyday hygiene. This attitude reflects the disciplined individual displaying an embodied civilisation. The same attitude is involved in a medical examination or adjustment situation. Here, the respondents find it embarrassing when the medical staff observes earwax in the ear or on the hearing aids. During the participant observations, I have often heard the comment: 'But I cleaned my ears this morning!' A few respondents in general find hearing aids repulsive because they are associated with earwax or/and prostheses. In addition, some respondents find it unpleasant when they see a hearing aid user operating the volume control or changing between different programs. Our civilisation is embodied to a degree that it is repulsive to touch the ears – even to adjust technology.

Another aspect that touches on fetishizing – not of the body but of the hearing aid – is advertising. Advertising is jubilant about the positive sides of hearing aids – forgetting about the troublesome aspects of becoming a hearing aid user. It creates a fiction of naturalness, a touch of ecology and organic feelings. Sometimes hearing devices are linked to prestigious sport requisites such as golf clubs or tennis rackets. Advertisements of hearing aids depict togetherness and inclusion in social networks – all qualities that the hearing aids as such are unable to produce. Naturalness, ecology and organic feeling illustrate the problem for the hearing aid user. They are indeed very far from hearing aids, but over time, they may become natural to its user. It can be a matter of habituation lasting from a few weeks to six months. When advertising combines naturalness, ecology and an organic touch with hearing aids, it represents an attempt to eliminate the association of the technology-governed individual. The two latter features, togetherness and inclusion in social networks, are exactly the situations from which most hard of hearing feel isolated. Sometimes advertisements promise more participation than the hard of hearing ever had as a normal hearing person. For many hearing aid users, the desire to remain part of a social group is what motivates them to acquire a hearing aid. The public sector blames the hearing aid manufactures for creating unrealistic user expectations. However, few of the respondents have looked at folders or newspaper ads. Few have made an effort to find out what hearing aids are all about, what models are available and what specifications they have. There seems to be a considerable reluctance to occupy oneself with the theme. What matters to the prospective users is that the hearing aids should be as small as possible, though a few have said that it is up to the doctor to decide. Reflecting about something requires experience.

> «Experience contains ordinary acts, from the casual to the most eventful occurrences. It embodies both meanings and feelings, the flowering of individual response that continually gravitates toward typicality, so that afterward we can find words to talk about what happened» (Abrahams R. D. 1986: 49).

Acquiring a hearing aid is formative and transformative and can be seen as a reflection of the *Nervous Body*. It is a distinguishable, isolable sequence of an external event and internal responses to it. It is an initiation into a new way of life (Turner V. W. 1986: 35). The new way of life is a path that the respondents never desired to take. At the same time, the hearing aid could mean the re-inclusion into the social networks from which the hearing impairment threatens to exclude them. These circumstances are reflected in the varying degree of nervous tension I find during the participant observation of new hearing aid users when they receive their hearing aids.

As shown above, there are more factors to a hearing loss than a declining audiogram. Also, the *Anguished body* play a role. Anguish may stem from feelings of shame and guilt often connected to a hearing loss. Although this may be difficult to understand, there are several reasons for this. As already said, some hard of hearing people try to pass as people with normal hearing, pretending to know what is going on when interacting with others. It may be to avoid being troublesome and appearing stupid because one needs to have everything repeated. The hearing-impaired person is on the one hand being considerate to other people and on the other hand trying to make a good impression (BOISEN G. 1989). But this is a dual misrepresentation: 1) Cheating others is not considerate; 2) One cheats oneself into thinking one is being considerate. The deception is connected to feelings of shame, and the risk of embarrassment is substantial, if for example one smiles happily when someone actually is speaking of a family tragedy.

However, there is something more to it. The act of listening involves a number of factors. On the one hand, listening means capturing and understanding the sound signals entering the ear. On the other hand, it means being smart enough to understand and react to what is being said. Through our upbringing, most of us have been told by parents and teachers that we will get in trouble if we do not listen. This makes some people feel guilty if they misunderstand things. A hearing loss forces the hard of hearing to challenge both their own and other people's assumptions that they did not understand because they were not paying sufficient attention. It is a lose-lose scenario, in which people not only feel ashamed over the hearing loss; they also have to cope with people's irritation over them 'not listening properly'.

