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A Crack in the Looking-Glass Self: Hearing and Socialization

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Abstract

A significant problem of classic theories of socialization, such as Cooley's looking-glass self, is that such theories fail to consider biological factors such as hearing in the process of socialization. To address this problem, I raised a two-pronged question: how does deafness affect social interactions upon which much of socialization is dependent and can the experiences of one person's lifelong socialization help uncover limitations of a classic theory of socialization? The key study participant in this instrumental case study is an individual with moderately severe hearing loss and whose lifelong experiences were collected primarily through ethnographic field techniques. Findings from secondary data provide ample evidence that hearing loss can have serious effects on social interaction and socialization and findings from the individual case itself, while somewhat inconclusive, are suggestive of how hearing loss affected this individual during her lifetime, this being more strongly observed in the later stages of her socialization. Key points that emerge from this study are that (a) the complexity of socialization poses great challenges in teasing out its many factors, but (b) including hearing as a factor advances our insight of the process and (c) this in turn, has implications for how educators understand and teach the concept, and (d) this insight can increase our sensitivity for individuals with hearing loss.

Keywords

instrumental case study, socialization, hearing loss, deafness, looking-glass self theory

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A Crack in the Looking-Glass Self: Hearing and Socialization

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A significant problem of classic theories of socialization, such as Cooley's looking-glass self, is that such theories fail to consider biological factors such as hearing in the process of socialization. To address this problem, I raised a two-pronged question: how does deafness affect social interactions upon which much of socialization is dependent and can the experiences of one person's lifelong socialization help uncover limitations of a classic theory of socialization? The key study participant in this instrumental case study is an individual with moderately severe hearing loss and whose lifelong experiences were collected primarily through ethnographic field techniques. Findings from secondary data provide ample evidence that hearing loss can have serious effects on social interaction and socialization and findings from the individual case itself, while somewhat inconclusive, are suggestive of how hearing loss affected this individual during her lifetime, this being more strongly observed in the later stages of her socialization. Key points that emerge from this study are that (a) the complexity of socialization poses great challenges in teasing out its many factors, but (b) including hearing as a factor advances our insight of the process and (c) this in turn, has implications for how educators understand and teach the concept, and (d) this insight can increase our sensitivity for individuals with hearing loss.

Keywords: instrumental case study, socialization, hearing loss, deafness, looking-glass self theory

Introduction

An average person on the street hardly gives a thought to the details of how they learn language and all the customary behaviors and thought patterns that come to define them as a member of a society. Socialization is the process by which humans learn the behavioral rules and culture of their society and develop their sense of self (Griffiths & Keirns, 2015). At first glance, socialization appears as a simple and natural process experienced by everyone, but upon closer examination this seemingly natural process is hardly simple. Much has been written in the attempt to understand how socialization occurs (e.g., Cooley, 1964; Denzin, 1977; Erikson, 1964, 1982). Trying to tease out specific details out of the myriad factors that contribute to socialization is daunting. While all members of a society undergo socialization (barring the exceptional stories of isolated children and persons with brain abnormalities or other medical or psychological conditions), the specific factors in this process may vary slightly or dramatically from one individual to another. Socializing agencies, such as the family, school, peers, and the media, are highly variable with equally variable impacts (Griffiths & Keirns, 2015; Grusec & Hastings, 2007).

Most sociologists look at socialization from the context of social and cultural factors. In this paper I take the unusual approach of looking at socialization by also including our biological sense of hearing. This factor is rarely mentioned in sociological discussions of

socialization. I explore the potential impact that hearing loss has on socialization at every stage of an individual's development. The tremendous importance of language in socialization is generally accepted since much of socialization involves linguistic interaction. However, the role of hearing is generally neglected, unless of course, the person is profoundly deaf.

Deafness or hearing impairment ranges from mild to profound (Table 1 summarizes the degrees of deafness). Research on Deaf Culture is substantial with a focus on the profoundly deaf whose major means of communication is American Sign Language. Little sociological research has been done to answer this question and yet audiologists (e.g., Bess, 1985; Bess et al., 1998; Tharpe, 2008; Tharpe & Bess, 1999) point out that even mild to moderate hearing loss can have a tremendous impact on a child growing up in a hearing world. By focusing on the role of hearing, fundamental concepts of socialization used in sociology and other social sciences can be considered in a new light. The profoundly deaf (those who at 70 or more decibels cannot hear speech sounds) are likely to be socialized into Deaf Culture using American Sign Language but individuals whose hearing loss is mild to moderate are generally not part of the deaf community but rather part of mainstream culture and education.

Therefore, I do not focus on the socialization of the profoundly deaf, but on how mild to moderate hearing loss may affect an individual's socialization. This is given little attention by social scientists and it may go unrecognized by the individual with mild hearing loss as well as by the individual's family and friends. Mild hearing loss may seem insignificant, but it can have important consequences to the individual. In this paper, I explore the experiences of one individual, whom I will call Jane, to illuminate how hearing loss can impact a person and more specifically, how hearing loss affects socialization. This research is rather unique among studies about socialization because it considers hearing as an important factor in the process of socialization as exemplified in the experiences of the individual I describe in this paper.

Background: The Impetus for Research

The impetus for this research came about in an unusual manner shortly after I met "Jane" (not her real name) in the fall of 1999 when she enrolled as a non-traditional student in one of my anthropology classes. She explained she had recently retired and now had time to engage in new activities. She introduced herself by saying, "I am a deaf psychiatrist." This rather surprised me because at that point I had not noticed anything that might indicate that Jane was "deaf" or even "hard of hearing." Jane informed me she had discovered that she was hard of hearing only a few years earlier at about the time she had retired. She suspected she might have some hearing loss but was surprised to find that her hearing was "moderately severe" and congenital. Since I knew little about deafness, Jane's description of some of her experiences with hearing impairment seemed unusual, unique, and at times perplexing. She related to me how for much of her life she had felt excluded from many social activities and how she thought that others, including her family, saw her as distant, "weird," "aloof," and "not bright." While she had always thought that "there was something wrong" with her, she could not explain why and now thought this may have been due to her hearing deficit. I found this a bit puzzling in as much as I was largely unfamiliar with issues of deafness, and I had not observed anything odd in her behavior that would be considered "weird."

Jane enrolled in another anthropology class in the spring of 2000 explaining that she now had the time to explore topics that interested her. She was interested in anthropology because she thought it could possibly offer insights on human behavior, and by extension to her own behavior. I came to know Jane well not only as an excellent student but also a person with an interesting past.

