

Commentary on *The Psycho-Social Impact of Hearing Loss in Everyday Life: An Anthropological View*

Commentaire sur L'impact psycho-social de la perte auditive dans la vie quotidienne : perspective anthropologique

Patricia Bender Kricos

University of Florida, Gainesville, Florida

The contents of the December 1994 issue of the *Journal of Speech-Language Pathology and Audiology* were refreshing to read. As someone with a long and avid interest in both audiologic rehabilitation and the professional education of audiologists, I found the various discussions of the psycho-social impact of hearing loss in everyday life to be lively and timely, with numerous implications for the direction that the audiology profession needs to take, as well as for the educational preparation of audiology practitioners. The anthropological perspective contributed in this issue encourages us to manipulate everyday contexts to reduce handicap, rather than treating the individual with a hearing impairment in isolation. Accordingly, Pichora-Fuller and Kirson's taxonomy of problem sources in understanding speech serves as a beacon as the field of audiology undergoes transformation in its preferred practice patterns. Their list of problem sources considers all aspects of everyday communication and stands in sharp contrast to the audiologist's usual armamentarium of clinical tools such as nonsense syllables, phonetically-balanced word lists, and speech-reading tests that consist of unrelated sentences presented in the absence of sound. I was self-congratulatory until I read this issue, that I at least had the good sense to include "significant others" (usually spouses or children of the individual with a hearing impairment) in my hearing aid orientation programs for older adults. But Pichora-Fuller and Robertson inform me that that is not enough, that I must (and I agree) take an even broader view of communication partners. Significant others may include the bus driver from whom directions are solicited, the minister, or the librarian.

There seems to be a renewed interest in audiologic rehabilitation in recent years. This renewed interest may be due, in part, to the fact that the majority of audiology practitioners are now involved in the dispensing of hearing aids (in sharp contrast to the situation less than 20 years ago) as well as to the recent explosion of technological advancements in the field. The cochlear implant, a wide array of assistive listening devices, sophisticated real ear gain measures, laser videodisk applications, and digital

signal processing hearing aids have generated a renewed interest in the area of audiologic rehabilitation. Although these technological breakthroughs have refocused audiologists' attention on the rehabilitation aspects of audiology, they may also undermine the success of our services to persons who are hearing impaired. Too narrow a focus on the technical aspects of audiology - on the machines, devices, and objective tests that we now have at our disposal - may cause us to lose sight of our original goal: to help the person with hearing impairment. Before we become totally absorbed with our precise measures of, for example, real ear gain, we must consider whether the parents of the child we are fitting emotionally accept the child's hearing impairment. Before we convince administrators of long-term care facilities of the need to equip their facilities with state-of-the-art assistive listening devices, we must ascertain that the nursing home resident has the motivation to communicate better as well as the availability of satisfactory communication partners. We must ask whether the resident's refusal to try our array of devices is due to "denial" or, as Pichora-Fuller and Robertson suggest, to "successful aging". Before we become over-zealous with the wide range of laser videodisk applications becoming increasingly available, we need to consider the level of concern, patience, and support exhibited by the hearing-impaired person's communication partner. Before fitting the adult with a hearing impairment with the latest, most sophisticated digital signal processing hearing aid, we must ask ourselves what our client's expectations are for the outcome of the fitting. McCormick et al. and Getty and Héту also suggest asking how the stigma the client associates with hearing loss may increase after the hearing aid fitting, which in turn may affect coping abilities. The technological advances in audiology are exciting, but they have posed a number of challenging issues for the profession of audiology and for university education programs specifically.

Chief among the issues for university education programs is the need to instill in students a healthy balance between technology and more humanistic concerns, such as the

psycho-social aspects of hearing impairment discussed in this issue of *JSLPA*. Too many education programs have emphasized a medical model of patient management, one in which the focus has been on the impaired ear rather than the person with a hearing impairment. In the medical model, a person receives a hearing test and is given a cursory explanation of his or her hearing difficulties based on the audiometric results followed by a recommendation, perhaps, to purchase a specific hearing aid arrangement. It has been a one-sided affair, with little input obtained from our clients regarding their views. An over-confidence in our increasing technology could worsen the situation even further. It will be critical, then, for university programs to strive for a balance so that graduate clinicians are as comfortable in personal interactions with their clients as they are with the technical aspects of their field.

To achieve this goal, appropriate role models will be essential for graduate clinicians. The opportunity to observe practising clinicians must be available and the clinical experience must be extensive to ensure absorption and refinement of the interpersonal skills and attributes modeled by master clinicians. The current requirement of 300 contact hours for certification by the American Speech-Language-Hearing Association (350 hours for CASLPA certification) represents less than eight weeks of experience, hardly an adequate time frame for acquisition and honing of the technical and interpersonal skills necessary to practice audiology.

A major challenge facing university programs will be recruiting students who have the backgrounds necessary to both apply highly technical information toward solving the communication problems of the person with hearing impairment, and effectively interact with the client. University audiology programs need to engage in competitive recruitment efforts to attract top-notch graduate students from undergraduate disciplines such as pre-medicine, business, and the basic sciences. These students then must be taught, by their audiology mentors, to use their knowledge to engage in meaningful dialogue with their clients with hearing impairments so that joint problem-solving can be accomplished.

