1976 PROCEEDINGS
THEME—REHABILITATION OF THE NON-INSTITUTIONALIZED GERIATRIC PATIENT

Problems of Rehabilitative Audiology in the Retirement Community Setting

ETHEL F. MUSSEN
East Bay Audiology and Speech Pathology Services
Berkeley, California

The original paper prepared for this program was filled with statistics which have been ably presented by earlier speakers, so much of this basic material has been deleted. I do, however, want to discuss the characteristics of the age group, especially those who do not live close to a University or Medical School. My first intent was to share some of the frustrations of what I termed a "failure" in working with this group, and why I thought it failed. Next, after hearing some of the other presentations of honest efforts around the country, I feel it is time again to review the growth and development of the Aural Rehabilitation programs in the San Francisco Bay Area and what made them a community-wide success. And last, my general impression of what occurs during the successful aural rehabilitation program—some hypotheses and practical modifications which evolved from my experience. This, then, became not one paper but three, rewritten on the spot, which may prevent others from floundering too long through the same exploratory avenues we trod.

First, I would like to share with you my mental picture of Aural Rehabilitation. I have come to see AR as a partnership, not unlike a love affair, entered into between consenting adults, the audiologist and his client—the hearing impaired. It requires intensity, devotion and understanding, and a certain blindness to the personal faults of the partner. If hearing loss is our most prevalent social disease, then achievement of better communication skills is the healthy climax of the restoration pro-

cess. There is a form and a rhythm to it which varies with the individuals involved. The end is achieved in differing styles and techniques depending on who is interacting. The development is an exhilerating relationship which is terminated when the needs are met.

To leave this lyrical metaphor for a moment, let us turn to demography and the prediction of population characteristics and needs. To refer to the data presented earlier, the population over 65 has increased by 20 percent between 1960 and 1970, in comparison to an increase of thirteen percent for all other age groups. This means an increase of 300-400,000 people in this age group occurring every year. The big jump in the population over 65 years old is projected at the decade between 2010 and 2020, when the post-World War II babies have passed 65. In other terms, in 35 to 45 years from now many of us will have been gone. Others who are young people now will be included in those particular statistics. Still others will presumably be in the field giving help to that group of elders, if, in fact, the field still exists.

These are the figures of age distribution. What are the figures of hearing loss? At present 14,000,000 of all ages indicate hearing loss is a problem. Thirty percent of those over 65 admit to a hearing loss. This is the single most mentioned complaint. We can only presume this will still be true when the younger group reaches that age. Further contemplate the fact that those oldsters of 2010 were youngsters in the days of discos, acid rock and amplified music, industrial noise, jackhammers, and traffic and other earmarks of urban living. Is this going to double the number with describable hearing loss? How amenable to amplification will those ears be? What will their lifestyle be? What social and communicative patterns will be the mode then? Think about their patterns now. Will their language patterns by anything like those of the younger people who are helping them. What richness or poverty of vocabulary will the ordinary person of 65 have at that time.

What I am trying to bring out is that extrapolation to a distant future is somewhat dangerous. It assumes homogeneity of population and similarity of goals, needs and social trends, which in fact often change direction and character. Masterplans of universities, secondary schools and the mushrooming needs of child care centers depended upon an even continuing baby boom which in fact did not materialize. Why? Because several changes occurred. With the universities, the numbers were there, but the lifestyles and goals had changed. For the child care centers, zero population growth as a choice, intervened. I think it is an interesting exercise but potentially futile for us to anticipate needs of that aging population of 2010, even though we can predict for sure that the percentages of people with hearing loss will be greater than today.

Rather than be concerned with what will be possible around the year

2000, I would like for us to look plainly at those who are now our elders. Living on their fixed incomes, many get by on a median of $7500 compared with a median for the general population of approximately $13,000. Of course, there are those with a great deal more, and they are able to live in the setting I will be discussing today.

Who are all these people? What is their history? What are they like? This generation is our concern for the next 10 to 15 years. Why be concerned with those who will be in this age group 35 years from now, until we have learned more about the needs of this generation of elders. Who were they? Children of young people in World War I; they were "swingers" in the 20's; adults in the depression; experienced officers in WWII. Their lives have bridged two cataclysmic wars and two tumultuous revolutions spawned by the wars. Now they have looked upon the Viet Nam incident and its aftermath—somewhat smaller but similar in impact to the two previous military and social disasters.