One day she asked me to help her in her quest to understand aspects of her life that she found difficult to explain, including her strained relationship with members of her family. She

engaged me as an independent researcher to try to explore the anthropological view of hearing loss and specifically to do a small exploration of her own family's views and experience. I was hesitant since I had a teaching job and had not considered doing consulting or private research of this kind. Nevertheless, the topic was intriguing, and I viewed it as worth exploring from an anthropological perspective. Anthropology is unique in the social sciences because of its holistic approach that integrates cultural and biological factors to understand humanity. The project Jane was proposing suited my research interests in both medical anthropology and linguistic anthropology. Medical anthropology is a specialized subfield in anthropology that typically takes a biocultural approach to health issues (Wiley & Allen, 2016) and linguistic anthropology examines the relationship between language and culture (Stanlaw et al., 2018). Such a project would almost of necessity require that cultural, linguistic, and biological factors be considered. Thus, after numerous conversations with Jane about her experiences, I decided to accept her request to do the research she proposed. When the project was completed, I submitted a written descriptive report to Jane in which I summarized my observations. Methodological considerations used for this project are discussed below.

This project made me realize how significantly hearing impairment might affect an individual's life, and thus, I began to explore the topic from a more general and theoretical level. Jane was very encouraging in this endeavor, sharing with me several books and articles on the topic of deafness and agreeing to continue our conversations so I could collect more of her experiences. In the preceding paragraphs, I described the context and events that provided the impetus for my research and something about my background in medical anthropology. My training in anthropology and my teaching career further explain why I found Jane's experience particularly intriguing and meriting research. I was trained within the four-field approach of anthropology that encompasses archaeology, biological, linguistic, and cultural anthropology and this approach is one I also use in teaching. My teaching career has also included teaching some sociology courses in which I often covered the topic of socialization including Cooley's theory of the looking-glass self. Learning about Jane's experience led me to question Cooley's theory as it is typically presented to students. This project, therefore, opened an exciting opportunity to look at the interrelationship between deafness and socialization from a more holistic perspective.

Methodology and Theoretical Concepts

The process that led to this paper consists of two parts. The first was the initial research I carried out between 2000 and 2002, which came about as described above. The second part or current project began in 2003 and continued for several years but with several interruptions due to work schedules and personal circumstances. In the following paragraphs, I describe the key research concerns, concepts, and procedures I used in my research to answer a two-pronged question: How does deafness affect social interactions upon which socialization is based and can the experiences of one individual (as a case) help uncover the limitations of a classic theory of socialization (Cooley's theory)?

Instrumental Case Study

The research that I conducted on Jane's behalf was ethnographic in both process and product. I collected data using typical ethnographic techniques such as participant observation and the result was a descriptive report submitted to Jane in 2002. The intent in the initial project was to describe behaviors, beliefs, and practices observed about a specific individual's enculturation, which is a term used in anthropology like socialization but with an emphasis on

culture (Grusec & Hastings, 2007; Poole, 2002) and carried out within the context of a small group, namely Jane's family, plus a few others with close links to her.

For my current project I use an instrumental case study approach as defined by Stake (2005) because my goal here is to consider the possible limitation(s) of a classic theory by examining one person's life history. To use Stake's words, "I use the term *instrumental case study* if a particular case is examined mainly to provide insight into an issue or to redraw a generalization (2005, p. 445). Unlike intrinsic case studies, where the goal is to understand the case itself, instrumental case studies use a case to "provide insight into some issue or to refine some theoretical explanation" (Berg, 1998, p. 216). In this paper, I explore whether theories of socialization are limited or incomplete in their explanation of how socialization occurs. I treat material gathered in the initial project as a single case to show that Cooley's theory of the "looking-glass self" is limited because of its failure to include hearing as a critical factor.

Research Considerations

The context and objective of the initial project indicated that an internal review of the research would not be needed for two reasons. First, the research was unusual in that the study subject (key participant) was in fact the person who requested and funded the research and was not an institutionally based research. Secondly, the project did not fall under the types of research that normally require IRB approval because it did not meet the definition of research provided in federal guidelines, which defines research as investigations that are "designed to develop or contribute to generalizable knowledge" (CFR 46.101b). The initial project was not designed to develop generalizable knowledge; rather, it was for the private information and enlightenment of the key participant herself. Nevertheless, I considered it important to have a clear research structure and to use guidelines that ensure the protection of subjects generally required of standard research projects.

Before beginning the initial project, I drew up a contract, which Jane signed, outlining the objectives of the project and a number of elements such as funding, an estimated timeline for completion of research, and ethical considerations that included how the data would be used and provisions for the voluntary participation of individuals. To this end, I drew up informed consent forms that I used with individuals I interviewed such as Jane's family members.

Although Jane had provided her consent in the original contract, she gave her permission to use her life experiences as a basis for expanding research for the second project. In a personal communication she added, "you have my permission to publish your articles on me. Wish you well on publishing." Indeed, she encouraged me to pursue this research believing that the link between hearing and behavior had not been investigated by social scientists. Jane told me, "Good luck with your articles. Keep trying to break through the pervasive scientific narcissism. This is important sociological insight that has been under the radar." To ensure proper protections were met for the second project, I requested a review of my work since at this point the objective was for a broader application. The study was given approval by the university's Internal Review Board.

Participants

The focal participant in this research was introduced above as Jane, a retired M.D. in psychiatry. I did not select this participant but rather she presented herself to me as described earlier. Other participants were selected based on their relationship with Jane and their availability. These included several family members and individuals who knew Jane in some capacity during various stages of her life. Contact information for most of these participants was provided by Jane. All individuals were informed about the purpose of the study and given

the opportunity to drop out of the study at any time. Some signed the informed consent form I had created, but some indicated they did not wish to sign but gave their verbal consent. The major categories of participants surrounding Jane were family members, neighbors, friends, and colleagues. The only participant I interviewed who did not know Jane at all was a medical doctor who had served on the board of a school for the deaf in San Antonio. She (Dr. K for future reference) is deaf herself and thus her personal experiences provide insight and comparative data. During the second part of research, I also consulted two audiologists who provided valuable insight and additional information on various details of deafness.

Data Collection

Data for this study consists of both primary and secondary information. Primary data collection was achieved by conducting fieldwork using ethnographic techniques, described below. Secondary data was collected by searching published materials (case studies, books, journal articles, reports) from sociological and audiological perspectives on socialization and deafness in the United States.

I used ethnographic research strategies, especially participant observation and open-ended interviewing, to gather data in the initial project (Berg, 1998; Bernard, 1995). Ethnography has long been associated with anthropology but is now widely used by sociologists and others as a qualitative research method. As used in anthropology, ethnography is both a product and a process. As a product, ethnography refers to the descriptive writings about culture, groups, and specific socio-cultural phenomena. As a process, ethnography refers to the activities used in fieldwork such as participant observation, informal interviewing, recording, and other techniques. As noted by Hesse-Biber and Leavy (2006): "Ethnographic research aims to get an in-depth understanding of how individuals in different cultures and subcultures make sense of their lived reality" (p. 230). More specifically, I adopted "person-centered ethnography" that is commonly associated with research in psychological anthropology, but which is also well-suited for this research.

