

PRESENT BARRIERS TO AURAL REHABILITATION
OF THE ELDERLY*

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During the past several years, the Audiology Section of the Purdue University Department of Audiology and Speech Science has been conducting a diagnostic and rehabilitative audiology program in conjunction with the Indiana State Soldiers Home in Tippecanoe County. This ongoing program has variously included identification audiometry, diagnostic audiometry, hearing aid evaluations, hearing aid orientation, and speech reading and auditory training. We would like to spend our brief time today describing this program and, in particular, dwelling upon some of the major problems we have encountered.

The Tippecanoe Soldiers Home, as it is popularly called, has facilities for the housing and management of approximately 400 persons. It routinely operates at or near full capacity. The home has three part-time general practitioners on its medical staff, along with approximately nine registered nurses and a sizeable number of nurses aids.

The requirements for admission to the Home are twofold: First, the individual must be a veteran of war-time service. Second, the individual must have lived in the state of Indiana for at least five years prior to admission to the Home.

If the prospective occupant satisfies these two requirements appropriate financial arrangements are made prior to admission. Normally, in order to be eligible for admission, the individual should possess \$ 3,000.00, or less, in total assets. Needless to say, this means that all residents of the Home are quite restricted in the amount of reserve finances available to them.

On a month-to-month basis, residents make support payments to the Home in relation to their monthly income. Specifically, assuming either a pension or a social security check each month, the resident is permitted to keep the first

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\$30.00 of this monthly income. The Home receives 80% of the remainder of the monthly income, with the individual receiving whatever funds are left over. Thus, the individual with a monthly income of \$230.00 keeps the first \$30.00, the Home gets 80% of the remainder, or \$160.00, and the resident then receives the last \$40.00. We should all keep in mind, however, that many of the residents do not have an income compatible with the example just given.

This monthly payment covers all normal living and medical expenses except dental care and prosthetic appliances such as eyeglasses or hearing aids. We should point out immediately, regarding hearing aids, that the local hearing aid dealers have all been barred from the grounds of this facility. This action was prompted as a result of several unfortunate incidents in the past. These incidents specifically involved the sale of aids that the user could not successfully wear, the sale of aids to individuals who would not ordinarily be considered hearing aid candidates, and the sale of aids to individuals who obviously do not have the funds to consummate the purchase. Since incidents of these sorts ultimately demand a sizeable expenditure of time and effort on the part of the medical staff and the social workers to rectify, it was decided to totally isolate the residents of the Home from all hearing aid dealers.

The initial phase of our program involved identification audiometry. Since the Home is located approximately four miles from our department, and since no residents of the Home have their own transportation, it was determined that we could most efficiently accomplish this phase at the Home itself. A final testing location was selected, not because of its beauty and modern conveniences, but because the building was used primarily for storage, and hence, there was little traffic or noise during the time we were testing.

The individuals selected for this phase were brought to our attention by both the medical staff and the social workers. These individuals were not selected in any systematic fashion, but rather were scheduled because they manifested a noticeable communicative problem that appeared to stem primarily from a hearing deficit. Our Speech Pathology Section was, at the same time, providing speech and language rehabilitation for those individuals who displayed predominantly non-auditory pathologies.

For this phase, all individuals were scheduled in pairs. This particular procedure was carried out for two reasons.

First, it provided a memory jolt for each person scheduled. That is, they had someone they could meet in the dormitory or dining hall and walk with to the testing site. This practice cut down markedly on the number who simply forgot about their appointment. Second, since the demand for testing was so great, and since our room was large enough, we decided to initially utilize two clinicians with a supervisor and evaluate two persons at a time.

The first session was opened with a detailed case history. Within the case history, special emphasis was placed upon age of onset of the loss, progression of the loss, and a detailed account of the individuals description of the loss, his feelings regarding the impact of the loss, and his hopes or expectations regarding remedial work. We then obtained a pure tone audiogram in the frequency range from 250 to 8000 Hz.