What do they have in common besides ears and years, canes and dentures, and cataract-dimmed eyes? They have survived—many with distinction and humor, some with dependency and complaint—but mostly by striving and attaining what they wanted, or learned to accept. And almost all had to work hard. Many have earned, won and then lost fortunes and savings. And what do they want now? They want to participate and to enjoy the good life—to let that perpetual thirty-ish person encased in that stiffening body be as socially active and appreciated today as they were or dreamed of being yesterday. They are aware of sharing a long and difficult time in history, struggling and coming out on top. They are willing to work and keep learning for that keeps them alive, but not too fast now, and on their own terms. They want to invest and look forward to tomorrow, but not too much. For most, their carefully planned retirement income is not inflated, but today's prices are. They seek advice when something goes awry, but they do not expect to follow it too slavishly, unless it directly concerns life support systems such as hearts or kidneys. They feel that they generally know their problems and what they must cope with, and they ask mostly for reasonable directions which they can carry out on their own terms. They must work to protect their financial investments, and they work likewise to preserve their physical strength and resources. They do what they can and what they want, and little else, no matter how good for them you say it is.

I have dwelt at length on these characteristics because we see them repeatedly in hearing aid evaluations and rehab groups. These strengths and resistances govern how much we can impose on or bring our elders in the days of Gray Panthers when they consider and verbalize their "rights" just as much as farm workers or other put-upon groups. Whether these

particular characteristics will be equally common in 2010 depends on whether the youngsters of today will have the same values and reactions. Those who are young at that time will still experience a generation gap. But by then, there may be in fact, no contact at all between the two age groups.

So, rather than pontificating and writing volumes of predictive analyses, I would like to see us encompassing new models, not old, with constant updating on the prevalent 60-70 year-old group. Many of us are in the 50's now. Which will *we* behave more like, our elders or our juniors?

Now a brief historical note on the nature of our course content and its development.

Those of you who have been presenting papers on the work in Illinois feel that you alone are blessed with having drunk at the fount of John O'Neill's guidance. For those of us just a little bit older, academically speaking, we knew him "way back when" he was at Ohio State, a young assistant professor following in the footsteps of Louis di Carlo and Marie Mason. I learned my tricks of the AR trade at that young father's knee. And when I was next to give courses in Aural Rehabilitation, it was at the Veterans' Hospital, San Francisco. I took over a routine begun and developed by Mark Ross and Charles Berlin as a once-a-week, twelve week course for veterans, most from World War II.

All the vets, many my own age contemporaries, had their audiological evaluations, had been issued aids, and those who still had difficulties or were severely impaired were then referred for AR. For those from great distances, one-week crash courses were also provided. I was guided through some materials left by my predecessors, and my vision of John O'Neill striding about the room, flicking noise from one speaker to another, and presenting lipreading sentences forward, sideways, some voice, no voice, listening, focusing and integrating information derived from partial cues in addition and vision; and that's what I strove to improve.

My own added interest stemmed from my dissertation and work in the probabilities of language segments, so I added this. As I learned more about psycholinguistics and details of generating sentences, I added this material. The familiar course outline went something like this:

1) A group of 6 to 12 or 15 meets, introductions are made around the table, and spouses are invited.

2) A statement of the problems of communication is made and listed on the board, with the quick discovery of the commonality of difficulties.

3) A discussion of individual hearing loss with audiograms. Basic explanations of frequency and intensity, and the implications of particular audiograms both medically and socially. Some discussion and under-

standing of speech perception, that is, threshold and comfort levels versus discrimination scores. The nature of their organic interference with the function of this system. An explanation of the communication model and where the break down had occurred—whether it was in the encoding, delivery, noise in the communication medium or transmission, or in the reception and processing end.

4) From there on various amounts of familiarization with phonetics, audible versus visible characteristics of sounds, words and sentences, and actual lipreading practice dealing with longer and longer segments. And finally the addition of noise and increasingly adverse listening and watching situations. All along the way, combined with this intellectual, didactic approach to the problem, a handy hints and lists of do's and don't's about "stage management" of the difficult situations were included. Each class session was an opportunity for direction in how to inform the speaker that he was not understood and how the listener could more effectively ask for repetition of the specific information he had not caught. "Speech Reading Reminders for the Hearing Impaired" was one handout, "Tips for Talking to the Hard of Hearing" was a take home for the family. An attempt at instant coping was made from the first session with the aim being gradual improvement in skills and adjustment to hearing handicap. For the veterans, I paraphrased the tagline of an old wartime joke—"when hearing loss is inevitable, relax and enjoy it."

