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# Group Audiologic Rehabilitation for Adults and Their Communication Partners

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*"What's the worst thing about having a hearing loss?"*

This question is the basis for a group audiologic rehabilitation (AR) exercise described in *Hearing Rehabilitation for Deafened Adults: A Psychosocial Approach* (Hogan, 2001). This seemingly simple question helps group AR participants face the psychosocial effects of hearing loss and helps remove obstacles to successful audiologic rehabilitation.

At the University of Louisville, we use this exercise in all of our AR groups. The leader asks the question and then moderates a discussion. The AuD students who lead these programs are typically intimidated at the thought of leading an AR session, particularly this exercise. Most often students are concerned that the group members will choose not to participate and the leader will face a silent and unproductive assembly. Some are worried that group participants will bring up difficult topics and strong emotions. The students' fears of difficult group experiences, however, are usually unfounded.

When the leader asks, "What's the worst thing about having a hearing loss?" the responses are typically what we would expect: "I don't like to go to restaurants to meet my friends," "I have difficulty using my cell phone," or "I am concerned about my job because I have trouble following the conversation in large meetings." When someone speaks up with a problem or an emotion, the group leader writes it on a whiteboard and asks the participant to expand on the problem (e.g., "What is it like for you when this happens?") or may ask if others in the group face similar problems. Discussion is usually unforced and supportive. Participants are eager to share their difficulties; others in the group are quick to empathize and share similar tribulations. Often group members share humorous examples (e.g., "I have difficulty understanding what people say on the party bus to the University of Louisville football games" or "I find that people don't speak very clearly when they have been drinking") and this humor adds to the camaraderie.

Ironically, I am the one who typically has difficulty leading this exercise. When participants raise problems, my first impulse is to try to solve them with assistive technology or communication strategies. But solutions are not the purpose of the exercise. Rather, the purpose is to enumerate the difficulties associated with hearing loss and to demonstrate that the

participants are not alone in facing these problems (Hogan, 2001).

Most individuals know that hearing loss causes communication problems, but they may not realize the broad range of typical psychosocial reactions (Trychin, 2002). Individuals may experience frustration, embarrassment, anger, and depressive symptoms as a result of hearing loss, but may not realize or may choose not to acknowledge these unpleasant feelings. People with adult-onset hearing loss often feel stigmatized by shame or disgrace associated with hearing impairment, a condition that often is regarded as socially unacceptable (Hetu, 1996). As a result of this stigma, individuals are often unwilling to use hearing devices, or communication strategies. When group participants learn of others' hearing-loss difficulties, they may begin to recognize their own experiences and feelings. Acknowledging hearing loss and the associated feelings and problems helps to alleviate the stigma and is often necessary for successful audiologic rehabilitation.

## Group Activities

A group AR class typically provides a mix of activities, including communication strategy training, speech perception training, informational lectures, psychosocial and stress reduction exercises, and group problem identification and solving (see [Table 1 \[PDF\]](#)).

Communication strategy training may focus on different topics and take several forms. Together as a group, class members may try to solve communication problems revealed in the "What's the worst thing about having a hearing loss?" exercise. The result is often a discussion of anticipatory or repair strategies. This type of exercise also is an example of group problem identification and solving. Alternatively, more structured communication strategy exercises may include participants offering anticipatory strategies to situations described on a worksheet. Or group members may be asked to listen to specific sentences or stories and use repair strategies to ensure correct understanding of the material. These exercises can be used to role-play communication strategies in a supportive environment, an activity that is especially useful for individuals who do not feel comfortable using these strategies in daily life. (See sidebar on p. 16 for a sample communication strategy exercise.)

There is variety in psychosocial exercises as well, including short prompts (e.g., "What is the worst thing about having a hearing loss?") or discussion of a particular scenario. We often use the scenario of "You know I can't hear you when the water is running!" that describes an encounter between a husband with hearing loss who is washing the dishes and his wife and daughter, who become increasingly frustrated as a result of their communication breakdowns. (After reading this scenario, I often have had participants ask, "Did you have a tape recorder in my kitchen?")

After introducing the scenario, we ask open-ended questions: How does this situation make you feel? What do you do when this happens? How does this affect your communication partners? Instructors conducting psychosocial training exercises receive a one-page guide that includes the prompt, the expected responses, and questions to generate discussion.

AR group leaders may give presentations on topics not explored in the typical audiology encounter because of time constraints. A favorite topic of class members is assistive listening devices. For example, the leader can present a 10-minute talk on how to select a cell phone, or where to find and how to use rear-window captioning. Typically these are not lectures, but demonstration and discussion.

Some AR group leaders choose to include stress reduction exercises in their classes. In these exercises, the leader points out that people with hearing loss have to expend energy to focus and concentrate to understand speech, and that this heightened level of listening effort can be stressful. Group members can discuss the positive (and negative) ways in which they cope with stress. Exercises such as these reinforce the concept that group members are not alone in their struggle with the psychosocial effects of hearing loss.