This concept was originally called "person-centered anthropology" by Robert Levy (1994) who saw it as an attempt to address the problem encountered in anthropology between the concept of "culture" and "culture carrier." Levy proposed that anthropologists should "examine the person as an active center of history and context and of psychological and biological potentials and constraints" (p. 183). Others, notably Doug Hollan (2001) use the term "person-centered ethnography" as a useful tool when focusing on "how the individual's psychology and subjective experience both shapes, and is shaped by, social and cultural processes" (p. 48).

Such research generally yields rich descriptive data but requires an extensive involvement with the subjects one is studying and is quite time-consuming. Over the course of several years, I spent countless hours in conversation with Jane and visited Jane's mother and siblings on numerous occasions. Besides family members, I also interviewed neighbors, friends, and acquaintances. I attended family get-togethers, spent time with Jane's family, and took part in activities with Jane, such as accompanying her on walks, on her volunteer work, and social gatherings. Most conversations and interviews were face-to-face, but I also spoke to a few individuals on the telephone.

This approach was quite appropriate to my research since the study explores one individual's experience within the context of her family. In addition to participant observation and interviewing, person-centered ethnography also uses other types of data such as documentary data. I examined personal records, letters, and notes belonging to and provided by Jane herself and others provided by some family members. The study also included numerous email communications I had with Jane and others.

Data Analysis and Organization

My analysis ultimately rests in using comparison and contextualization, two key concepts used in anthropology for data analysis (Sanjek, 2013) and commonly used in case studies (Stake, 1995, 2005). To arrive at what Stake (1995) calls “categorical aggregation” and also “direct interpretation” (p. 74), I first had to manage and organize the field material. Given the relatively narrow focus of my initial project, I found that using basic computer tools was adequate for the task of data management, much as Berg (1998) and Babbie (2005) point out. First, while reading fieldnotes and transcripts, I highlighted key concepts (represented by phrases, statements, time periods, and words) and made annotations along key passages. Then, using a variety of Microsoft word processing tools, I organized key concepts into broad and specific categories and themes, and created an index to facilitate retrieval. I also found concept mapping (Novak & Cañas, 2008) somewhat useful at the beginning of the project as a succinct way for me to graphically organize some information (e.g., relationships of participants and observational contexts). Concept mapping is an effective learning tool, one which I had used with my students, but its utility is also recognized for qualitative research (e.g., Babbie, 2005).

I based the definition and categorization of deafness and socialization on sociological and audiological sources since these fields already have a system of organizing deafness (audiology) and socialization (sociology). Sociologists generally use factors such as family, school, and peers to analyze socialization (Griffiths & Keirns, 2015) as it occurs over a person’s lifetime (Erikson, 1964, 1982). Categories of deafness established by audiologists (e.g., Roesser, 1986) provide an indication of patterns of behavioral effects in each of the levels of deafness presented in Table 1 below. My goal is to analyze Jane’s experiences within the context of socialization to illustrate how her experiences suggest a gap in the theory of “the looking-glass self” (Cooley, 1964).

Social Science, Hearing, and Socialization

Jane and her family’s history introduced me to the possible consequences of hearing loss that social scientists may have overlooked. More specifically, Jane’s experiences raised the possibility that hearing loss may affect socialization in ways that social scientists, including myself, had not previously considered. Jane’s experiences provide an example of how a social process (socialization) and a biological factor (hearing) may be linked. Since Jane is not profoundly deaf, I specifically searched for sociological and anthropological data on how mild to moderate hearing loss impacts socialization that would provide insight into Jane’s reported experience. As I attempted to locate published research materials on the topic, I found a wealth of information on “deaf culture” but relatively little on what most people would regard as the hard of hearing. Much of what is available comes from specialists in audiology and far less from social scientists.

There exists a rich and extensive literature on the profoundly deaf, sign language, and deaf culture (e.g., Bellugi, 1972; Branson, 2002; Groce, 1985; Lane, 1984). However, far less is written about people whose hearing loss is mild or moderate and which in layman’s terms would be described as “hard of hearing” (e.g., Bess, 1985; Bess et al., 1998; Lazlo, 1994; McKellin, 1994; Reisler, 2002). Some sociological studies of particular interest include works by Higgins (1980), and Higgins and Nash (1987), both of which address issues of identity and stigma among the deaf. Stenross (1999) provides a brief but revealing description of some coping mechanisms employed by the hearing impaired. Research on how hearing loss affects socialization does not generally come from the social sciences but from audiologists (e.g., Bess, 1985) whose focus is mostly on the socialization of the profoundly deaf. For instance, both Meadow-Orlans (1987) and Becker (1987) address socialization but focus specifically on the

profoundly deaf and not on those whose deafness is mild or moderate. Anthropologists have not paid much attention to the hearing impaired. Typical texts in medical anthropology (e.g., McElroy & Townsend, 2009) may cover a variety of health issues but deafness is mentioned only briefly as a disability with which people must cope. Only a few anthropologists have dealt directly with the topic of deafness in general. For example, Groce's work (1985) is a well-known ethnography of a community in Martha's Vineyard, but, again, the focus is not the hard of hearing but the profoundly deaf. Jepson (1992) is an anthropologist, but her work focuses on writers who explore the range of emotions of living with deafness. Two works that examine the hard of hearing are those of McKellin (1994) and Lazlo (1994). Using an anthropological perspective, McKellin examines how hearing impairment impacts individuals in their everyday life but without explicitly addressing its potential impact on socialization itself and Lazlo attempts to answer the question of whether the hard of hearing have an identity analogous to the well-defined identity of the profoundly deaf.

Social scientists have made notable contributions to our understanding of how one acquires social norms and develops a sense of self and personality (e.g., Cooley, 1964; Denzin, 1977; Mead, 1934). Sociological definitions of socialization generally consider not only the acquisition of one's culture but also the individual's sense of self. A typical sociological definition of socialization states that socialization is "the process by which people develop personal identities and learn the ways of a particular group or society" (Sullivan, 2004, p. 70). Sociologists are explicit in enumerating the various agencies of socialization and in developing theories that attempt to explain the process itself such as the classic symbolic interactionist theories of Charles Cooley (1964) and George Herbert Mead (1934). Cooley's "looking-glass self" and Mead's treatment of the self in society provide a theoretical basis for understanding how socialization occurs but details of how meaning is created within the interaction process itself should be further clarified. Socialization produces a "social self" that Cooley (1964) says, "might be called the reflected or looking-glass self: Each to each a looking-glass reflects the other that doth pass" (p. 184). Cooley certainly would agree that language is critical in social interaction and the creation of shared meaning and yet he never considered hearing as a factor related to language. Hearing is simply taken for granted. Psychologists have also provided insights into the development of the self and personality but again the various elements involved in the process are incomplete (Grusec & Hastings, 2007). Beginning with Erikson's psychosocial model (1964), psychologists have recognized the impact of biology and culture on processes such as personality development and socialization (e.g., Matsumoto & Juang, 2004), but the role of hearing is taken for granted and never explicitly addressed.

