

A Peer Mentor Training Program for Aural Rehabilitation

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This article describes a new training program at Gallaudet University that aims to prepare peer mentors to work under the supervision of hearing-health professionals in the area of aural rehabilitation (AR). The paucity of AR programs for consumers with hearing loss in the United States has been documented. The peer mentor training program is an attempt to harness the energies, skills, and knowledge of people with hearing loss; to expand them through a program of academic and experiential learning; and to put them to work in audiologic practices and other

hearing-health care settings in order to improve the quality and quantity of AR available to consumers. A peer mentor training curriculum is described, and the current status of the educational program is reported. Initial anecdotal evidence suggests that the program has the potential to contribute to the development of a more comprehensive model of AR service delivery.

Keywords: mentoring; hearing loss; aural rehabilitation; training

Ross's¹ definition of aural rehabilitation (AR) is "any device, procedure, information, interaction, or therapy which lessens the communicative and psychosocial consequences of a hearing loss." AR is available through most audiology clinics and other facilities where certified audiologists dispense hearing aids. Structured, formal AR programs have consistently been shown to be effective and beneficial for people with hearing loss, improving audio-visual speech recognition performance, psychosocial functioning, and reducing hearing aid returns²⁻⁷; however, the scope of AR is often limited. The primary emphasis is usually on the use of technology and is predominantly informational, focusing on how a hearing aid works and troubleshooting simple problems with it. In most programs, far less support is provided for the development of communication skills and strategies

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or to help with the psychosocial adaptation to hearing loss.^{8,9} A survey of audiologists conducted in 1990 indicated that only 23% were providing communication training such as speech reading and auditory training; this was a decrease from 38% in 1980. A more recent survey of 275 American Speech Language Hearing Association (ASHA)-certified audiologists was conducted by Millington in 2001.¹⁰ Although 92% of the respondents reported providing "general counseling" and 60% provided counseling that was described as "adjustment/support counseling," the nature of the counseling provided was not clear from the survey. Almost 92% of the respondents reported providing "general communication training"; however, only 23% of the sample said that they provided auditory training, and 12% reported providing speech-reading training.

Carmen¹¹ recently described the results of an online survey of audiologists. Of 217 respondents, 85% reported dispensing hearing aids, but only 24% reported that they provided "AR classes." Sixty-five percent reported that they provided "therapeutic counseling," which was defined as "helping patients overcome the emotional influences caused by hearing loss." Another recent survey of audiologists⁹ (110 respondents) about the frequency of provision of AR services revealed that although audiologists frequently provided information about assistive listening

devices (ALDs); (84%), communication strategies training (83%), and informational counseling (82%), they less frequently provided information about coping strategies (57%), psychosocial adjustment (45%), and partner training (38%). The most neglected areas of AR were auditory training (about 18% provided services) and speech reading (only about 6% provided services). Of perhaps greater interest is the format of service delivery reported: an informal approach was used 66% of the time. Although a very small percentage reported providing group AR services (5%) or a combination of individual and group sessions (16%), these were provided informally in all cases but one.⁹

This picture of inattention to many aspects of AR is confirmed by consumer surveys. The Rehabilitation Engineering Research Center on Hearing Enhancement and the Rehabilitation Research and Training Center for Persons Who Are Hard of Hearing or Late Deafened¹² surveyed 942 consumers about the provision of hearing aid related services. Many of the questions posed in the questionnaire used in that study related to AR services. As Stika et al noted, "Neither audiologists nor hearing instrument specialists did a very good job in conveying information about T-coils, directional microphones, and other types of hearing assistive devices."¹² AR services, so important to successful outcomes when matching people with hearing loss to technologies, are clearly not being adequately delivered.

These surveys seem to indicate that the profession of audiology has moved away from a formal, global approach to the provision of AR services to an approach that is informal and less comprehensive. Furthermore, the focus of current rehabilitation services appears to be informational (the use of technologies in the context of strategies to enhance communication) to the detriment of addressing psychosocial issues (adjustment and coping in the context of the family) or communication skills (speech reading and auditory training).