This was the essential outline, which then spread with variation through the Bay area, at a cost of $30.00 to $50.00 per course, when pay was required. Margaret Fleming overlapped with me at the V.A., developed and carried on this essential program with the Hearing Society, San Francisco, back again to the V.A., modeling and changing it over the years as her own interests moved. From there courses became available around the bay at the Hearing Society, Marin County, San Francisco hospitals and to the East Bay where I moved; and Linda Begen and I carried this on separately and together in Berkeley. In each case the "course" characteristics varied with the practitioner—each person adding his or her own skills and interests, and changing group psychology techniques, but all of us striving for the same end point; that is, acceptance and understanding of one's own loss, mechanisms for dealing with it more effectively, including amplification, and being able to decode rapidly an imperfectly heard message under some adverse circumstances.

Two phenomena emerged very early. One was that with all groups a certain camaraderie developed. Within the group, the individuals worked on each other so that they became generally more relaxed and competent when they left than when they entered. The veterans were all good troupers, who worked together regardless of former rank. Those who

weren't dropped by the wayside rather early, but most came regularly, whether to the one-week, six-week, or twelve-week course. In addition, one pattern of learning appeared repeatedly. About halfway through the course, using the basic principles of good communication from the beginning, most of the people in the class caught on; they became fairly proficient in all skills. Then background noise was introduced. Two sessions later, or in an equal time proportion, they were exercising the same skills and could tolerate noise more easily. Once they learned to cope with competition, the rest was consolidation, really frosting on the cake, a sweet refinement of all skills, with the group achievement jelling. The final test usually showed some improvement in discrimination scores and speechreading to most clients' satisfaction. Long before this, the change in competency was evident to the leader, but not always clear to the patient. Closure and a fond farewell—a mutual parting occurred regretfully; the feeling was nice but not considered necessary, with the older women wondering what they would do with that time now.

The interesting point of the entire change was that it occurred about halfway through the course, regardless of the actual length of that course—at six weeks of the twelve, three weeks of the six, or Wednesday afternoon of the one-week mass training. There seemed to be a genuine "Aha!" experience of insight of what was required to reorient oneself to new needs of communication.

The consistency of this group experience combined with my other clinical experiences have persuaded me that a child learns to attend selectively in an over-stimulating world, and that by school age the normal child learns to be tuned in to the required message. Some storage of auditory and visual cues occurs, is filtered, and then responded to selectively so that too much noise no longer constitutes a mass of bewildering information. When that individual loses his hearing, the communication system becomes noisier, and he must relearn these early-developed skills. To deal more effectively with all these disturbing elements, he often needs amplification and those handy hints which constitute stage management. The better the defective system can be compensated for with amplification, the less re-learning is required. The same principles of learning behavior can be used with the very young, the very old, or the hearing impaired. The same good techniques of communication apply—adequate speech level, proper lighting, distance, topic orientation, etc., can be used with the aphasic, or with the young hyperactive child with learning disabilities. I so counseled families and professionals working with both populations. I long sat on my professional laurels and felt that I could adapt these principles anywhere, anytime, to any group. It is easier, of course, to group those with similar ages, severe losses or poorer intelligence, to prolong a course for the more handicapped or to shorten it for

the brighter. (IQ alone, we know, is not directly correlated, for empathy, anticipation and willingness to listen seem equally important.)

In the early days in the Bay Area, because of a general uniformity of cost and content, when an audiological evaluation uncovered a need for the additional aural rehabilitation, the patient was referred to the next most appropriate available course in his vicinity. Once a group was set, those people, especially the older ones, protected their investments. In addition to the processes described before, these groups were paying privately. They worried about every session missed. They had to learn what the teachers had to give, because they couldn't afford not to. When the going got rougher, with noise and competing talk in the background, exercises in cross-talk and question asking-and-answering, forced speech-reading and stage management, they were often left exhausted with headache and strain. BUT THEY CAME. They paid their money and they worked at it. They rode buses, arranged rides, came on time and left on time. Some complained at the end that they still weren't good lip-readers, but their improvement could usually be demonstrated and attested to by their friends in the class. Many read speech better than they knew and most agreed that they were getting along much better and were more comfortable with their losses and less fearful of their problems. At a time when these ARA meetings were filled with questions on how to attract people to AR, we were concerned with how to provide enough for the market.