To appreciate how hearing loss may have affected Jane's personal experiences and even her sense of self at different stages of her life, a basic understanding of hearing and deafness is important. The audiological findings described below provide insight into how hearing loss affects social interaction. Viewing Jane's experiences against the backdrop of this audiological data has implications for Cooley's theory of the looking-glass self.

Audiologists Point the Way

While social scientists have not focused on the role of hearing in social development, audiologists certainly have. They have shown how deafness impedes interpersonal interaction in each of Erikson's stages of socialization (Schum, 1991). Audiologists point out that hearing loss has a great impact on a child's social interaction and learning (e.g., Bess et al., 1998).

Audiologists measure and describe a person's hearing ability using a variety of scientific tests. The science of audiology (e.g., Northern & Downs, 2002; Roesser, 1986) is beyond the scope of this paper but a brief summary of the levels of hearing loss and resulting effect on speech is important in order to understand Jane's lifelong experiences. Table 1 below

summarizes the levels of hearing loss as measured in decibels (dB) and the impact such impairment can have on a person's ability to hear speech sounds and engage in social interaction (Meadow-Orlans, 1987; Northern & Downs, 2002). Someone with the ability to hear sounds from zero to fifteen decibels is generally considered to have normal hearing. At 15 - 30 decibels, a person exhibits "mild" hearing loss and at 70 decibels a person is considered profoundly deaf (Northern & Downs, 2002; Roesser 1986; Schwartz, 1987). The significance of these levels of deafness becomes clear when one considers that much of our socialization relies on the vehicle of language and if speech sounds (phonemes) are not heard adequately, effective linguistic communication is impeded. Hence, a person whose hearing is between 30 - 50 decibels may have moderate hearing loss, and yet, at a normal conversational level, this person would not hear most speech sounds. Jane's deafness falls within the moderate to near severe range at 50 dB (Marenda, personal document, September 1, 1998).

Table 1
Degrees of Deafness

Hearing loss	Decibels (dB)	Effects—what is heard and/or missed (without amplification)
Mild	15- 30 dB	Soft speech and unvoiced consonants are difficult to hear; vowels are clear
Moderate	30-50 dB	Most speech sounds are not heard at normal conversational level; speech therapy, speech reading may be necessary
Severe	50-70 dB	Speech sounds at normal conversational level are not heard; results in severe speech problems
Profound	70 + dB	No speech or other sounds are heard; severe speech problems

Note. Based on Northern & Downs (2002), Roesser (1986), and Schwartz (1987).

Aside from degrees of deafness, the etiology of hearing loss is another factor to consider. Hearing loss can be congenital (via genetics, disease, infection, and other factors at birth) or it may have a later onset from such things as trauma and as part of the aging process. Audiologists point out that congenital hearing loss can worsen over time (Tharpe & Bess, 1999). Jane's hearing loss is congenital but of unknown specific cause and likely worsened from the mild level to moderately severe according to her audiologists (Marenda, personal document, September 1, 1998; Andrews, personal document, December 1, 2000).

Audiologists are aware of the impact that hearing has on social behavior; they point out that children with even "mild" hearing loss often are adversely affected in their social interactions (Bess, 1985; Bess et al., 1998). Audiologists and deaf individuals have long recognized the fundamental connection between hearing ability and social development (e.g., Foster, 1986; Oliva, 2004; Reisler, 2002).

Socialization in the Concrete: Findings

In the earlier section on data analysis and organization, I stated that I categorize deafness and socialization using existing models employed by audiologists (deafness) and sociologists (socialization). Table 1 above summarizes the degrees of deafness and their effects as recognized by audiologists. Erikson's model of lifelong socialization needs some clarification here since it provides the context within which I present my findings regarding Jane's case.

Erikson's model of life-long socialization (1964, 1982) suggests eight major stages through which socialization takes place. Sociologists give Erikson much credit for recognizing that socialization is a lifelong process but, unlike Erikson's detailed psychosocial development of individuals from infancy to adulthood, most sociologists give greater focus on more general transitions experienced by individuals. A typical sociological view of lifelong socialization states: "In the United States, socialization throughout the life course is determined greatly by age norms. As we grow older, we encounter age-related transition points that require socialization into a new role, such as becoming school age, entering the workforce, or retiring" (Griffiths & Keirns, 2015, p. 104). In this paper, I collapse Erikson's eight distinct stages into four in keeping with the more general sociological approach but retain Erikson's view that socialization occurs throughout the lifespan of an individual. The four age-related stages I use as a framework for Jane's life experiences begin with her earliest years at home when primary socialization occurs, followed by school-age experiences when peers become significant, young adulthood, and finally adulthood to retirement. Her experiences provide concreteness to the felt experiences of someone with hearing loss.

Certainly, some of Jane's experiences are unique but others echo the experiences of some individuals with a similar hearing deficit. This expectation is grounded on the sociological assumption that a person's "biography" is to a considerable extent shaped by the social structure and historical context in which he or she lives (Mills, 1959; Shanahan & Macmillan, 2008).

Early Childhood & Family Environment

It is generally accepted that the family is one of the most important socializing agencies since it is within the family where primary socialization occurs (Griffiths & Keirns, 2015). Research studies presented in Grusec and Hasting's *Handbook of Socialization* (2007) point to how parenting, sibling factors, and the content and types of interactions between members of the family can have significant effects on a child's socialization. Thus, a glimpse into Jane's early childhood within the context of her family can shed some light on the connection between hearing loss and socialization. In Jane's case, we can safely assume this conventional wisdom; family dynamics no doubt contributed to Jane's socialization, but what may be easily overlooked is how her hearing deficit may have affected those dynamics.

Born in 1940, Jane was the second of four children of Mr. and Mrs. West, a working-class Midwestern family that experienced a couple of moves before settling in Houston, Texas. Since the family is central to a child's primary socialization, I asked Jane to describe her recollections about her family in her early years:

There was no bonding with anybody. I mean, there were people coming and going in and out of the house, [but] I spent many years by myself. My Dad showed me attention and I was closer to T [her brother]. Mother was not around and when she was around and when somebody else was in the house and was interacting with them...she just seemed to reject us...As a toddler, I would roam the house. I'd be by myself. I'm wondering if she wasn't in bed asleep, closed the door and I just didn't...There was no one around, except T. When he went to school, well then, I was all alone again... (Jane)

As a child and for most of her life, Jane and her family were not aware Jane had a hearing deficit. However, it is quite possible that her father's deafness may have affected family interactions and thereby also the children's socialization. As far as is known, Mr. West never had his hearing tested but family members I interviewed agreed that he was "hard of hearing."