The Hearing Loss Association of America published a position article on the issue of Group Hearing Aid Orientation Programs in which they recommended that hearing aid dispensers make such programs available. While not presuming to define the components of such a program, they offered guidelines that include many of the elements important to a complete program of AR, including "hearing assistive technologies other than hearing aids," "speech reading and auditory re-learning," and

"coping and conversational repair strategies."¹³ The fact that this recommendation comes from a consumer group strengthens the argument that such programs are considered beneficial by consumers and will be used by people with hearing loss.

Economic factors may be the basis for the limited scope of AR. There is little reimbursement potential for the provision of such services, and many clients view it as an expendable service when considering the high price of hearing aids.¹⁴ When comprehensive AR services are found, they are generally at training institutions that provide them as part of their professional training programs. Prendergast and Kelley⁹ reported that 48% of all survey respondents and over 70% of those working in hospitals and private practices indicated that they lacked time to provide AR services, despite the fact that they were interested in the issue.

Given the dearth of inclusive AR services, consumers have turned to each other for support. This self-help approach has been fundamental to the development of such organizations as the Hearing Loss Association of America (formerly Self-Help for Hard of Hearing, Inc) and the Association of Late Deafened Adults. A casual survey of members¹⁵ suggests that they perceive audiologists as focusing on the ear rather than the individual. Members report that when they have "fixed" the ear using amplification, they seem to think their job is done. Follow-up appointments for adjustments may be difficult to schedule expediently and may incur additional fees. Few clients are referred for additional AR or support services.^{12,15}

To complicate the issue further, many audiologists do not assess, prescribe, or fit assistive listening systems such as FM systems or dispense technologies that support telephone use or visual alerting and signaling. Millington¹⁰ reported that although 79% of the audiologists he surveyed in 2000 dispensed hearing aids, only 27% dispensed hearing assistive technologies. As a result, consumers with hearing loss tend to have little knowledge of hearing technology beyond hearing aids and often turn to their peers for information about how to deal with listening needs that are not being met by use of a hearing aid alone.

The greatest advantage of peer support is that those who are imparting their knowledge and wisdom have "been there." They have the experience and empathy to respond to the needs of others. Antithetically, the greatest weakness of peer advice is that it may be based exclusively on the individual's unique experience and may not include knowledge

of the many options available beyond what they have personally experienced. For example, a person with hearing loss may recommend an assistive device or hearing aid with which he or she may have had success rather than providing alternative technologies that could better serve the client's specific needs. It is also possible that the degree of hearing loss experienced by the mentor will affect his or her understanding of the issues confronting a client with a different degree of hearing loss. For example, it remains an open question whether a mentor who considers himself a member of the deaf community can be an effective mentor for a person with late-onset moderate or severe hearing loss. It is possible that peer mentors will choose to specialize and work exclusively with certain types of clients.

It is reasonable to believe that if persons with hearing loss who wish to support their peers are given access to up-to-date information about hearing, hearing loss, approaches to rehabilitation, and training in basic mentoring approaches and are provided with support from a certified hearing-health professional, they could mentor more effectively. The availability of rehabilitative services could be significantly increased for the more than 31-million people with hearing loss in America.¹⁶ Further credence is given to this idea by the successful use of peer mentoring programs in dozens of other health-related contexts (eg, stroke, eating disorders, vision impairments, cancer, HIV/AIDS, smoking cessation, aphasia, alcoholism, and depression).¹⁷

Some of the areas in which peer mentors could be supportive are listed by ASHA as AR knowledge and skill areas for certified audiologists and speech-language pathologists.¹⁸ Examples of such potential areas of support include the following: provide for the administration of assessment measures in the client's preferred mode of communication (eg, American Sign Language); administer . . . standardized self-report measures of communication difficulties and of psychosocial and behavioral adjustment to auditory dysfunction; monitor fitting of and adjustment to these devices and technologies to ensure comfort, safety, and device performance; identify environmental factors that affect the individual's situational communication needs and performance; provide assessment of family members' perception of and reactions to communication difficulties; and use effective interpersonal communication in interviewing and interacting with individuals with hearing impairment and their families.

