

EDITORIAL:

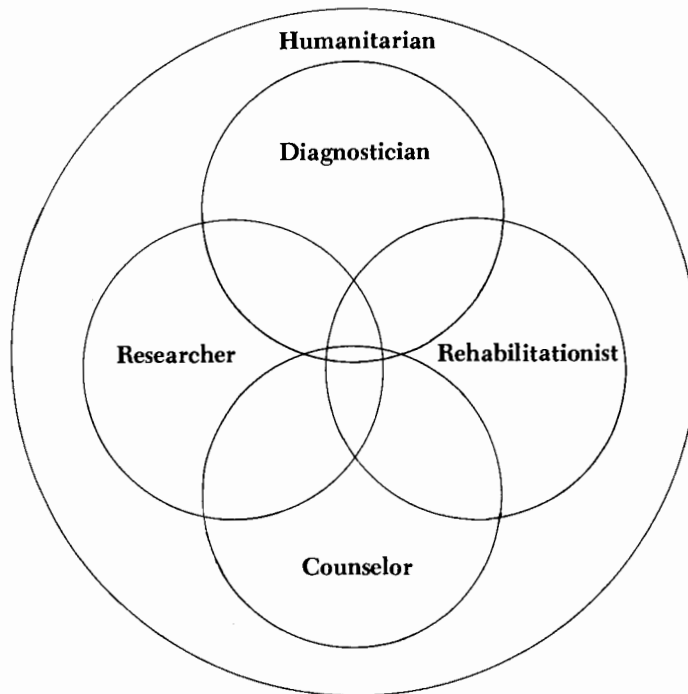
The Roles of the Audiologist— A Philosophical Overview

RALPH R. RUPP, Editor
The University of Michigan
Ann Arbor, Michigan

An audiologist measures hearing, identifies hearing loss, and works out programs of rehabilitation. He does not perform these tasks in a sterile laboratory, but rather he works in a clinical environment. His specific clinical setting—whether it is in a hospital, a public school, a well-baby center, a geriatric convalescent home, a community agency, a university center, or an industrial complex—is one that is oriented to people. In any clinical program, the commodity that the clinical audiologist has to offer is service—direct, personal, and professional service to clients who have hearing handicaps. In his diagnostic regime, the audiologist may use highly sensitive electronic equipment, but the ultimate findings which he records as data are those reported to him by his listeners. Similarly, as he compares his findings for certain techniques with those already recorded in research reports, he recalls that subjective reactions of people were the basis for the findings. When he works out a program for optimal communicative rehabilitation, he assigns this therapeutic regime not to the static hearing loss but rather to the person who has the hearing loss. As an audiologist works with a client and his family in a counseling and guidance program, again, the thrust of his advice and recommendations is toward the person with the hearing loss.

Overriding and permeating all of clinical audiology, must be the feeling of being people oriented. People who happen to have hearing problems are the primary focus and concern.

The five major roles of the clinical audiologist may be viewed as a series of four overlapping and interdependent circles of function all contained within a larger all-encompassing circle of *humanness*—the constant reminder that all efforts in a clinical audiologic practice are people oriented.



HUMANITARIAN

A feeling of appreciation of and an attitude of compassion for people should be the orientation of the audiologist. Every assignment which he accepts in his clinical practice involves an interaction with a person who may have a problem. In his various roles, the audiologist performs as a friend to his clients—as a friend who is interested in them and who cares about their problems. He must be able to understand the effects of auditory sensory deprivation on these people. Though the audiologist is not also a clinical psychologist or a psychiatric social worker, in his professional interactions he must always keep in mind the fact that service to people is his business. Without people and their problems, he would have no business.

DIAGNOSTICIAN

As the audiologist performs his various diagnostic testing activities with a client, he must remember that his recorded data represent volitional responses that are influenced by the subjective set of that client. The strength of subjective audiometric information is enhanced or diluted by

the psychological orientation of the patient to the assigned tasks. Newby (1971) suggests that audiology is an art: it is a skill superimposed on a positive orientation to people. While many diagnostic problems in auditory measurement may be attributed to electrical and mechanical mal-performance, these problems can be checked by appropriate calibration and monitor observations. The diagnostic problems or errors that arise out of subjective confusion or misunderstanding on the part of the listener may usually be attributed to poor preparation of the listener for the specific task by the audiologist. Canfield (1959, 45) warned that "close cooperation between the patient and tester is of prime importance in hearing evaluation. A test result can be wrong if the audiologist does not use the instrument properly, if he hurries beyond the patient's own speed of response, or if he fails to instruct the patient before the test." Further, if the patient did not wish to be tested for some reason, or he was too immature to understand the direction, or was thinking of something else, the test might be of little value. How valid and accurate would be the audiologist's findings in the above situations?