The hearing impairment and its consequences seem to counteract the *disciplined body* in the sense of 'The Foucauldian question': «What kind of body does society want and need?» (SCHEPER-HUGHES N. 1994: 132). There is the restriction that the respondents are not without agency, and will react to the pressure exerted on them. The initial degree of confidence in the chosen system is high, but as individuals gain experience with the hearing aids, the intangible will become palpable. Questions may be asked, strategies can be developed to embody the idea of being a hearing aid user – or the hearing aids may be rejected. As already stated, Denmark may still have the best hearing care system in the world. In this respect, the answer to the Foucauldian question is: 'Society wants and needs independent citizens who can communicate and participate in all sectors of the modern state'. Still, only about half the people eligible for hearing aids actually

decide to acquire them. If hearing aids are such a wonderful vehicle for individuals to remain in touch with their social networks, then what has gone wrong?

In connection with this study, I also find elements of the *Consuming* and *Commoditized Body*. The hard of hearing consume the services of the public and private health services and hearing aid industry, at the same time, they are the object of the hearing aid industry and the public and private hearing health services. It often takes a resourceful person to become a satisfied hearing aid consumer. It may require many trips to the clinics to come to terms with one's new hearing device. The problem can be the level of amplification, the quality of the sound, the earplugs, how to handle the technology or a psychosocial problem. Acquiring a hearing aid might also lead to an initial or more enduring alienation in as much as the user will have to get accustomed to hearing electronic sound. Although a hearing device can be seen as a means of perceiving the sounds around them, some users complain that the technology forms a barrier between themselves and their environment. They may find the tiny hearing aid difficult to handle. They complain that what they hear through the hearing aids is not natural to them. They may feel alienated because voices of loved-ones sound different. They may experience that they are out of control, that the hearing aid determines how they perceive the world around them. Some people feel controlled by the way the computer regulates the sound levels around them. Many of these problems are transient, and the respondents seem to get used to the different sound quality. They enjoy the fact that they can now hear certain bird songs, can take part in meetings, and gain more pleasure from listening to music. This group is likely to experiment with the technology to establish where a hearing device is helpful and where it is not. But really enjoying being a hearing aid user is something that does not apply to the respondents at this stage.

Lock and Scheper-Hughes ask whether our humanity is being compromised in the process of being put on the machine of modern technology (Scheper-Hughes N. - Lock M.M. 1987: 23). The following adaptation of Haraway represents a different attitude to technology which I find important, and which I will elaborate on in my future work on this topic. Haraway starts the chapter by saying: «This chapter is an effort to build an ironic political myth» (Haraway D.J. 1991: 149). More than irony is implied here; from a feminist viewpoint, she deals with the fear of alienation connected to modern technology. I would like to extend her idea to encompass not only women, but both genders when she writes:

> «Intense pleasure in skill, machine skill, ceases to be a sin, but an aspect of embodiment. The machine is not an *it* to be animated, worshipped, and dominated. The machine is us, our processes, an aspect of our embodiment» (HARAWAY D.J. 1991: 180).

The above quote can be paralleled by the example of one of my informants. She is 82 years old, has an artificial hip, uses hearing aids and has had surgery for a cataract condition. She teaches a German class five days a week, visits museums and goes to the theatre. What would her life be like if she had turned down the offer of modern technology?

Conclusion

The analysis and collection of data for this study has not yet been completed. However, it is not too early to conclude that some people just turn on their hearing aids, they can hear, and they are satisfied. In other cases, it requires a resourceful person to become a contented hearing aid user. Users need to be curious about what life has in store for them, daring to try something new when it appears, persevering when difficulties appear in adjusting to a different quality of sound, persistent when explaining to professional staff why the hearing aid is unbearable to listen to, or why they do not fit. One of the respondents who uses a public sector hearing aid provider remarks: «The staff provide good service before you get the hearing aid, but once you have them, they seem to consider you a burden when you turn up for help!».

The present situation with private and public hearing aid clinics has complicated the situation for the users. The lack of agreement between the involved parties as to the future organisation of the sector affects the users. Their 'journey' through the system is characterised by randomness and routine. Randomness, because the way in which they solve their hearing problem depends on whom they talk to at a given time. Routine because the system they choose propels them towards an outcome that may or may not prove to be effective. It is only during the process that they gain experience. Hence, one of the respondents remarks: «It is not until you come home with your hearing aids that you know what to ask!».