Training by hearing-health professionals as well as establishment of a formal liaison relationship with them could establish mentors as viable paraprofessionals. The use of support personnel "where appropriate" was supported by ASHA in a 1998 position statement¹⁹ noting that a certified supervising professional would be mandatory. The position article outlined minimum qualifications, which included a high school degree or equivalent, good communication and interpersonal skills, an understanding of the needs of the population, completion of competency-based training, and additional qualifications as needed.

A formal peer mentoring training program could result in several beneficial outcomes. Persons who had already experienced hearing loss and made successful adaptations to it would provide a support system for others with hearing loss who need help. Mentors would be professionally trained and monitored paraprofessionals supported by a broad body of knowledge and resources related to hearing assistive technology and psychosocial adaptation to hearing loss as well as a network of professional and mentor support. They would empower peers by modeling, providing information, and mentoring, rather than counseling.

Peer mentoring could also have beneficial effects for audiologists who, with the additional help provided by peer mentors, could expand their practices to include more comprehensive AR services for a greater number of their clients. Among the possible benefits of expanded AR services are improved patient satisfaction, better communication outcomes, and lower hearing instrument return rates.

The Gallaudet University Peer Mentor Training Program

Gallaudet University initiated the Peer Mentor Training Program in the summer of 2005. The peer mentoring training program is part of a larger research and development project funded by a grant from the National Institute on Disability and Rehabilitation Research of the US Department of Education, the goal of which is to develop a new innovative, systematic, modular model for the delivery of AR services to people with hearing loss. This academic and experiential learning program, which terminates in a continuing education certificate in peer mentoring, is guided by a 2-year curriculum designed and implemented by the authors, who are certified clinicians and AR providers (Dr Bally in

Speech-Language Pathology and Dr Bakke in Audiology), as well as faculty members in Gallaudet University's Department of Hearing Speech and Language Sciences.

By the time of graduation, peer mentors will be expected to have established a collaborative relationship with supervising credentialed audiologists or speech pathologists. This aspect of the program is of great importance because the success of the peer mentoring program is likely to depend greatly on a strong collaborative relationship between an audiologist or other hearing-health professionals and a knowledgeable, motivated peer mentor. Peer mentors will work with their supervising professionals to provide support to peers and to help them foster a proactive and problem solving mind set (eg, encourage them to practice communication repair strategies assertively). In concert with the hearing-health professional, they can determine the need for various assistive devices and help the person acquire and use them appropriately (such as personal ALDs, wake-up alarms, suitable smoke and carbon monoxide detectors, and television-listening devices). They can work with a client's family to help them understand the realistic auditory limitations of their loved one, conduct communication strategy training, and encourage repeat visits by the clients to their audiologists. Above all, perhaps, they can be knowledgeable and sympathetic listeners to the many problems and issues that arise when one is attempting to "live with a hearing loss."²⁰

Before designing the mentoring program, surveys, focus groups, and interviews were conducted with hearing-health professionals as well as consumers who were then working in mentoring roles at a local Washington, DC chapter of the Hearing Loss Association of America and the Northern Virginia Resource Center for Deaf and Hard of Hearing Persons. Learning objectives were identified, and a curriculum was developed. Candidacy requirements were established that exceeded those recommended by ASHA.¹⁹ Aside from a requirement that candidates for the program must have a documented hearing loss, the mentoring training program required that applicants have a college degree and submit a letter of application describing related experiences and reasons for applying. In addition, 3 letters of recommendation from individuals who knew the candidates in a helping or teaching capacity were required.

In 2004, the mentoring training program was announced to the membership of the Hearing Loss

Association of America. Applications were received and screened, and a class of 12 students was selected to participate in the first class, which started in June 2005. The first class consisted of 9 women and 3 men whose hearing losses ranged from mild to profound and who represented 11 different states. This launch group will complete requirements in July 2007. A second, equally diverse group of 13 started the program in June 2006. One third of the new group had strong affiliations with the deaf culture and American Sign Language, and several had cochlear implants.