Similarly, Hood (1969, 695) is concerned about the need to understand the person undergoing a battery of audiologic tests. "Patients . . . vary considerably in their intelligence, their age, their ability to cooperate in the face of their disability and in their psychological make-up, and all these factors must be given serious consideration and the manner of application of the test procedure matched to their capabilities." The elderly patient cannot be expected to respond with the speed of the younger, more healthy individual and the pace of the test must be slowed to match the response rate.

Support for Canfield's precaution about careful instructions to the patient is given by Jerger. (1952, 1320) "The importance of careful instructions to the patient in (the) test cannot be overemphasized. Unless the patient understands exactly what is expected of him, the measures obtained are meaningless. Like many other . . . tests, the task must be carefully structured for the patient if meaningful responses are sought."

High, Glorig, and Nixon (1961) identified a series of possible problems that might reduce the efficiency and reliability of pure tone threshold assessment. Of six major classifications, four are directly attributable to the subject under study and include: physiological variables, psychological variables, intellectual factors, and response conditions.

In his diagnostic activity, the audiologist may expect that his success as a data collector will be largely dependent on his ability to instruct his patient in the task and then to pace the task within the rate of the patient's abilities. As the patient's ability to perform the requirements of an auditory task improves, so directly will the reliability and validity of the recorded results for that particular task improve. Subjective auditory

impressions constitute the base of reported findings. It is important that the audiologist keep focused on the patient and his performance.

REHABILITATIONIST

As in a diagnostic regime, the scope and pace of the rehabilitational program must be geared always to the needs and the abilities of the patient. In such a projection, the audiologist first must be concerned with the listening needs of the individual. For example, the teacher with 25 third graders has quite different listening needs from those of the elderly grandmother living in a retirement home with her children and grandchildren living several hundred miles away. In each instance, a carefully developed case history should identify the areas of greatest listening challenge for the client. Since the elderly client spends most of her time in environments which are relatively quiet, her requirements for a hearing aid will be quite different from those of the third grade teacher who spends five or more hours a day with a large group of energetic children.

The success or failure of a rehabilitational program usually is directly related to the effectiveness with which the patient is prepared to handle the communicative challenge.

Citation of two examples from the patient files may help to illustrate.

Case file A: Mr. A. has been a very active member of his community and has served on several governing boards in his town including the board of education. He has had a moderately-severe unilateral hearing loss for several years and had adjusted to it with minimal reduction in group conversation efficiency. Suddenly, a viral-type infection produced a similar irreversible sensori-neural hearing loss in his better hear. In the ensuing months since the onset of the second loss, Mr. A has been participating in a rehabilitational program in our center which includes adjustment to and management of binaural amplification, intensive auditory training, extensive speechreading instruction and counseling.

Gradually Mr. A. has accepted the fact that he will not hear well again, and he has outlined to his rehabilitation counselor the kinds of goals that *he* would like to achieve within the limitations of his present hearing level. Since his work environment places few listening demands on him, the emphasis in his program has been on improving his listening skills at home with his family and in the environments of the several boards on which he serves. He has secured the help of a fellow board member on each board. This assisting listener helps him keep up with the agenda; and on critical issues, his teammate writes telegraphic notes on the pad in front of him. Mr. A's skills in auditory and visual listening at a measured rate are now developed sufficiently so that when he requests a

brief review of a board deliberation, he can understand the essence of the review even without his teammate's help.

Mr. A. is not yet content with his new functional level of listening, but his periods of depression are markedly shortened and fewer in frequency. He spends considerable time in his therapy sessions working out strategy for those communicative environments which are still challenging to him. It is expected that his therapy program of two hours a week will continue for several more months. Following cessation of this weekly program, the staff anticipates meeting with him on a monthly basis for reinforcement and review of his progress. Without the clear statement from Mr. A. on the specific goals he wished to achieve in a rehabilitational program, low motivation and subsequent low achievement with possible marked depression might have occurred.

