Student Participation in Aural Rehabilitational Programs

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Training programs and their relationship to the development of community aural rehabilitation programs for the elderly, is, to say the least, a very broad topic. In the interest of organization these two areas will initially be dealt with individually and finally, conclusions as to their relationship will be drawn.

Only within the past year has ASHA actually required that audiology students have a minimum of 50 hours of aural rehabilitation practicum in order to meet certification standards. Therefore, many audiologists have completed their graduate training with little, if any, exposure to aural rehabilitation. Even today, if a course in aural rehabilitation is offered, it may not deal with the development of programs of management from diagnostic data and/or therapy techniques. Further, such courses may not be taught by audiologists who are not genuinely interested in or trained in aural rehabilitation.

One of the main problems in training is motivational. Most students do not choose the area of audiology because of its' association with aural rehabilitation. Therefore, self-motivation may not initially be a major factor. Secondly, if the course instructor/clinical supervisor is not truly excited about the area they cannot be expected to generate any abiding interest among or within the students. This second factor gives rise to a third which operates to a lesser degree, but which is a realistic consideration nonetheless. Without enthusiasm and knowledge relative to the area of aural rehabilitation the instructor/supervisor cannot effectively employ the "guilt-respect syndrome" of some students. This syndrome requires that the instructor/supervisor gain the student's respect. Once this has been achieved, in many instances, the student will assert a more concerted effort so as not to disappoint the instructor/supervisor. Al-

though this may sound somewhat hard and manipulative, it may initially be one way to shape a student's professional attitude and behavior.

In general, it is not exceptionally difficult to motivate students to work with children, but work with the geriatric does not naturally appeal to many students. Part of this may stem from the fact that the geriatric does not fall within a familiar frame of reference. Exposure to children is the norm for the vast majority of people, but many people are not exposed to the elderly on any regular basis. Even on a family level, the geriatric may not be considered a vital and unique member, if they are even acknowledged. We stress dealing with the "whole child" yet how often does the concept of the "whole geriatric" enter our training? How often is the geriatric merely classified as "hearing-impaired due to cochlear lesion; probably etiology, presbycusis", with little or no attention paid to the social and emotional problems caused or accentuated by this type of communicative handicap? The geriatric entails much more than a pair of decaying ears on a greying head. Their lifestyle, interests and overall communicative needs are definitely different than for any other population which with we work. As instructors/supervisors we sometimes fail to realize that the geriatric himself may be the best teacher. Students need to recognize that while they may be improving communicative skills they are gaining, from the geriatric, as much, if not more, than they have to offer. Many of these elderly clients can point out mistakes and weaknesses in the therapy while offering viable alternatives that we as instructors/supervisors might never suggest. They can do this because they are constantly dealing with the problems of hearing impairment on a very practical level.

Aural rehabilitation with geriatrics, and in general, is a difficult area to master. There has been very little controlled research in this area and therefore, there is a limited theoretical framework for therapy. Therapeutic techniques are still frequently discovered through a trial and error procedure and there is no real agreement in the literature as to therapy methods. Therefore, students must be given a great deal of support when they begin their aural rehabilitation practicum. We as instructors and supervisors need to openly acknowledge the difficulties a new A.R. therapist encounters. Without support, and a great deal of it, the aural rehabilitation practicum could rapidly become the most frustrating clinical experience of a student's career.

Students can frequently be heard stating that they want exposure to and experience in the "real world". What better way is there to provide such exposure and experience than the community aural rehabilitation program? The goals of such a program are twofold:

1. To provide a badly needed service to the community on a consistent basis.

2. To offer the students the opportunity to become involved in a grass-roots community project.

Many aural rehabilitation programs for the elderly, whether in nursing homes or independent living units, would like to be able to offer aural rehabilitation therapy on a weekly basis, if not more frequently. In many rural areas this poses the simple and yet complex problem of transportation to and from the site by the student clinician. Further, many of the elderly derive the most benefit from an intensive exposure to therapy. For these two reasons, the use of lay personnel as "teachers" has been explored.

In conjunction with the Champaign and St. Croix County Offices on Aging two programs were implemented. In both of these programs, the lay personnel received approximately 17 hours of pre-training which would enable them to function as "instructors". The Champaign Project was the first implemented.