On the basis of the findings of this initial session, those individuals tested were classified as:

1. Essentially normal and in need of no follow-up other than periodic re-evaluation;
2. In need of aural rehabilitation;
3. In need of both further diagnostic testing and aural rehabilitation.

The criteria for determining into which category an individual should be placed were as follows:

1. If the pure tone average in the poorer ear was better than 40 dB, and there was no reported communicative problem, the individual was considered essentially normal;
2. If the pure-tone average in the poorer ear was greater than 40 dB, diagnostic testing was recommended;
3. If the case history revealed a significant communicative problem suggestive of hearing involvement, diagnostic testing was recommended;
4. If the case history revealed an active medical pathology, diagnostic testing was recommended;
5. If the medical director referred any patients for follow-up, diagnostic testing was recommended;
6. If the individual owned or had owned a hearing aid, diagnostic testing was recommended;
7. If the individual fell in any category other than "essentially normal", aural rehabilitation was recommended.

We realize that these may seem to be a set of very relaxed criteria. Considering the population we were dealing with, however, any more restrictive would have included virtually everyone and our concern was to identify those most in need of help. We should point out, at this time, that approximately 80-85% of the residents tested fell outside the "essentially normal" category. Not surprisingly, the majority of those classified as "essentially normal" were under the age of 65.

Our next step was to initiate a program of diagnostic testing and aural rehabilitation for those individuals for whom it was deemed appropriate. It immediately became obvious that logistics were to become a major problem. All diagnostic testing was conducted at our clinical facility on the Purdue campus. This meant that transportation had to be provided for each individual. In an attempt to alleviate this problem, we agreed to always conduct two separate evaluations at the same time. In so doing, we cut in half the time required on the part of the social workers who were used to provide the transportation.

One additional problem of surprising dimensions confronted us. This appeared in the form of a distrust on the part of many of the individuals being tested. This distrust became evident in several forms. For example, some individuals were highly indignant because we had interrupted their routine. Others, although we had great difficulty communicating with them, suddenly professed an over-riding belief that they were having no problem after all. Perhaps the most suspicious group were those who firmly believed that we were in some way connected with the hearing aid industry.

These attitudes very quickly pointed up the necessity, on our part, for a much more comprehensive education program. Working with the social worker who had prime responsibility for this program, we began an intensive counseling and orientation regimen with the residents prior to the diagnostic testing sessions. We soon learned that once these individuals fully understood what was being done, why it was being done, and what we hoped to accomplish, they not only lost their suspicion, but some became our undying fans. Their initial distrust and suspicion seemed to stem from a word-of-mouth misunderstanding that was spread and reinforced as only an institutional rumor can be. These people were not sure, presumably because their communicative problem prevented their understanding of the original instructions and explanations, what was happening to them. Since medical

treatment was routinely provided at the infirmary, and since the hearing testing was of a quasi-medical nature, and since none of them had ever heard of or visited our clinic before, they tended to not only question the proceedings, but to be occasionally antagonistic.

As soon as we, with the assistance of the medical staff and the social workers, were able to overcome this misunderstanding, we were met with enthusiasm and remarkable willingness to cooperate. To be honest, we were perfectly aware of the fact that some of the residents looked upon this evaluation program as a pleasant diversion. This provided them with trip to the Clinic, they had an interview during which they were able to discuss their problems in detail, they received an evaluation, and the whole visit ended with a discussion of the results and recommendations. Many of these persons did not seem to want, nor did they expect, any specific help. They were very grateful for the brief diversion we had provided, and they were then ready to go back to their world of communicative isolation. Fortunately, there were also those who were genuinely interested in the results and were very eager to follow through with the recommendations for rehabilitation.

Up to this stage in the over-all program, we had actually faced no problems that were distinctly unique to the institutionalized elderly. When we reached the stage of rehabilitative management, however, the institutional population began to differ markedly from its non-institutionalized counterpart.

Obviously, a sizeable number of the individuals we evaluated were in need of amplification. Equally obvious, however, because of the limited financial resources of these individuals, only a very small number were able to afford a hearing aid. We have been able to make available a small number of used instruments. With these aids, and with appropriate hearing aid orientation, we have been able to make some of the more motivated individuals successful hearing aid users.