Another challenge facing university education programs is the need to foster in students the attitude that audiological rehabilitation is an indispensable part of the hearing-impaired person's total treatment program. That is, treatment begins, not ends, with the provision of hearing aids. The audiology major frequently participates in practica in which groups and/or individuals receive comprehensive hearing aid orientation and counselling. Yet, too frequently upon graduation, this type of programming is abandoned in the audiologist's dispensing practice. It is incumbent upon

university education programs, therefore, to develop and involve students in service delivery models that are economically feasible in the private sector, as well as to instill in the audiology student the irrefutable notion that every new hearing aid user needs and will benefit from an organized program that goes beyond a cursory explanation of how to use the hearing aid.

Audiological rehabilitation (previously referred to as "aural rehabilitation") has become a vague and ill-defined entity, connoting images primarily of lip reading and auditory training in some minds, and hearing aid fitting in others. Its demise is ironic given that it was the rehabilitation component of audiology, following World War II, that gave rise to the field. As we sit on the cusp of a new century, it is encouraging to see that a redefinition of audiological rehabilitation is emerging. Graduate students in audiology are increasingly being exposed to a much broader definition of audiological rehabilitation, one which goes beyond lip-reading and auditory training to include components such as psycho-social aspects of hearing impairment, hearing aid orientation, cochlear implants, vibrotactile aids, programming for significant others, and tinnitus rehabilitation. Two recent articles in the *Journal of the Academy of Rehabilitative Audiology (JARA)* are indicative of the changes in and redefinitions of audiological rehabilitation that are emerging. Erdman, Wark, and Montano (1994) delineated the implications of service delivery models on treatment outcomes, such as patient satisfaction and compliance and treatment efficacy. They described service delivery models as being characterized, in large measure, by the communication patterns between service providers and service recipients. Contrast, for example, the "one-way" communication typically found in the medical model of service delivery with the interactive communication that would occur in a rehabilitation delivery model. Erdman and her co-authors pointed out the success of audiological rehabilitation, post World War II, in military rehabilitation centres when the focus was on the *person* and what it meant to live with hearing impairment. When emphasis shifted focus to the *impairment* (i.e., diagnosis), there were less successful outcomes and, consequently, fewer people with hearing impairments seeking the services of audiologists. Erdman et al. (1994) urged audiologists to put the emphasis back on communication and psycho-social and behavioural effects of hearing loss and to achieve some balance in the diagnostic and rehabilitation coursework in our educational programs. In a second *JARA* article, Gagné, Héту, and McDuff (1995) suggested the need for increased emphasis on problem solving in audiological rehabilitation, with the patient involved in goal setting.

This expanded definition of audiological rehabilitation has, of course, resulted in the identification of additional areas

that need to be covered in the graduate audiology curriculum. In view of the prevalence of hearing problems in the older adult population, it is desirable for audiology students to have gerontological coursework included in their education programs. Indeed, at a few universities in the United States, graduate students in audiology are encouraged to obtain a Graduate Certificate in Gerontology, wherein a set number of interdisciplinary courses are taken, such as Psychology of Aging, Counseling needs of Older Persons, and Biological Aspects of Aging. At the other age extreme, authorities in the field of audiology have repeatedly lamented the lack of training in paediatric audiology, particularly in the area of parent counselling. Add to this the need for marketing savvy (especially since it is estimated that only about 10 % of the elderly who might benefit from hearing aids actually own them), and knowledge of government/legislative issues so that today's student becomes tomorrow's practitioner who can effectively lobby for and obtain third party payment for audiologic rehabilitation. The list goes on and on.

Given the increased curriculum needs evident for graduate study in audiology, a re-organization of the audiology curriculum in the university seems essential. Coursework in gerontology, counselling, professional ethics, business management, assistive listening devices, and marketing, to name but a few, needs to be infused into the existing curriculum. Those of us in university settings, however, are keenly aware that adding coursework to an already tight, two-year master's program requires that something else be dropped, lest a four-year master's program evolve. The debate and discussion (and implementation in the United States) of the Doctor of Audiology degree (AuD) come at an opportune time for addressing these curricular issues.

In summary, the December 1994 *JSLPA* special issue directs our attention towards the everyday milieu of the person with hearing loss. Instead of focusing on the *client* who presents in our clinic with a hearing problem, we are directed to focus on the person's everyday life, having, as McKellin eloquently states it, a dialogue with the person about "access to the soundscapes of everyday social situations" (p. 212). This problem-solving orientation to the everyday problems, dilemmas, and experiences of individuals with hearing impairments is more likely to result in the audiologist truly deserving to be considered the hearing care expert and a crucial resource for the hearing-impaired population.

References

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Editor's Note: These commentaries were invited by the guest editor of a special issue of *JSLPA* entitled "The Psycho-Social Impact of Hearing Loss in Everyday Life: An Anthropological View". They were not submitted to the peer-review process.