During this time the big world had been changing. Violence had crept in to surround and invade us. Retirement communities proliferated, either the high rise towers or acres of condominiums had become the walled ghettoes of the aged. The residents were frequently infirm, unable or unwilling to stray too far and so the parent, protective companies arranged for the adult education departments of nearby school systems to provide the "Aural Rehabilitation" which was now often provided in the public schools at $4.00 a semester. The same enrollment fee permitted attendance in weaving, photography, French, How to prepare your own tax report, or flower arranging. The lower price also meant that a greater number of pupils was required. The courses ran once a week for a quarter or a semester. AR was very big in the San Francisco area.

But many of the people giving these courses were from speech therapy rather than audiology and related little to hearing loss or amplification. Although it was called AR it was really the old-fashioned Hearing Society lipreading meetings, but it was cheap and created a place to go and make friends. It filled social needs only. Instead of costing $30.00, $50.00 or $75.00, you could now pay $2.00 or $4.00. Furthermore, the class size had to be 15 to 30 rather than under 15, to pay for the teacher.

* * * *

For me, a professional change saw my return to the Veterans Administration, not at San Francisco, but in another Bay Area setting which had a higher proportion of inpatients in its caseload, and cared for men from the north and eastern remote parts of California who might be hospitalized for short periods and require many systems corrected during their stay. Audiological and Hearing Aid evaluations were often performed in one or two rapidly successive meetings. Earmolds had to be quickly adjusted, and orientation and followup—and all the learning skills developed within as much as two weeks for some or as little as 3-5 days for others. Return follow-up visits might be scheduled irregularly to coincide with other medical appointments. Family might or might not be present at any of these points.

Rehabilitation thus came to mean three stages to me, which must sometimes be accomplished in as few as three sessions: 1) aid fitting, 2) orientation and general principles, 3) skill development and aid/earmold adjustment or replacement. Because of their availability requirements, men and women at different stages of the process might be thrown together, with and without family, and all managed to work together in just the same way as had the other groups with their slower information. I learned how much more important aid and earmold adjustments are with the newer aids, and how quickly even a small group can attain that vital moment of insight and mastery. I at this point lost enthusiasm for the old, longer courses, except for those who could not use amplification at all.

When I next opened my own clinic practice, I used the same grouping schedule. A family member was always involved if possible in the aid selection procedure to help understand and confirm the selection in terms of discrimination scores, speed of response, voice quality, fit and/or ease of handling the instrument. A normal room with multiple speakers was used for additional orientation and after the selected aid was ordered, it was picked up. Then return sessions were scheduled for one week later and two weeks after that. People in the return schedule were grouped wherever possible, regardless of their point in the thirty-day trial period, because they learned so much from each other and evoked questions and comments which might not have arisen with the audiologist alone. A total of 6-8 hours spent this way was the norm for most of those under sixty-five, with many more return visits the rule for those over 75, mostly for reorientation on earmold insertion and some coping problems.

At the same time I was asked to teach an adult education type AR class in Rossmoor. I accepted reluctantly, hoping to educate this upper

middle class retirement community as to how easy hearing adjustments could be with the newer aids and approach.

* * * *

Rossmoor is a condominium, cottage/apartment village in the Diablo Valley. It is similar to many Leisure World-type of arrangements. Forty-five is the lower age cut off; late sixties is the median age. 30% of those 8000 people should have measurable hearing loss. In my three quarters there, 150 devoted souls signed up and paid their $4.00 for twelve weekly 2½ hour sessions. Vainly did I try to get them over to my clinic or another for a proper aid evaluation. Most had audiograms and workups from somewhere, but did not want to bother with both AR and an aid selection. I was back at the old stand—only worse.

We used the same old outline and lots of new materials. Explanations of basic principles and facts were often missed because of a sick spouse or a rainy day. Some people entered when the doctor suggested they come in, and found themselves in the midst of strange discussions and drills. Others left midway through because of a good cruise or Seniors' trip, and the promise of picking it up the next time around!