Members of the family describe Jane's father as exhibiting some of the same characteristics possessed by Jane herself—introverted, intense, laconic, and not very sociable. For example, one of Jane's sisters stated, "Daddy really didn't interact with anybody," and the mother agreed, saying, "No, Daddy didn't; Daddy would never join in." A neighbor and long-time friend of the West family described Jane's father as "abrupt" and that he "did not socialize." While these characteristics can apply to anyone, such behavioral traits are a fairly common coping adaptations of some deafened individuals (Becker, 1987; Oliva, 2004).

While the exact degree of Jane's hearing loss in her childhood years cannot be established with certainty, audiologist Susan Marena (personal document, September 1, 1998) describes Jane's hearing loss as congenital based on audiometric tests. Another of Jane's audiologists, Seth Andrews (personal communication, December 1, 2000) believes that Jane's hearing loss in childhood was possibly within the mild range. Even with mild hearing loss, Jane would have been at considerable risk of experiencing linguistic and social problems (Bess et al., 1998; Tharpe, 2008). Children with mild hearing loss risk missing significant phonemes or confusing them with similar sounds. This can result in misinterpretation of what is being said and to inappropriate responses. While this is particularly important in the context of school where soft speech sounds and unvoiced consonants may be difficult to discern in noisy environments or when the speaker is at distance from the child (Bess, 1985; Bess et al., 1998; Schwartz, 1987; Tharpe & Bess, 1999), it is also significant within the home environment. An utterance that is not heard will produce no response and the lack of a response may lead to an erroneous interpretation about the motives underlying such unresponsiveness. For example, a child who does not respond as expected to a mother's command may be perceived as ignoring the command or as being defiant, whereas the child may not have heard the command clearly if at all.

Jane recalls family members would comment on her "funny way of talking" and said she talked "like a Dutchman." One of Jane's sisters confirmed Jane's recollection stating: "I remember that he [the father] would always say, 'You talk Dutch,' meaning he didn't understand what she was saying." As Table 1 above indicates, individuals with mild loss have difficulty hearing unvoiced consonants. In a young child, this could lead to potential problems of hearing and reproducing certain phonemes as the child acquires language. Speech therapy has been shown to help children acquire language in such situations. Jane had speech therapy to improve her speech but not until she started school. The mother, however, did not associate this with hearing loss but simply that Jane did not speak well.

Even with a mild hearing deficit, baby Jane may have not responded to all the phonemes or linguistic subtleties to which she was exposed. This combined with the fact that Jane's mother (according to Jane and her siblings) was not overly demonstrative and suffered depression, may have affected the mother-daughter interactions in an unconscious manner. Thus, hearing loss, both Jane's and her father's, could have played a role in the nature of interactions during this early stage of socialization. The impact of hearing loss at this early stage of socialization adds another dimension to theories of socialization proposed by Cooley (1964) and Mead (1934) since neither considered how their theories would apply to individuals whose hearing was less than normal. It is not uncommon for parents to fail to recognize mild hearing loss during infancy. Patterns of unusual verbal behavior and peculiar responses may then be attributed to personality, such as is illustrated by the statement: "a parent may confuse a decline in hearing sensitivity with seemingly unwarranted obstinate behavior" (Tharpe & Bess, 1999, p. 72). This is like how Jane's mother described Jane as a child, saying that "she always had a mind of her own." Mrs. West's statement about her daughter exemplifies Tharpe and Bess's observation that parents may attribute a child's behavior (being obstinate or not following expected rules) to personality rather than to a possible hearing impairment.

Family members recollect that Jane often “kept to herself” (much like her father) spending much time in her bedroom, indicating that Jane missed out on some, if not much, family interaction. This is typical of people with varying degrees of deafness. Social isolation is a common “adaptation” of the deaf (Meadow, 1980; Stenross, 1999). Lack of engagement with family members was noted by one of Jane’s cousins who described her as “an invisible cousin” because she was quiet and did not engage as the rest of the children. She was described as “quiet” and somewhat “introverted.” Audiologists point out (Northern & Downs, 2002) that shyness and withdrawing from social activity is a common behavioral feature of children and adults with hearing loss. Tharpe and Bess (1999) state that children with hearing loss may experience “a variety of communicative, academic, psychosocial, and emotional difficulties (p. 65) and according to Northern and Downs (2002) such children “may act out their needs in aggressive behavior or in withdrawal” (p. 25). In *The Psychology of Deafness*, Vernon and Andrews (1990) describe psychological implications and consequences of being deaf or hard of hearing. Personal accounts of individuals with hearing loss resonate with many of Jane’s own experiences. Gina Oliva (2004) recounts how she “had been so quiet and withdrawn” and goes on to explain that “I was not shy or stupid or odd; I am just deaf” (p. 61). From the symbolic interactionist perspective, then, having a hearing deficit could lead to a type of “breakdown” of socialization from the very earliest stages of this process.

Peer Interactions & School Experience

After the family, peers play a significant role in one’s socialization and schools obviously provide a major environment for establishing peers. The importance of peers is widely accepted in the social sciences as being one of the major agencies of socialization (Harris, 1998; Macionis, 2007). Bukowski, Brendgen, and Vitaro (2007) conclude

that both a child’s peer group and his or her dyadic friendships constitute fundamental domains of social experience. As a consequence, a lack of positive experiences in either of these domains suggests significant disadvantages for the child’s social development and adjustment. (p. 374)

Upon entering school, children begin to establish friendships and peer groups. Jane’s memories of her early school years are not very positive. To suggest that her hearing loss, although probably mild at this stage, played a role in negative experiences is based on Jane’s recollections, inferences drawn from school records, and similar experiences of other hard-of-hearing individuals.

Jane’s school records from the 1940’s were not easy to find, but I was able to obtain a *Medical Inspection and Health Record* from the office of the Muncie Community Schools in Indiana (Barbara Neff, personal communication, June 15, 2004) indicating that Jane’s hearing was tested in kindergarten and in first grade but the handwritten notations on the record are unclear in meaning. Jane’s hearing is marked as “N” in kindergarten and “ab” in first grade, perhaps indicating normal and abnormal, but when I sought clarification, Ms. Neff said because of the age of the record she could not clarify. On the same record, a handwritten note states, “...she [Jane] has speech deficiency [and] drill in speech still need”:

I remember that [speech therapy]. And I would be taken out of my class into another room where there were a handful of kids. All of us, oh, were talking to each other. We were just in there and the teacher is like making us, making me, it seemed like it was one on one, pronounce things and she would really get irritated with me...a couple of years [of therapy] taken out of the classroom

And I knew I was different. I mean they were always doing things I couldn't do... (Jane)

