Task Force 13:

Aural Rehabilitation for Adults

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Many of the topics our committee will review in this brief overview have been identified in earlier task force reports. This is to be expected. In his letter of advice to our Committee of February 16, John O'Neill reported that he was not too worried if committees overlapped in their considerations. We were to decide what we wanted our committee to do and not to worry about what the other committees did. We did just that. The body of this review is presented below in outline form.

I.

Goal: The development of a patient's maximum efficiency in gathering linguistic meaning through a set for gathering meaning. (O'Neill, 1964).

A. developing readiness to attend
B. developing a relationship between sound and meaning
C. employment of visual stimuli and / or amplified sound
D. understanding of the individual's intrinsic capabilities and limitations
E. understanding of the environmental factors which facilitate or impede communication (O'Neill, 1964).

II.

Frameworks within which program theory and strategies may be structured

A. Language
   1. Lenneberg (1964)
   2. Mowrer (1958)
   3. Myklebust (1954)
   4. Piaget (1955)
B. Models for communication
   1. Carhart (1969)
   2. Fairbanks (1954)
   3. Myklebust (1954)
C. Psychology of hearing loss
   1. Heavenrich (1964)
   2. Levine (1960)
   3. Vernon and Mindel (1971)

III.
Definition of the population in need of services

A. Language capable
1. Congenital loss
2. Adventitious loss, adult
3. Adventitious loss, geriatric

B. Language defective

IV.
Definition of the services needed

A. Professional estimates of services needed
1. Review of existing services
a. Diagnostic
b. Rehabilitative, behavioral
1) Auditory Training
2) Speechreading
3) Combinations of audition with speechreading through manual cues
4) Non-aural communication
5) Family counseling
c. Rehabilitative, electroacoustic
1) Selection of amplification
2) Use of amplification
d. Speech conservation
e. Peripheral services
1) Psychological
2) Vocational
3) Medical
4) Unique services

B. Patient estimates of services needed
In view of the absence of such information, surveys of such memberships as the National Association of Retired Persons and the National Association of the Deaf need to be conducted.

V.
Settings for the delivery of services

A. Community hearing and speech centers
B. Hospital / Medical clinics
C. Other community centers
D. Organizations of the hearing impaired
E. Retirement residences
F. Programs conducted with non-resident therapists at any of the above
G. Self instructional materials

H. Veterans Hospitals and other federal institutions
I . Prisons

VI.
Funding of services
A. Client payments
B. Third party payments, private
C. Third party payments, governmental
D. Health maintenance organizations

VII.
Evaluation of the efficacy of the rehabilitative process.
A. Research to produce more valid and reliable test instruments
B. Indices of improvement
C. Indices for alternate modes of therapy
D. Indices for referral beyond the limits of audiology

VIII.
Prototype Programs
A. Michigan Visiting Nurses Association Program (Rolnick, 1969)
B. University of Michigan, Senior Citizens Programs (Harless and Rupp, 1972)
C. Walter Reed Army Hospital (Ciliax, et. al., 1968)

IX.
Recommendations
A. Each adult with a hearing loss must be considered uniquely in terms of his / her communicative needs.
B. A way must be provided to pay for the rehabilitative services needed by the client.
C. A way must be provided to make these rehabilitative services accessible to the client
D. Alternative or optional rehabilitative routes must be made available as possible units in rehabilitative packages.
E. A means should be provided which will permit input from the hearing-impaired consumer which will guide the audiologist in goal setting for his / her patients.

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