Some others stuck valiantly through everything up to the point where noise was gingerly introduced and then increased, until speechreading and questioning had to be used. One quarter a particularly good group seemed fast and secure, moving along with a good core of ever-present regulars in spite of ill spouses and a rainy winter. Background speech from radio and recorded TV programs was introduced on the third from last session. I asked them first to listen to the recorded interview to see how many of them could follow the speakers, some of whom had an accent. Then we began with competing speechreading with and without voice against the conversational background. It was hard work. Even the best listeners felt the strain. Half the class never returned.

My conclusion was that since their investment was minimal—patience extended only to what was pleasant. Had the course cost more, they would have stuck it out through every session, complaining about the noise but persisting. (In fairness to the group, which had seemed involved regardless of cost, I must admit that another taboo may have been ignored. The recorded interview itself, which I had made without listening carefully, had specifically to do with sexuality of senior citizens, including characteristics of arousal and endurance. Although nothing was said about this content, it may have been taken as a breach of good taste on my part, since this was a working group, not a friendship cluster. Certain members of this generation are much more candid about "intimate" matters than anticipated; others are much more private and

formal. Since the absent members never returned, I never found out which was the offense. In a true group this would have evoked some comment and been worked out.)

The next quarter, the class was large and varied, and to allow for the drop-ins, I delayed the usual beginning of introductions. The group formed slowly and evolved into one group of regulars and another of repeaters and occasional drop-ins. They got along well and worked well together, but didn't know much about each other. This time I slowly, carefully and selectively introduced background noise to everyone's tolerance. One day toward the end we focused activity on roundtable cross talk and conversation. We set up a "share and tell"—Who are you? What did you do? Where did you come from? When did you discover you had a hearing impairment? What in this class has been most helpful? What would you still like to get out of it for the rest of the quarter?

The session was a delight; everyone gave long fascinating monologues filled with details, worthy of Paddy Chayevsky dialogue. They were strong people who had struggled through depression and prosperity and moved mountains. They all felt the "Tips for Talking to the Hard of Hearing" handout was most helpful because they could involve their families in this program of mutual aid and understanding. The feeling of shared drama was intense; they used their skills well. It was an exhilarating session which almost compensated for the previous disappointment. Fifty percent of *that* magical group never returned—the love affair reached its climax and ended. Those who did return demonstrated their mastery by drilling on lipreading stories and crosstalk, and then vowed that they could hardly wait for next quarter to enroll again. Once the first group really communicated, it saw no need to continue. The others so loved that experience that they wanted it to go on forever, like bridge games or art class. A greater dollar investment would have given greater definition to their commitment—a real beginning, middle and end. Also, an additional aspect was that they were coming to a community recreation center rather than a clinic for help, and viewed the classes as optional fun rather than medically determined.

If these examples seem diffuse, let me bring together the major points. The present elders have this in common: 1) To a work-ethic generation, money is an obsession. An investment of dollars will be matched by an investment of time, if time is involved. They will demand some product in return, whether it is service, tangible goods, or a new skill. If they don't get their money's worth, they will complain, but they will protect the investment. If there is no investment, they will treat the whole idea as a peripheral, interesting experiment, to be entered into as long as it is pleasant. That is, if it is too difficult to teach the old dog this new trick, he or she will go on to another. There will be no complaint, but a disappear-

ance, out of politeness if they like you, out of disdain if they don't. 2) Old proprieties are easily offended. Too much contemporary talk and attitudes may be disturbing and insulting. The Leisure World residents came as conservators, although not necessarily political conservatives, to preserve a hard-won life style of manners. They gratefully abdicate many responsibilities to the management. They avoid the unpleasant when possible, for many had struggles and tragedies enough or have ill and disabled spouses now who cannot be left alone too long. In spite of apparent open friendliness, many individuals are anxious, tense and under constant strain. In class then, they learn slowly and forget easily, because—in addition to their age—their attention and involvement is minimal.

I am firmly convinced that rapid learning and change can only be accomplished if the retirement resident leaves the village to seek help and spends a reasonable amount of money, time and energy to attain a new skill. Minimal expenditure yields minimal results. I am also convinced that improved amplification should be tried before or at the same time as the classes, not after, since many questions of management can be asked at that time. For this reason an audiologist and the connection to a center rather than a speech pathologist from a school system is the aural rehabilitationist of choice, unless the two work closely together. This is a paramedical clinical service as well as a social or educational pastime. As in other physical problems, each afflicted population must be examined anew; as pharmacology has altered epidemiology, so we must be prepared to reexamine each affect group and adjust the treatment to their needs. Because the frightened villager does not leave his ghetto, we must devise more enticing prospects, like any other vendor.