Jane recalls that often she did not understand what was going on in the classroom. She recalls, for instance, that her kindergarten classroom was noisy with all the children and "I could not hear what the teacher was saying, I saw her mouth moving...so I got bored, I walked around the classroom." Beyond elementary school, Jane recounted how she did well in some subjects, but some word activities were difficult for her. For instance, while spelling words was easy, she found that spelling bees were not:

I enjoyed science, geography. The spelling I could do because you had a set of ten words and you know she's going to call out these words, so I could pretty much guess what she's saying. Made good grades on spelling if I knew the ten words she was going to call out. But a spelling bee, forget it...what they say? I mean, I may know the word. I may recognize the word, but to hear a word without any context, without knowing it's one of ten words; I don't know what she's saying. (Jane)

Jane's discomfort with spelling bees points to the importance of context and environment for the deaf and hard of hearing. For instance, the deaf medical doctor I interviewed (introduced as Dr. K above), commented that face-to-face contact and context are extremely important for her. She said that if she is given a list of random words without context, she will "probably only get about 30% of them." Gina Oliva (2004) recounts that due to where she sat in the classroom, reading out loud was problematic because, "I couldn't hear the other students and never knew where they were in the chapter when my turn to read came (p. 43)."

In addition, a teacher may say something that to the child sounds like something else and hence the child's response seems inappropriate. Not only may the teacher in such a case consider the response inappropriate but children may laugh or ridicule such a response, thereby impacting the child's own sense of self. Bess (1985) shows how a child with mild hearing loss may appear withdrawn or may become reluctant to participate due to such experiences.

Jane recalls that she had no friends in school, rarely was able to join because she felt mistreated. Jane's mother recalled: "Well, she didn't go out to play with the other children. [her brother] always had friends coming in and out, but [Jane] never did." This sort of experience is consistent with children today who have mild to moderate hearing loss. As Table 1 indicates, individuals with mild to moderate hearing loss find it difficult to follow conversations in spaces where background sounds (noise, music, din, etc.) impede hearing. While this is a problem encountered by persons with normal hearing, it becomes more pronounced for the hearing-impaired even when hearing loss is minimal. A common reaction of individuals with hearing loss in such situations is to retreat to a quieter place. Consequently, such children are often seen as shy or are labeled loners (Foster, 1986). Such was the recollection of a neighbor who remembered Jane as a very shy child and noted that she rarely saw Jane playing outside with the other children. Learning that takes place in such groups, among playmates and peers, helps individuals develop the finer nuances of social folkways and norms. Jane's perception is that children never invited her to join peer groups. When she did play with others, she recalls feeling "rejected" or not "fitting in" and so she came to prefer the solitude of books and the company of her brother with whom she had a close relationship. Jane's exclusion from peer activities may have served to breakdown the normal socializing experiences during this phase of her socialization.

Jane's memories of her school days are often negative regarding her experiences with peers and friendship. By the time she is nearing the end of high school, Jane had learned to

adapt or cope in a way that is like that of some deaf and hard of hearing individuals (e.g., Lazlo 1994; Oliva, 2004). Jane's own words provide a glimpse of her coping strategies:

High school was miserable for me. I mean, peers are just so cruel. If they see some somebody who's different, it's like it's going to rub off on them. Their popularity is so important, so you know, I was like, "go away"... but I didn't know what I could do differently to make myself fit in, at which point, you know, you process... "well, I don't need them anyway." And peer pressure, who needs that! ... I mean, the indignity of being rejected. I mean, you learn...we want to get through life and survive but we also want to feel good. You know what's going to happen, you're going to get rejected. What's the point of it? And to join a group; I mean, I just couldn't function in groups. (Jane)

Young Adulthood & Medical School

Erik Erikson (1964, 1982) rightly points out that socialization is a life-long process. As we follow Jane through later stages of her life, her congenital hearing deficit continues to impact her socialization as she adjusts to new situations and experiences. Jane's family describes her during her school years as very studious and suggest that she did not socialize because she was always studying. Her mother described Jane's daily pattern as, "always the same. Went to her room and studied her books." Jane was accepted into the University of Texas Medical Branch at Galveston after completing only two years of her undergraduate studies at the University of Houston where she excelled in the pre-med program. Early in my conversations with Jane, she told me why she decided to go to medical school: "I can tell early on, [I thought], I'm going to become a doctor. I'm going to find out what's wrong with me...and do something with my life."

Jane found dormitory life at medical school uncomfortable because she felt she could not fully participate in the normal chitchat and social activities of dorm life. Her solution was to keep to herself, either by reading or by leaving the common areas where students congregated and socialized. She recalls feeling overwhelmed by all the "verbal noise" that she was unable to understand. She reports that she simply did not know how to engage in small talk and found it difficult to keep up with the meaning of conversations as topics changed unexpectedly. Individuals with moderate hearing loss report similar experiences (Stenross, 1999). As a student in medical school Jane reported that she had difficulty hearing the heartbeat through her stethoscope. The interpretation by the professor of this inability was that this was a skill that would increase with practice. It is interesting to note that when I interviewed Dr. K, she too reported a similar inability to hear the heartbeat, adding that today stethoscopes have amplifiers. While Jane did well in written exams, she performed poorly in oral examinations and interviews. Dr. K also recalled being unable to hear in large lecture halls and failing an assignment because she was not able to hear the instructions.

By the time Jane was in her mid-twenties she had developed strategies for coping with life situations. At the time, neither Jane nor others were aware of her hearing deficit; it is possible that Jane's hearing loss was progressively getting worse. Jane's mother recalls Jane's behavior changed during this time, stating: "Well, my idea is that it [strange behavior] started in medical school...When she went to medical school, that's when I saw a difference in her." In a similar way, one of Jane's siblings noticed "personality changes" in Jane during this time and also commented that she became "hoity-toity" and was upset because fellow medical school students, most of them male, did not treat her the same and did not invite her to events.

The mild hearing loss that Jane may have experienced in childhood may have progressed by this time for as Tharpe and Bess (1999) point, minimal hearing loss can

progressively worsen. Given that Jane was naïve about her hearing loss, the “looking-glass” that she was peering into was perhaps not reflecting an accurate image upon which to base her actions and sense of self.

Adulthood to Retirement

Despite the challenges posed by her hearing deficit, Jane’s coping strategies have served her well enough in her adult years in terms of her profession. Her successful career as a psychiatrist as a solo practitioner in Dallas was achieved through determination and by adopting various strategies that worked for her. For instance, Jane maintains that she realized that to be successful in psychiatry she would need to be a solo practitioner so that she could have better control of the environment in which she worked. It is interesting to note that others with hearing impairment also try to create better working conditions to accommodate their hearing limitations. For instance, Bruce Kent (Kent et al., 2007) states: “When teaching I structured work environments to suit my condition and would set up small group work rather than large group lessons” (p. 6). Similarly, when I interviewed Dr. K, she said that she tries to avoid problems by creating a routine in order to have “a degree of control.” Jane attributes her success to her coping strategies and personal traits, such as her determination and confidence, which are exemplified in the following interview excerpts.

