Task Force 7:

Development of Workable Aural Rehabilitation Programs

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Our committee interpreted the meaning of a "workable" rehabilitation program to be a program that is salable to the hard-of-hearing public because it meets their needs and is financially feasible both for them and the clinic. Each member of the committee investigated the present clinic programs in their home area including the philosophy and / or goals of the programs.

The results of trying to determine what was happening in each of our prospective areas showed one interesting contrast. Dr. Israel reported that in the District of Columbia there is a population of 2,900,000 and more than a dozen speech and hearing clinics available to the public. (This does not include Walter Reed or the V.A. Hospital.) He further reports that no clinic carries out an aural rehabilitation program. The clinics only provide therapy to an occasional individual client. The closest such service is through evening lip reading classes taught by a lay person at the Washington Hearing Society. In contrast, the San Francisco Bay Area has a population of 4,761,000 and 21 clinics, not including three V.A. Hospitals, to service the public. Ten of these settings have established ongoing aural rehabilitation programs that provide a definite therapy program over and above diagnostic evaluations and hearing aid evaluations. The differences in these two geographic areas points out the differences in attitudes about importance of a total rehabilitation approach by audiologists. This makes it even more difficult to agree as to what a workable rehabilitation program should consist of. After considerable discussion it seemed that activities for an aural rehabilitation program should be centered on the following: 1) practice in physically positioning oneself to maximize lighting, reverberation, and s / n factors; 2) successfully engaging in conversation under conditions of poor speechreading and audition conditions; 3) successfully engaging in conversation under randomly varying conditions of speechreading and / or audition opportunities; 4) development of expertise in "controlling" conversational partners and teaching them to be cognizant of the communication problem imposed by loss of hearing and to exhibit communication "manners" that will enable the hard-of-hearing party to keep pace; 5) maximizing acoustic and lighting conditions in client's most frequently occurring conversational settings (office, living room, etc.); 6) improving telephone communication; 7) learning how to become a better "listener," more interested and attentive; 8) training in coping with the normal hearing conversational partner who is impatient or unaccustomed to dealing with hearing-impaired people; 9) involving family members and / or close friends, for better understanding of the problem; 10) increasing success in real-life com-

munication encounters, such as in restaurants, movies, etc.; and 11) providing specific training in listening and speechreading, and in how to maximize the use of hearing aids.

The committee also believes that group therapy was more effective than individual therapy and that homogeneity of age and degree of loss were necessary for grouping.

Lydia Birkle stressed the importance of initial individual conferences but that learning and reinforcement occur faster in group work.

Gerald Miltenburger feels that most programs are structured for a set amount of time and that at the end of this time therapy ceases regardless of where the patient is. He stresses the need for open ended therapy programs in terms of closure for individual clients.

In conclusion this committee stressed that although approaches may vary from therapist to therapist, that this kind of variation is good only if it meets the needs of the patient. Since there are many opinions of what a workable aural rehabilitation program consists of even within this task force, it seems that the direction that should be taken next is to evaluate several systems to yield data on program effectiveness.