The next thirty years may bring a very different kind of customer for our product. For now, the retired affluent or semi-affluent person must be reminded that he gets what he pays for. Even in a service such as aural rehabilitation the hearing impaired must buy a product, and we must deliver one.

APPENDIX I

TIPS FOR TALKING TO THE HARD OF HEARING

1) Face the hard-of-hearing person directly, on the same level with him whenever possible.
2) See that the light is shining on the speaker's face, not in the eyes of the hard-of-hearing person.
3) Be aware of the possible distortion of sound for the hard-of-hearing. He may hear you, but still have difficulty understanding some words.

4) Do not talk from another room; if you must, make sure the person has heard you call him and tell him what room you are in.
5) Recognize that everyone, especially the hard-of-hearing, hears less well and understands less when he is tired or ill.
6) Speak in a normal fashion without shouting, or elaborately mouthing words. Words spoken a bit more slowly, not run together too rapidly, are clearer than those which are shouted and exaggerated.
7) Keep your hands away from your face while talking. If you are eating, chewing, smoking, etc., while talking, your speech will be more difficult to understand.
8) If a person has difficulty understanding some particular phrase or word, try to find a different way of saying the same thing rather than repeating the original words over and over.
9) Avoid talking too rapidly or using sentences which are too complex and go on too long. Slow down a little; pause between sentences or phrases; wait to make sure you have been understood before going on.
10) If you are giving specific information, such as time or place, be sure it is repeated back to you by the hard-of-hearing person. Many numbers and words sound alike!
11) Avoid sudden changes of topic. If the subject is changed, tell the hard-of-hearing person, "We are talking about ——————— now."
12) The hard-of-hearing person may be very sensitive to loud sounds, even though he does not hear faint ones. This reduced tolerance for loud sound is a freqent occurrence in impaired hearing.

APPENDIX II

SPEECHREADING REMINDERS

1) Remember the four points for better speechreading:
   Concentrate on the thought rather than individual words.
   Do not interrupt the speaker until he has finished.
   Observe expressions, gestures, and the face of the speaker.
   Relax while you are speech reading. Do not strain.
2) A combination of hearing and seeing enables you to understand most speakers readily. Watch the speaker carefully so that you can see his total expression because it will give you a clue to what the speaker is saying. Don't concentrate on the speaker's lips alone. Look for ideas rather than for isolated words.
3) Inform the speaker that you are hard of hearing. Many people are embarrassed because they have no idea of how to talk with the wearer of a hearing aid or with a speechreader. Put them at ease and

assure them that quiet, natural speech is their greatest favor to you. Exaggerated lip movement and shouted spech is very difficult to understand.

4) Educate your friends and family to speak to you only in the same room and after they have gotten your attention.
5) It is always polite to look at the person who is talking to you. Don't be afraid that people will think you are staring at them while you are speechreading.
6) Try to determine the topic under discussion as quickly as possible. Friends can be coached to give a lead unobtrusively, such as "We are discussing the housing problem." Or, perhaps you can quietly ask someone in the group to tell you the subject under discussion.
7) If you ask for repetition, try to state first what you understood and ask what you missed. This will help the speaker to repeat more slowly and clearly what was difficult the first time and will make repetition of an entire statement unnecessary. Don't bluff!
8) Maintain an active interest in people and events. Knowing about national and world affairs, as well as those of your community and friends, will help you to recognize current vocabulary and follow any discussion or conversation more readily.
9) Try to stage manage the situation to your advantage. Since lighting is important, avoid facing a bright light, and try not to allow the speaker's face to be shadowed. Keep about six feet between you and the speaker so that you can observe the entire situation. Sit with the speaker on your better ear side. Then face him rather than just turning your ear toward him.
10) Watch your own speech. Because you have a hearing problem, you do not always hear correctly what people are saying; therefore, you have a tendency to drop the ends of your words or to slur your words. Don't let your own speech become sloppy. Be aware of words that end in s, z or t.
11) Remember that conversation is a two-way affair. Do not monopolize it in an attempt to direct and control it.
12) Don't get into the habit of mouthing words or the sounds that you are seeing.