## **Benefits**

Research has consistently shown the benefits of group AR. For example, individuals who participate in group AR show better psychosocial outcomes (e.g., hearing-loss-related quality of life) in comparison with control subjects (Hawkins, 2005). Additionally, group AR participants have lower hearing-aid return rates as compared to non-participants (Northern & Beyer, 1999). At the Audiologic Rehabilitation Research Lab at the University of Louisville, we have been examining what types of class content result in the best outcomes. We found that speech perception training—specifically speechreading training and auditory speech perception training—does not result in improved speech recognition as measured by tests of auditory-alone or auditory-visual speech perception. However, many individuals who participate in AR classes that include only speech-perception training exercises still demonstrate improvements on hearing-loss-related quality-of-life scales. Additionally, the majority of these AR participants report their auditory and visual speech perception skills improve following this training (when, in fact, there is no evidence of improvement when measured under controlled conditions; Preminger & Ziegler, 2008). As a result of these findings, we recommend that group AR time be spent on communication strategy training that emphasizes the importance of speechreading (such as the exercise shown in the sidebar at right), and not on specific analytic or synthetic speech perception training.

In a separate experiment we evaluated the effectiveness of three types of training: communication strategies training, psychosocial activities, and informational lectures. Session content had a small influence on outcomes; however, there was evidence that sessions with psychosocial exercises resulted in the best outcomes on measures of hearing-loss-related quality of life (Preminger & Yoo, 2010). That is, larger effect sizes were measured from participants who took AR classes that included training or information plus psychosocial exercises, as compared to participants whose classes included only training or information. We recommend, therefore, providing classes that provide a mix of content (see Table 1), particularly activities that focus on problem management (communication strategies training, informational lectures, and/or identifying and solving problems) and managing one's emotional response to

hearing difficulties (psychosocial exercises and/or stress reduction). Research from our laboratory (Preminger & Yoo, 2010) and from other fields suggests better outcomes when both problem-solving and emotional coping activities are used (Duangdao & Roesch, 2008; Lazarus & Folkman, 1984).

## Communication Partners

Additional research at the University of Louisville has focused on including communication partners in the AR group. One study evaluated the benefit of including communication partners in a typical AR group experience (Preminger, 2003). Communication partners actively participated in communication strategy training, speech perception training, and informational lectures and discussions. The results showed that all adults with hearing loss benefited from the AR program; however, individuals who participated along with a communication partner demonstrated significantly more benefit on a measure of hearing-loss-related quality of life than individuals who participated alone.

More recently we wanted to determine whether separate classes for communication partners (spouses, in this particular study) were a useful addition to the group AR experience. Two groups of individuals with hearing loss participated: one group participated in group AR while their spouses participated in a program designed for communication partners, and a second group completed the group AR program while their spouses received no attention (Preminger & Meeks, 2010). The class for spouses used traditional AR activities that were modified for people without hearing loss. For example, spouses were given earplugs to use while the group leader read stories aloud in a noisy environment. The leader read the first story from the hallway and the second story in the room with the spouses. This exercise was designed to demonstrate that spouses need to be in the same room when they want to communicate with their partners.

We also used modified psychosocial activities. While the AR participants were discussing "What's the worst thing about having a hearing loss?" their spouses were in a different room discussing "What's the worst thing about living with someone who has a hearing loss?" Some comments were expected, such as, "It's frustrating to have to repeat what I say all the time," "The TV is too loud," and "He never wants to go out with our friends." We also heard more unexpected comments, such as "I am concerned about her safety when she travels; she would not hear the smoke detector in a hotel room" and "I am concerned about his safety when I travel; he cannot hear the tornado warning signal."

Through these discussions and activities, spouses learned that the difficulties and problems they experience related to their partner's hearing loss are typical and expected. The most important outcome of this study is that following the treatment, the experimental group couples (in which both members completed AR programs) showed greater congruence in hearing-loss-related quality-of-life scores than control couples (only the person with hearing loss completed an AR program; Preminger & Meeks, 2010). Future research can determine whether greater understanding of hearing-loss-related quality of life in spouses leads to more effective

communication techniques.

## Feedback

Following their participation in group AR, we expect that people with hearing loss will feel more empowered to practice good communication strategies or may have a more positive outlook regarding their communication difficulties. We believe that this outcome is due, at least in part, to the skills that they learned in class and their improved emotional coping skills.

After the study that included AR programs for spouses, for example, we received an unsolicited letter from a spouse of an individual with hearing loss: "On our trip back from Florida this weekend, J and I were discussing the communication classes. I told him I notice his hearing seems to be less of a problem. After the classes with you, he seemed to relax about his hearing problem ... that made us both feel better. He seems to hear more because he's not stressing about what he hears and doesn't hear. He has been more social when we're out with friends, although background noise is still a problem, but he interacts more than he did."

More research about the design of effective group AR programs is needed. We need to learn if patients with specific characteristics show more benefit from participation than others. For example, do new hearing-aid users receive more benefit from group AR than experienced hearing-aid users? Do poor communication-strategy users gain more benefit than good communication-strategy users? We need to determine the best schedule for groups: how many sessions, how often, and how long for each meeting. We need to know the best way to combine individual home-based training (e.g., auditory training on the computer) with group AR. In the meantime, we know that group AR is beneficial to individuals with hearing loss and their communication partners.

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