Case file B: Miss B. had been followed annually at our clinic. In the early spring of her senior year in high school, she appeared at the clinic for a hearing aid evaluation, since her body-type hearing aid was then seven years old. She expressed a marked interest in the ear-level hearing aids. Our staff agreed that there was at least a possibility of finding a strong ear-level instrument for her, although they were concerned about the adequacy of such an aid knowing her bilateral hearing levels to be approximately 70-75 dB (ANSI-1969).

A number of ear-level and body-type instruments were compared on a variety of objective and subjective measurements. During the follow-up conference with the girl and her mother, the reluctant decision on the part of the staff was that an ear-level aid would not be appropriate. In an almost hysterical reaction, the client insisted that she *must* have an ear-level aid and that she refused to accept the clinical recommendation of another body-level instrument.

The client had been integrated successfully into regular junior high and senior high school programs for several years and had not complained about a body aid before. The staff was at a loss as to how to proceed since it was very apparent to all, *including* the client, that auditory performance was consistently superior on *all measurements* with a specific new body-type hearing aid. It was at this point that the client's mother made the critical contribution to the discussion. It seemed that the senior prom was soon to take place, the all-important young man had asked for a date, and *most* crucial to the success of the evening, the exactly *right* dress had been purchased. And here was the challenge! Nowhere within the design of the dress had any allowance been made for the wearing of a body-type hearing aid!

When gently questioned about the crucial evening and the dress, the client admitted that she did not really want an ear-level aid because she

realized the superior performance that the body aid gave her. However, the importance of the evening was overshadowing reality just then.

A happy solution followed. She would borrow the best performing ear-level aid we could recommend for *one* night, with the participating dealer's approval. The following Monday morning, she would return the small aid to our library, and she would again wear her own aid until a new body aid was purchased. The client, her mother, and the staff were pleased. Later reports confirmed that the evening had been perfect; communication level remained high; and the dress was a sensation. Several years later, a successful secretary and wife still wears a body-type aid.

In a rehabilitative plan, the audiologist must always be concerned about the needs of the patient beyond those that pertain only to the hearing deficit. Service to people is the business of the audiologist.

COUNSELOR AND TEACHER

As suggested earlier, the roles of the clinical audiologist are not exclusive. They overlap and interweave continually. In the diagnostic role, the audiologist must act as teacher. Clarity in the presentation of instructions to the subject is crucial. Recall the admonitions of Canfield, Hood and Jerger. During a test procedure, evaluation of the subject's performance is being made constantly. Is his performance acceptable? Does he seem confused? Why does he seem inconsistent? Within clinical performance variability, the audiologist must reach decisions about the validity of the subjective performance of his patient. If performance is inappropriate or confused, then additional teaching or training for the task may be necessary. When test results cannot be used or reported because of the audiologist's lack of clarity or preciseness, a professional disservice has been done the client. In diagnostic evaluations the audiologist tries to keep the assigned tasks for the client as simple and as easily understood as possible. The interaction between clinician and client is a straight-forward one. Important data must be obtained in the most supportive and least threatening way possible. When a client comments at the end of an audiologic assessment that it was the most thorough and pleasant hearing test that he has had; or that it must be very exciting and rewarding to be an audiologist, then the teaching role was well executed.

Similarly, in the rehabilitational setting, as the clinician is concerned about behavior modification or improvement, he must be very clear and specific in setting goals with the patient. In all instances, it should be clear to the patient that each technique developed and each approach employed leads to the realization of the goals established jointly by the patient and clinician. In both diagnostic and rehabilitative environments,

the audiologist needs to be a good listener. Many times the client may be unable or unwilling to discuss certain adjustment areas, or actually may be unaware that resolutions exist for certain of his areas of concern. Within the limits of his professional expertise, the audiologist may work with the client in identifying areas of concern. In many instances, the audiologist may be the first *professional* worker who has demonstrated a willingness to be both teacher and listener. Certainly when the problems or concerns reviewed by the client in any way appear to be beyond the professional area of the audiologist, referral is made to the appropriate resource in the community. Sometimes, the client needs to feel confidence in his first professional contact in order to be able to identify verbally more deep seated concerns for other types of help. Having achieved this confidence with the audiologist, the client may be quite willing to follow-through on the recommendations of the audiologist to seek help from other qualified professionals.