The peer mentor training program consists of a combination of academic and experiential learning. A graduate-level professional training program certificate is awarded to those who successfully complete program requirements. The Gallaudet University grading system is employed to evaluate performance.

Coursework includes information about hearing loss and its effects on function and participation, a basic understanding of audiologic test results and hearing assistive technology, rehabilitative strategies, and approaches to mentoring. Practical knowledge and skills are also an important part of the curriculum and include techniques for educating others about hearing loss, organizing and implementing group and individual sessions, and one-on-one mentoring. Opportunities for experiential learning include observations, interviews, surveys, writing of position papers, group discussions, team and group projects, selected readings from consumer and professional literature, role plays, research, discussion forums, and case studies. Practical experiential learning opportunities are made possible by teaming up each mentor with an audiologist or other hearing-health professional in his or her local area. Thus, each peer mentoring student is able to observe clinical practice in real settings and do their own supervised clinical work. The students themselves must recruit their supervisors, who become part of the larger peer mentoring network.

Assessment of student progress is provided by the program instructors (university faculty and supervised doctoral students), designated supervising hearing-health professionals (as identified by students and approved by faculty), as well as through student self-assessment. Both academic and experiential learning is monitored and assessed. Assessment data will be analyzed and reported as part of a longitudinal study for this project.

Table 1.
The Peer Mentor Training Curriculum

Course Name	Units	Type
Opening Seminar: Orientation to Peer Mentoring	1	On site
Hearing Loss in America: An Overview	3	Online
Biopsychosocial Aspects of Hearing Loss	3	Online
Practical Audiology: Fundamentals for Consumers	3	Online
Hearing Assistive Technology	2	Online
Peer Mentoring for Hearing Loss	3	Online
Final Seminar: Applications of Peer Mentoring	1	On site

Certificate Program Curriculum

The mentoring program curriculum consists of 7 courses (16 credit units) given over a 2-year period. The curriculum is listed in Table 1. As shown in Table 1, the first and last courses are seminars that are given onsite at Gallaudet; the other 5 courses are provided online.

The opening seminar includes activities for team building, mastering the technology needed for online courses, and the establishment of a collaborative network so that the learners may work interactively online throughout the 2-year program.

The first course, *Hearing Loss in America: An Overview*, includes demographics, social impact, economic considerations, health care, related policy and law, accessibility issues, and community and national resources.

The second course, *Biopsychosocial Aspects of Hearing Loss*, focuses on the psychological and social effects of hearing loss on those who sustain it and their families. Students examine what people experience psychologically and socially as a result of hearing loss and adaptation to technology use. This includes such topics as the grieving process, hearing loss-precipitated crisis, coping and personality types, problem-solving approaches, cognitive restructuring, assertiveness, and parallel reactions of communication partners. Some basic information about communication theory, behavioral theory, and cognitive theory is included. The impact of hearing loss on families and significant others as well as in the work place, social settings, and everyday functioning is explored.

The third course, *Practical Audiology: Fundamentals for Consumers*, presents basic principles and processes of audiology. It includes some of the traditional

areas of basic audiology courses but uses practical consumer perspectives. Topics include scope of practice for hearing-health professionals, anatomy and physiology of the hearing mechanism, etiologies of hearing loss, and audiometric interpretation.

The fourth course is *Hearing Assistive Technology*. Students study hearing aids, cochlear implants, assistive listening systems, visual and auditory warning and alerting technology, and communication strategies that are supportive to technology use. Special emphasis is placed on a consumer-oriented, needs-assessment approach to the acquisition of goods and services related to hearing loss.

The fifth and final online course of the series is *Peer Mentoring*. The focus is on mentoring approaches and strategies. The course emphasizes the boundaries between what mentors may address and what should be referred to professionals. Potential relationships between the mentor and the hearing-health professional are explored. Other topics include needs assessments, consumer advocacy, assertiveness training, and problem-solving approaches.