The process of rehabilitation of the hard of hearing through a hearing aid is in many cases a formative and transformative process. Hearing loss makes itself felt in any activity in as much as the sound proof space does not exist in the 'real' world. Consequently, the interaction with the social and material world will gradually be reconstructed and redefined which the hard of

hearing with the gradual hearing loss may not notice. If the decision is made to acquire a hearing aid, another process of reconstruction and re-definition lies ahead. Not even the best hearing aid can restore normal hearing, but all the same, the hearing aid can be the bridge to inclusion and participation in many cases.

The Danish welfare state has constructed a system in which hearing aids by many are seen as a natural and rightful benefit. However, the modern welfare state is under attack from several sides, i.e. poor planning, increased medicalisation of society and the increased life expectancy. It remains to be seen if the Danish health care policy in future will define it as a right to hear for the widest possible group of people.

Note

(1) The capital D in Deaf refers to Deaf culture which compares to other cultural or language communities.

Bibliography

ABRAHAMS Roger D. (1986), *Ordinary and Extraordinary Experience,* pp. 45-72, in TURNER Victor W. - BRUNER Edward M. (editors), *The Anthropology of Experience*, University of Illinois, Urbana.

ARVIDSSON Torborg (2000), *Från förnekande till integration. En kvalitativ studie av kvinnors förhållningssätt inför audiologisk rehabilitering* (From denial to integration. A qualitative study of women´s attitudes before attending audiological rehabilitation), unpublished Master thesis in Audiology, Faculty of Medicine, Institute of selected clinical sciences, Department of Audiology, Göteborg University.

BLESES Dorthe - BASBØLL Hans (2003), *The Danish Sound Structure – Implications for Language Acquisition in Normal and Hearing Impaired Populations*, in SCHMIDT Erik - MIKKELSEN Ulla - POST Inge - SIMONSEN Jørn Borcher - FRUENSGAARD Kirsten (editors), *Brain, Hearing and Learning, 20th Danavox Symposium, September 9-12, 2003*, Danavox Jubilee Foundation.

BOISEN Grete (1989), *Psykosociale forhold i forbindelse med at være hørehæmmet* (Psychosocial circumstances in connection with hearing impairment), pp. 1-6, unpublished paper presented at the 10th Congress of the Nordic Audiologic Society 1989, Stockholm.

HARAWAY Donna J. (1991), *A Cyborg Manifesto: Science, Technology, and Socialist-Feminism in the Late Twentieth Century*, pp. 149-181, in *Simans, Cyborgs, and Women. The Reinvention of Nature*, Free Association Books, London.

HÉTU Raymond (1996), *The Stigma Attached to Hearing Impairment*, pp. 12-24, in ERLANDSSON Soly I. (editor), *Psychological and Psychosocial Approaches to Adult Hearing Loss*, "Scandinavian Audiology", vol. 25., suppl. 43, 1996.

MERLEAU-PONTY Maurice (2000), *Kroppens fænomenologi*, Samlerens Bogklub, Copenhagen.

POLLITT Katha (1982), *The Politically Correct Body*, Mother Jones, May 1982, pp. 66-67.

SCHEPER-HUGHES Nancy (1994), *Embodied Knowledge: Thinking with the Body in Critical Medical An-*

thropology, pp. 229-240, in Borofsky Robert (editor), *Assessing Cultural Anthropology*, Mc-Graw-Hill Inc., New York.

Scheper-Hughes Nancy - Lock Margaret M. (1987), *The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology*, "Medical Anthropology Quarterly", vol. 1, n. 1, 1987, pp. 6-41.

Stratton Alison (1999), *Hidden Stories of Hearing Aids: Technologies and Cultures In-the-Ear*, pp. 63-83, in Lundin Susanne - Åkesson Lynn (editors), *Amalgamations. Fusing Technology and Culture*, Nordic Academic Press, Malmö.

Turner Victor W. (1986), *Dewey, Dilthey, and Drama: An Essay in the Anthropology of Experience*, pp. 33-44, in Turner Victor W. - Bruner Edward M. (editors), *The Anthropology of Experience*, University of Illinois Press, Urbana.

World Health Organisation (2001), *International Classification of Functioning, Disability and Health (Icidh). Fifty-fourth World Health Assembly, 22 May 2001, resolution SHA54.21*.