My adaptive strategies appear maladaptive to others since it is inexplicable to most observers why I should be deviant...I’m very calculating. I am opinionated...Furthermore, I know that being in medicine, I [would] be able to work and earn a living...I have made my share of mistakes in my life and that those times I had some misgivings in my judgement [but] whenever I had absolute confidence in my correctness, time always proved me right...I’m very independent...In fact, self-reliance epitomizes my entire life. (Jane)

While her solo practice was successful, Jane’s social and family relationships were anything but smooth. Indeed, it is during this stage of Jane’s life that she went through some emotionally charged events that included a divorce after a few years of marriage, followed by complicated issues of child custody, and further estrangement from her parents and siblings. A contributing factor to Jane’s difficulties may have been a more serious deterioration of her hearing during this stage in her life, which may have magnified her feelings of frustration and alienation. Studies indicate that the social consequences can sometimes be more traumatic for individuals whose hearing loss is experienced more acutely or acquired in adulthood (David & Trehub, 1989; Rutman, 1989). For instance, one of her sisters commented: “I just remember as she got older...well, she was always reclusive. I remember when we were [visiting] in New Orleans, she always kept to herself.” And another sister described Jane’s behavior as “radically different...oh, yeah, she has weird behavior.”

When I spoke to Jane’s ex-husband, he recalled that during their marriage she was “for the most part” pleasant and cooperative but also “introverted and would not initiate conversation” in the context of groups. He said he was not aware of her hearing problem during their marriage and that her speech was “satisfactory.” However, he recalled there were “hints of unusual verbal traits.” One such observation he recounted was when Jane was doing her medical residency in New York. Jane was supposed to dictate the histories of patients to secretaries who would then type them up, but she asked him “to dictate into coherent narrative” and she would moderate because she felt “uncomfortable” performing this task. He said he found Jane’s isolation and estrangement from her family a “mystery and an enigma” to him.

Other family members thought Jane had brought much of her isolation on herself. As noted above, during her earlier school years, Jane believes her pattern of withdrawing to her room or from peers was her way of coping. The topic of isolation came up numerous times during conversations with Jane. As her comments in the previous sections indicate, Jane would distance herself from situations (peers, groups) where she felt she was unwanted or rejected:

But who is isolating them? Both sides are isolating. It's like they get tired of repeating...and I get tired of asking, "Would you repeat yourself?" And after a while I say, this is not worth it...yea, I think the early relationships one has, together with hearing impairment, you begin to think, alright, if everyone is going to treat me this way; then, I can be very independent, take care of my needs, and to hell with everyone. But anyway, I keep my distance from people, when I get negative vibes like they don't want to be around me, because I just don't want to get hurt like I have been all my life. (Jane)

Jane's estrangement and "keeping her distance" from people seem to have become more pronounced after she closed her solo practice in Dallas. She explained that she was forced out when "managed care moved into the area" in 1994. After that, she was largely unsuccessful in finding steady work in her field because she could not "get past the interviews." She believed she must have been doing something that "caused the interviewers to reject her applications." She was able to secure work as locum tenens (serving as a temporary hire) because these generally did not require an interview but even these jobs ended abruptly for reasons Jane could not fully understand but she felt that people "did not trust her" such as the following indicates:

I was working there [a prison] as a psychiatrist and they just dismissed me. The women decided that I was not to be trusted. [They said] "don't come to work tomorrow," and I said, "I want to know why." I knew it was coming, I mean, I saw those women and how they were treating me. "Well, we think you might bring in contraband." I mean, how do you defend yourself on charges like that? I looked suspicious. I mean, do you know how that makes you feel? (Jane)

After another failed attempt at securing a job, she became convinced that she was unable to find employment because there was something wrong with her. With no steady work and limited funds (at the time), she decided to "retire and live simply" in solitude. She describes that time of her life as "gratifying" and reflects on her coping strategies and self-reliance:

...six gratifying months living on 40 acres in the Siskiyou Mountains [Oregon] without any modern conveniences—no electric, no running water, and only a non-insulated cabin. There was not another soul around...I had no doubts about my survival skills. I cut firewood, planted a garden, tap the mountain spring for drinking water and took wonderful long walks every day in the old growth trees gathering berries and nuts. Tell me, how many women, or men, have had the rewarding experience of being totally self-reliant for any period of time? (Jane)

Nevertheless, Jane wanted to be a little closer to family, so she relocated to San Antonio, Texas. In March of 1998, Jane received a letter from one of her sisters informing her that their father had died. Her sister states in her letter:

I knew no one will write to let you know; mom's excuse is that she is too busy...this is one more thing you will be left out of. Since you don't have a phone, this is the best I can do.

As I described earlier in this paper, Jane has felt excluded most of her life and has searched for explanations for why many perceive her behavior as odd. She states: "Whatever makes me different from others, I'm not sure but I've been analyzing it all my life." With retirement her search intensified. For instance, while still in Oregon in 1997, she sought a psychologic diagnostic assessment, in part, to see if she qualified for disability since she could not secure a job. The clinical psychologist concluded: "It is clear that [Jane] is disabled, but I remain unclear about the nature of her disability. She does seem to appear to have symptoms of autism spectrum disorders." Then in 1998, after settling in San Antonio, she went to the Ear Medical Group (1998, personal document, September 1, 1998) to have an evaluation because she felt an "overall sense of difficulty with sensory perception and difficulty with interpersonal relationships" and thought it might be related to hearing. She was surprised to discover the level of her hearing loss but continued her search for underlying causes. She had a neuropsychological evaluation from the Texas Neuroscience Institute because she believed she had a "right hemispheric dysfunction" and "difficulties with linguistic processing" and she reported that, "in spite of the hearing report" she had recently received, she believed she could hear. By the time I met Jane in the fall semester of 1999, she had developed an intense interest in deafness. She took courses at the community college on topics such as Introduction to Deafness and American Sign Language.