The training consisted primarily of lectures and demonstrations dealing with the following topics:

1. Historical perspectives of lipreading—how long used, primary proponents.
2. Basic approaches to lipreading—analytic, synthetic, and combined. Which approaches have seemed most successful and why.
3. Basic organization of a lipreading lesson.
4. Lesson plans.
5. Sources of materials.
6. Types of materials.

Particularly stressed during these training sessions were three concepts:

1. That the clients use their residual hearing to the best of their ability.
2. The significance of adjusting materials and lessons to the basic skills of the "would-be" reader.
3. The manner in which to keep a lesson alive and moving.

In general then, the lay teachers were given the fundamental tools necessary for conducting a lipreading session. In addition, thought and not literal translation was stressed (in order not to turn these sessions into a grinding or testing situation).

At least one graduate student from the University's aural rehabilitation practicum was assigned to each aide. Their duties consisted of:

1. Teaching every third lesson.

2. Providing additional resource material for the lay teacher.
3. And, in some instances, where an individual client was having particular difficulty, conducting a one-to-one therapy session.

Further, these students conducted threshold, pure-tone audiometry on each client in order to determine who might be a candidate for a complete audiologic evaluation and possible hearing aid evaluation.

This program demonstrated definite weaknesses. Some of the particular areas of weakness are as follows:

1. Inability of University personnel to be at each meeting of each lipreading class. Because of this, the teaching aides have not become as proficient as they could have been if they had received both positive and negative feedback following each lesson.
2. The transiency of the lay teachers. In one instance this necessitated the University's assuming full responsibility for the site. Which in a way had its advantages also. This particular site has now become a satellite training location for our students in speech (aphasia) as well as hearing.
3. Perhaps the greatest weakness lies in the fact that the program has emphasized a unisensory rather than multisensory approach. As a result, the clients are not utilizing their residual hearing as well as they could for they have not been trained to do so. Therefore, they are not necessarily integrating all sensory inputs which could be of value to them.

After reviewing the Champaign Project, the St. Croix Project was re-designed to overcome these weakness. First, the aides of this second group were either nurses or geriatrics living and/or working at the particular site. Secondly, the aides served as adjunct personnel to the student clinicians. In other words, the students clinicians taught a formal, two hour class once a week and the aides attended this session. Then during the remainder of the week, the aides held mini-sessions based on that weeks' lesson. Thirdly, a multi-sensory approach to therapy was employed. The different groups of the St. Croix Project were arranged so that they were homogeneous enough, auditorily, to utilize and train residual hearing. The St. Croix Project did overcome the problem of transiency of the lay teachers and secondly; some time was devoted to maximizing the use of residual hearing. However, there were also weaknesses in this project. One of which is the fact that it was much more difficult to train lay personnel in the area of auditory training than in speechreading. The lay teachers handled hearing aid trouble-shooting very well; the primary difficulty arose when dealing with frequency

components, formants and so on in relation to auditory discrimination. And again, the aides did not receive immediate feedback regarding their skill or lack of skill in conducting a therapy session. Consequently, they did not become as proficient as they might have if they had been given more direction.

The use of teaching aides does have some strengths however. These aides may be able to provide a service which otherwise would not be offered at all in some communities. Secondly, when aides are used as adjunct personnel, the hearing-impaired geriatric receives a more intensive exposure to aural rehabilitation, and though not yet proven, this may lead to increased carry-over in daily communication situations. The student clinician also derives benefit from working with such teaching aides. First, it provides them with experience in dealing with paraprofessionals and it is highly likely that they will be dealing with such personnel during their professional career. Secondly, by observing and serving as resource personnel for the aides, they are able to gain insights into their own therapy techniques.

At the beginning of this paper, motivation was discussed in relation to the student clinician. However, it is also relevant to the teaching aide and to the hearing-impaired geriatric. Motivation encompasses many facets; three of which are knowledge, skill and attitude. Students and teaching aides need to develop, improve and refine their knowledge, skill and attitude in order to provide the hearing-impaired geriatric with the best possible service they can offer. The geriatric needs to develop, improve and refine their knowledge, skill and attitude so that they may continue to participate to their fullest capacity in the world around them. Each group involved in the community based aural rehabilitation program is unique and offers to the other individuals involved a chance to learn and to grow: it is a program of mutual benefits. In general then, community based aural rehabilitation programs do pose some difficulties. However, when these problems are compared with the benefits derived, both real and potential, by all individuals involved, they are well worth the difficulties.