In a University hearing clinic the primary business is training graduate clinicians at both master and doctoral levels. This allows the pacing of diagnostic and therapeutic procedures with clients to be somewhat less hurried than in some other settings. When the patient feels that the professional *has the time to* advise fully, to answer all the questions, and to listen effectively, then the people-oriented atmosphere is assured. In such clinical programs, the staff frequently report that clients make statements to them such as: "You care about me; you seem genuinely interested in me and my problems; thank you for taking the time to listen to me and answer my questions." People with hearing problems are both the resources of and the challenges for the audiologist. Each new client can be classed as a new and exciting case study in the human experience. The audiologist can do much to improve that experience in his role as counselor, teacher, and professional friend.

RESEARCHER

The clinical audiologist is in the most crucial location for the identification of research needs. He can put his professional finger on apparently incongruous or incompatible clinical findings and ask questions which in turn may stimulate research projects. The diagnostic and rehabilitational audiologist should be able to design and carry out clinical-research projects that stimulate his professional curiosity. Several of the references at the end of this editorial are research projects based on questions raised in clinical diagnostic environments and answered by data gathered in these same clinical environments from the patient population served. (Bartels and Rupp, 1970; Hemeyer and Rupp, 1970; Rupp and Gruber, 1970).

When an audiologist in a busy clinical program reports that he has

neither the inclination nor the time to pursue clinical research projects, then the growth potential for that clinician becomes “zero.” He may grow old in his job, but his zest and inquisitiveness as to why his patients perform as they do will cease. Perhaps the saddest professional situation is a “busy” diagnostic audiological setting where no signs of research are visible. When a clinical audiologist reports that he is too busy to do research—or to help gather data for a co-worker’s research project—the real excitement in looking at patient performance has exited. While the purist may reproach the zealot clinical researcher for his poor research design, it is conversely true that the pure research design may wither from lack of a clinical base. In the busy clinical setting, each research project may not qualify for doctoral dissertation status, but valid research can and should be an integral part of a clinician’s main focus.

SUMMARY

In the song, *My Task*, appears the line “To help a wandering child to find his way . . . this is my task.” (Ashford, Ray and Pickup, 1903) The orientation of the service-directed audiologist might be a paraphrase of that line: “To help a hearing-impaired client to find his way, this is my professional task.” The roles of the clinical audiologist are many. In addition to the five identified in this editorial, the audiologist should also be an engineer and physicist; but these roles apply more directly to his interaction with his machines. In his interaction with his clients—people with hearing problems—the audiologist must be a professional friend. Within that broad circle of humane compassion for his client friend, he will also fill the roles of diagnostician, rehabilitation worker, counselor and teacher, and researcher. People are the business of the audiologist. Without people, he has no business.

REFERENCES

- ASHFORD, E. L., Maude RAY, and S. H. PICKUP. "My task" (song). Chicago: Lorenz Publishing Co., 1903. (Renewal 1913, 1931, 1941).
- BARTELS, D. and R. RUPP. "Performance ability on a prolonged variation of the SISI task for subjects with sensory and organ hearing losses." *MSHA, Journal of the Michigan Speech and Hearing Association*, 6, 1, 17-25, 1970.
- CANFIELD, N. *Hearing, a Handbook for Laymen*. Garden City, New York: Doubleday and Co., 1959.
- HEMEYER, T. and R. RUPP. "Loudness discomfort levels in normal and pathological ears." *MSHA, Journal of the Michigan Speech and Hearing Association*, 6, 2, 14-20, 1970.
- HIGH, W. S., GEORIG, and J. NIXON. "Estimating the reliability of auditory threshold measurements." *Journal of Auditory Research*, 4, 247-, 1961.
- HOOD, J. D. "Basic audiological requirements in neuro-otology." *Journal of Laryngology and Otology*, 83, 695-711, 1969.
- JERGER, J. F. "A difference between recruitment test and its diagnostic significance." *Laryngoscope* 62, 1316-1333, 1952.
- RUPP, R. and Linda GRUBER. "The identification and resolution of audiometrically induced hearing loss due to collapsed canals." *MSHA, Journal of the Michigan Speech and Hearing Association*. 6, 1, 26-32, 1970.