During the time of my research, Jane was enjoying retirement immensely and engaging in activities independently. Jane is perhaps unusual as her hearing loss was discovered very late in her life. According to Jane, this discovery has helped her make sense of some of the anomalies and misunderstandings experienced throughout her life. She believes she can now make more sense of the mannerisms of her father and the difficulties her sister endured, which are very similar to Jane's. Family members do not totally accept "deafness" as the full explanation, but they do grant that it may explain some of Jane's "weird behavior." The sister with hearing loss stated that after learning of Jane's, and her own hearing loss, she sees the similarity in the problems they have both experienced, saying, "...frustration. She would do things, [and] I think it could be the hearing thing. I kind of see the picture more now than I did then." Her other sister commented that Jane's hearing deficit may explain why Jane often missed the punchline in jokes. She noted that Jane "never seemed to get jokes" and "always seemed so intense." Stenross (1999) observes that jokes are indeed often a problem for the hard of hearing since jokes often rest on an unexpected linguistic turn. Such linguistic surprises are difficult for the hard of hearing who depend on continuity of topic or context to grasp meanings. Similarly, almost any degree of deafness hampers one's ability to grasp nuances in everyday communication. For instance, when Jane had just moved to San Antonio where Spanish words and names are commonly used for business establishments and street names, Jane was seeking directions to a store and what she "heard" was that it was at the corner of Interstate-10 and "days of olives" whereas in fact the person had said "Interstate-10 and De Zavala." Being unfamiliar with the Spanish names threw Jane's interpretation off. Stenross (1999) recounts numerous such examples of misinterpretations among the hard of hearing.

In reflecting over her life, Jane sees her own development as a workable and authentic adaptation. Some family members interpret her behavior as her inability to conform to familial and culturally acceptable norms. This is revealed in phrases such as, "Jane needs to learn how to..." or "She doesn't know how to..." and "She has a mind of her own." In terms of socialization, these sorts of comments seem to suggest that perhaps Jane did not learn some commonly expected social norms. Jane agrees with some of these observations, saying during

her childhood she felt she was “different” and found it difficult to socialize with others. As Jane reflects on her life, she considers her success a “remarkable accomplishment” given her hearing deficiency. In discovering this hearing deficiency at this stage of her lifelong socialization, Jane has developed a new sense of self, which is revealed in how she introduced herself when I met her in 1999: “I am a congenitally deaf psychiatrist.”

Discussion and Implications: A Crack in the Looking Glass Self

Jane never considered her hearing and simply assumed, regarding hearing, she was the same as everyone else. Her ability to communicate well in face-to-face contexts provided the illusion that all was normal and that she could hear like everyone else. A common observation by the hearing impaired is that individuals who have normal hearing generally assume that if a person speaks and engages in normal conversation, they are not deaf (Stenross 1999). While speaking with Jane I found that it was, indeed, quite easy to forget that she could not hear normally because her conversations with me were generally fluid and normal. However, when I inadvertently lowered my voice, turned my head, or spoke to her when she was not facing me there would be a lack of response that reminded me that she had not heard me. The apparent normality that is typical of close face-to-face communication with a hard-of-hearing person belies the potential for numerous misinterpretations, as happens not uncommonly when a hard of hearing person answers a question in a seemingly inappropriate manner or altogether fails to respond because he or she has really heard something other than what the speaker uttered. Hearing loss creates a crack out of which misinterpretation is all too easily born.

Limitations

Learning about Jane’s experiences as a hard of hearing individual led me to examine the mechanisms of socialization more carefully. Teasing out the myriad factors involved in socialization is neither clearly nor easily accomplished. I attempted to show how one single factor, hearing deficit, has the potential of significantly affecting an individual’s socialization. I realized that singling out one such factor throughout Jane’s socialization would be difficult, especially given the nature and limitations of life-history and case-based research. The subjective nature of Jane’s recollections and interpretations of her experiences are issues that I tried to address by interviewing family members and others as I described above. In addition, I used various documents to verify and/or add to the orally based interviews. Such limitations, however, do not preclude the utility of using Jane’s experiences as an instrumental case to raise questions about socialization in general and, more specifically, Cooley’s theory. I have tried to recreate the socialization of one individual through the life stages. This has required a look backward into the past life of an individual. Much like an archaeologist, I have used available evidence to reconstruct the possible life-long socialization of one individual to indicate how hearing loss may affect this life-long process.

Implications

If hearing loss does affect socialization as I tried to demonstrate, then this has some implications at the theoretical, educational, and research levels as well as for the family and the individual. First, at the theoretical level, for sociological theories, such as Cooley’s looking-glass-self, this research points to shortcoming that were not previously considered. The variable of hearing is not commonly used in sociology to provide insight into how socialization occurs. Given its potential impact on socialization, theories of socialization should be re-examined. If a hearing deficit can lead to significant misunderstandings in communication, then clearly

socialization as generally perceived is also affected. In his theory of socialization, Cooley recognized the importance of language but never questioned how potential differences in hearing ability might affect language itself or the “reflected or looking-glass self.”

Secondly, my research has implications for educators who often use classical theories in the classroom without giving much consideration to unstated or taken-for-granted assumptions embedded in such theories. Socialization involves factors both conscious and unconscious and is affected by numerous familial and social factors. Textbooks and professors often incorporate such factors (family, agents of socialization, social variable) in their teaching of socialization, but I have not seen a sociology textbook used in college courses that includes biological factors such as hearing. As seen in this paper, the significance of hearing, as a biological factor, in daily interaction has been neglected in studies of socialization. We are quite aware of the importance of language as a key vehicle of social interaction and, therefore, of socialization. However, as Northern and Downs (2002, p. 3) point out, learning language can be “hindered even with the slightest hearing loss.” No one doubts the importance of language in socialization and yet the role of hearing in this process has not been closely investigated.

Given the shortage of research in this area in the social sciences, many questions are yet to be answered about the impact of hearing on socialization. In this paper, I focused on the impact that hearing loss has on socialization through the life stages. Yet, there are numerous other issues that merit further research. Until recently, clinical diagnosis of hearing-loss among children was difficult and often not detected until the child was about 30 months old. While hearing tests administered to infants and school-age children are common today, to what extent are some children still not receiving proper testing? Since socialization in the formative years is of critical importance, it is equally important to ensure that issues of hearing loss be addressed. At the other end of the life cycle, hearing loss is a significant issue for the generation of baby boomers who experience hearing loss as they age and enter the later stages of life-long socialization. There is much potential for further research in this area.

Lastly, learning about Jane’s experiences (as well as that of her father and her sister) was quite revelatory. My experience with Jane made me realize how hearing is taken for granted and, as I tried to show, how hearing loss can impact families and individuals. Socialization, after all, is experienced at the individual level. While Jane’s sister was not the focus of my research, I was struck by the similarities in the types of relationship problems both Jane and her hard-of-hearing sister have experienced and by how family members described both Jane and her father (also hard of hearing) with very similar behaviors and traits.

After learning about her hearing loss, Jane not only began to develop a new identity for herself, but she also began reaching out to her siblings, urging them to have their hearing tested. About a year later, Jane moved back to the Houston area to be even closer to her family, establishing contact with her brother and the sister whose hearing loss was discovered to be quite like Jane’s. In 2003, Jane was invited to her mother’s birthday party, an event to which I was also invited, and, thus, observed a remarkable occasion for Jane and her family. Of the two-dozen people in attendance, most had not seen nor been in contact with Jane for well over a decade. Jane’s socialization continues, but now, with the knowledge of her hearing loss, perhaps a crack in the look-glass is perceived.

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