



It Takes a Village: Lessons in Group Aural Rehabilitation Therapy

By Aaron M. Roman

Every Tuesday around 2:15 pm, a clamor of voices can be heard outside of my office.

These are not the voices of students, excited to end their school day, nor are they the voices of my faculty co-workers, filling their coffee mugs. Instead, these voices come from the six individuals that consist of the weekly group aural rehabilitation session. These six individuals come from a variety of backgrounds, with a diverse arrangement of hearing impairments, but all share one common goal—to improve their hearing beyond what their current situation provides.

As anyone who has worked with the hearing-impaired population is aware, there is no magical switch when it comes to hearing loss. Activating a cochlear implant after years of long-term hearing loss does not restore hearing to normal levels, nor does simply wearing a well-programmed pair of hearing aids. Instead, listening improvement occurs with time, acclimation,

patience, and, most importantly, persistence. In this article, I will outline the most important takeaways that I have learned through administering weekly group therapy. It is my hope that you may learn from where I stumbled.

Lesson #1: Developing (Measurable) Goals Is Hard

One of the most important lessons that I learned as a relatively recent graduate from my doctorate program is that the best way to ensure success is to develop realistic, measurable goals. As audiologists, we have a continually growing number of subjective questionnaires at our disposal, which can successfully assess individual performance. Using these questionnaires with a setting of six patients, however, has repeatedly proven a difficult task.

Having no access to the one, perfect questionnaire, my team begins group therapy by administering

the Patient Expectation Worksheet (PEW) to each individual at the very beginning of the therapy semester (group therapy is provided each semester), to assess the range of expectations within the group. Developing realistic expectations for therapy outcomes is essential for any intervention protocol, and helps create a strong initial dialogue with the patients involved (Palmer and Mormer, 1999).

The PEW allows the patient to reflect on individual goals and score their personal success in each situation from “Hardly Ever” to “Almost Always.” All of the PEWs were reviewed and the communication goals were divided into the following five categories:

1. Speech Reading
2. Lip Reading
3. Repair Strategies
4. Social Participation

5. Listening Effort

These categories were used to develop goals and activities targeted throughout the semester.

At the end of the semester, the communication goals set down by the patient were individually reviewed and re-scored. Overall, patients demonstrated improvement in four out of the five categories, with Speech Reading alone showing no change over the semester.

Lesson #2: Developing the Group Takes Time

In any group therapy setting, the clinician is exposed to a variety of patient personalities with diverse backgrounds. As you will see from the Hearing Handicapped Inventory for the Elderly (HHIE) scores, we had participants who demonstrated significant handicaps with a range in severity. Impact of hearing impairment, however, is not the only factor that make this group diverse.

For example, our recent group consisted of both men (n=3) and women (n=3), included ages ranging from the mid-60s to the mid-80s, and included both hearing aid users and cochlear implant users. All of this leads to the obvious fact that expectations from patient to patient were different, as was perception of relevance, depending on the task. Each individual patient involved in the group therapy sessions completed the HHIE (Ventry and Weinstein, 1982) prior to enrollment in the therapy. The average social and emotional handicaps of the group was 68 percent and 64 percent, respectively. For overall handicap, the group reported a 66 percent handicap overall, with scores ranging from as low as 56 percent, and as high as 100 percent handicap.

Those administering group rehabilitation should be pleased to read

that evidence suggests that as time progresses, members of the group tend to be more cohesive (Macnair-Semands and Lese, 2000), and my experience supports this finding. As the semester progressed, those who were initially more vocal, yielded to those more reserved. Individuals from within the group also began sharing their own insights and information that facilitated meaningful discussion. It was the supervising audiologist's job to ensure that the information was correct.

Lesson #3: One Size Does Not Fit All

The largest hurdle in group aural rehabilitation is developing effective goals that address the needs of the groups. Harder still is developing activities that appropriately move the entire group towards these goals.

Using the measurements discussed in Lesson #1, my team had goals and now had to develop ways to meet them. As audiologists, we are more than well-aware of the benefits of customized treatment. In hearing aids, we use real-ear measurements to customize the amplification to the ear. Treating a group in aural rehabilitation is very much like generalizing the measurements of one ear to a group. So how do you make effective activities?

According to a study by Boothroyd (2007), an effective aural rehabilitation program should have four components:

1. **Sensory Management**—addressing deficits in functionality. For audiology patients, this usually entails hearing aids and/or cochlear implants, although other sensory devices, such as alerting devices and assistive listening devices, could be applied in this area.

2. **Instruction**—discussing the use of the sensory management technique. This can include care and maintenance of the hearing aid/cochlear implant, and can also go so far as when to use certain device settings, or discussion on directional microphones or signal-to-noise ratios.

3. **Perceptual Training**—programs that are developed to target specific goals (i.e., “hearing in noise”). This is heavily focused on during group sessions. Perceptual training programs may include speech reading, working memory training, or listening-in-noise tasks.

4. **Counseling**—discussion of quality of life (QoL) impact to the individual and/or the group. Counseling can focus on emotional attributes to hearing impairments, or be educationally-driven in which the audiologist provides information about the hearing system and the impact of hearing loss to the physical body. Beyond hearing loss alone, evidence suggests that educational counseling can be extremely beneficial in counseling patients with tinnitus (Henry et al, 2007).

In the group setting, activities and goals generally focus on the later three components of Boothroyd's design. To address the individuality of the patient, it might be necessary to provide extra “homework” to individuals within the group. This homework may be informational in nature, such as doing additional research on assistive devices, or more based on training such as listening training software.

Lesson #4: Social Interaction Can Be Powerful Medicine

Remember that clamor of voices? One of the most beneficial rewards to observe as a clinician is the social growth of six persons with hearing loss. It is well established that hearing loss is linked to social isolation (Mick et al, 2014) and poorer QoL measurements (Ciorba et al, 2012). Thus, the social interaction of individuals with hearing loss can be beneficial by itself.

In the context of a group therapy setting, patients that participate develop a bond that allows them to share ideas, experiences, and set-backs. They teach each other self-advocacy skills, link them to other members in the community, and provide a canvas that each patient can use to comfortably discuss their situation that a clinician alone may not be able to provide.

One other benefit observed during group therapy was in the inclusion of significant others. Evidence shows that, in situations where group therapy members bring a significant other, both the patient and the significant other benefit (Habanec and Kelly-Campbell, 2015). In the therapy I supervised, the significant others brought about interesting topic discussions that even the patients did not bring up.

Onward and Upward: Where to Go From Here?

As audiologists, it is our job to ensure that patients function at the top of their listening ability. While the benefit of aural rehabilitation programs to help reach this goal is apparent, the current health-care climate is not supportive from a billing and scheduling perspective. It is my hope that through sharing my experience, you can reflect on your patients and

can begin to develop ideas on how to best serve their needs.

Moving forward, more research in the field of aural rehabilitation, particularly group aural rehabilitation, is needed to demonstrate the importance of this activity on patient outcomes. Through this research, the construction of outcome measurements specific to group therapy would be extremely beneficial to clinical practice. Furthermore, implementing group therapy will not only provide a much-needed benefit to those in the hearing loss community, but will provide visibility to the profession of audiology and the continued development of our field. 

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