We would like to be able to report more success in this area. At present, we feel that only about one in ten hearing aid candidates have aids available to them. We plan, early in 1970, to initiate a speaking campaign before the service clubs and service organizations in our area. As you know, however, we do not come from a metropolitan area. The Tiptecanoe Soldiers Home, like many similar institutions, is located in a predominantly rural area adjoining a moderate

sized town. We are sure that we would have no difficulty presenting a case for four or five persons who need amplification. To present a case for 200 or 250 persons, however, defies the imagination of even the most philanthropic listener.

In addition, we were constantly faced with those individuals who have lived in isolation for a long enough period that they lack the drive necessary to struggle with daily communication. They do not appear to be interested in amplification, and they frequently reject any suggestions in this direction. We wish to point out that this attitude is not unique to the institutionalized population, but it appears to be much more prevalent with them. These people have precious little motivation, and they seem to have lost all desire to improve themselves. These facts were clearly enumerated by ASHA's Committee on Communication Problems of the Aged in 1967. We have temporarily tabled any intensive work with these individuals due to the non-availability of hearing aids. Instead, we have attempted to involve them in an active program of speech-reading and auditory training.

This last aspect of the program is being conducted within the Soldiers Home facilities. We have attempted, according to the information available to us, to group those individuals slated for aural rehabilitation into small groups of common interest. We have confined ourselves to no one specific method of presentation. Indeed, with any given group we have attempted to tailor our approach to the interests and the needs of the group. In fact, the arguments concerning analytic versus synthetic approach seem to be irrelevant here. These people demand a combination of both approaches and the clinician, to hold the attention of the group on any given day, must be prepared to proceed utilizing either approach. In addition, the clinician must also be prepared to shift from a prepared lesson to the interest topic of the day. When these elderly persons are preoccupied with a given topic, whatever it may be, it is fruitless to fight them, but it can often be beneficial if our material for presentation joins them.

With this institutionalized population, we have encountered a situation which we predicted in advance. Those individuals that were highly motivated, and interested, attended regularly and encouraged their fellows to join them. In fact, this group has proven to be excellent recruiters for the rehabilitation program. As in other situations, however, they tended to attract others who also share their motivation and interest.

The other large group, comprising perhaps one-third to one-half of the hearing impaired population, has steadfastly avoided the rehabilitation program. Some have attended one or two sessions, but when they learn that there will be no instantaneous cure or improvement, they slide back into their normal mode of communicative indifference. The remainder have outrightly rejected any participation in the program. They are willing to listen to our discussion, they acknowledge that their communicative environment is difficult, they express appreciation for our interest, they state that they would like to improve their receptive skills, and they silently slide from view.

We have enlisted the help of the social workers with this group. Unfortunately, after they have taken the time to contact these individuals on two or three occasions with no positive results, even the social workers must give up in order to attend to other pressing demands.

In short, we find ourselves faced with both an encouraging and a discouraging situation. In the area of amplification, we feel that we can make major advances. We are confident that enlightened service clubs and service organizations can provide funds and used aids to partially alleviate the problems of many of these individuals. Some day even Medicare may become enlightened. Medicare, by providing hearing aids for the elderly, could offer a major rehabilitative breakthrough for populations such as this. Certainly, we should all do our part to make the importance of this necessary change known to our respective political leaders. An active hearing aid orientation program can then do much to transform half-hearted, unknowledgable, or dejected hearing aid users into better communicators.

At the present time, we plan to continue our approach to those who seem to have given up on the communicating world. Conceivably, a primary avenue of approach may be through amplification in the aural rehabilitation setting. This one single item may provide them with some of the instantaneous cure or improvement that they have given up hope of ever receiving. In the interim, however, we intend to utilize our in-service recruiters to their maximum. These individuals, who characteristically are least in need of our services, will be urged to continue to encourage and to foster an attitude of positive improvement among their fellows while we, in turn, attempt to develop the means to demonstrate this positive improvement.