At the end of the second year, a final in-residence seminar allows the student-mentors to integrate the academic and experiential learning that has taken place over the prior 2 years. Activities focus on practical application and integration of their knowledge and skills using case studies and role play.

Course materials include readings from both consumer and professional publications. When materials of appropriate educational level and focus were not available, they were developed. Some materials were created in a collaborative effort with the American Academy of Hearing Loss Support Specialists of the Hearing Loss Association of America. The support specialist program parallels the mentoring program but differs in significant ways. Of greatest importance is that the peer mentoring program is only for persons with documented hearing loss. Also of significance is that it awards university credit and is based on both academic and experiential learning. The Hearing Loss Association of America program is a purely academic program. Because many of the same topics were included in the curriculum of both programs, a collaborative development team, including faculty from Gallaudet and staff from the Hearing Loss Association of America, was established.

Program Assessment

A preliminary review of feedback from instructors and students has been positive. Students have noted

excellent course materials and challenging assignments. Peer collaboration has enhanced learning and the experiential learning experiences have been deemed worthwhile. There is clear evidence of integrating knowledge to current work and volunteer activities for several participants. Many of the students who were already doing mentoring in other contexts have indicated that they are more effective given their new skills, knowledge, and experiences.

Participants have noted some particular difficulties or challenges. One is the Blackboard technology; students need sufficient time to get up to speed in using it before activities dependent on it are required. In addition, some of the students have difficulty in finding time to integrate work on mentoring courses into their already busy lives. The challenges of distance teaching and learning are evident in some of the feedback that has been received from the students. Some of them have had difficulty managing online discussions via "chat" and specific rules of interaction needed to be established. For example, one class decided that the instructor should lead and direct all discussion and that questions should be cued by entering "q" and answers by entering "a." Students were then called on in the order in which they entered their question or answer cue. Another group chose a different strategy, in which questions were raised by the instructor and students were given a time frame (perhaps 2 minutes) to enter their responses or questions. Neither seems ideal, and it seems to be important for the instructor to work with the group to find the most acceptable means of real-time interaction.

An attempt was made with one group to conduct interactive classes by means of a teleconference with captioning and other visual interaction tools (PowerPoint, Chat) using a Webex online teaching tool (www.webex.com). Unfortunately, this attempt was unsuccessful with this group, who reported difficulty managing the multiple visual inputs while trying to integrate the auditory signal supported by captioning. Although the attempt was aborted with this group, it will be tried with several groups to determine whether a more formal evaluation should be made of its potential for online learning for people with hearing loss.

Another difficulty for some has been the establishment of professional liaisons with audiologists or other professionals. Students were hesitant to contact audiologists and propose the establishment of a collaborative relationship. It is possible that the developers of the program underestimated the difficulty of

consumers establishing such relationships. Additional support is being provided in this area, and better means of regular communicating with the professional sponsors are being explored.

Instructors have noted that teaching the online courses for this program is extraordinarily time consuming. It has been observed that the more the participants learn the more that they want to know. They have been an extraordinarily enthusiastic and thoughtful group, and their questions have been challenging.

Presentations about the Peer Mentor Training Program were made at the ASHA convention in 2005 and at the Hearing Loss Association of America convention in 2006. Both audiences expressed enthusiasm for the peer mentoring concept as applied to people with hearing loss. Several professionals expressed interest in working with mentoring students and providing them with training experiences.

Efficacy studies are planned to measure the impact of peer mentoring on (1) the peer mentors themselves, (2) the professionals with whom they work, and (3) the clients whom they serve. Methods of assessing efficacy will include formal and informal feedback instruments from the trained peer mentors and their cooperating professionals and outcome measures applied to the clients served. In addition, we will be very interested in documenting the ways in which peer mentors are employed and compensated as well as ways in which they interact with hearing-health professionals.

The business model or models that peer mentors will use in their practice are yet to be fully determined. Although we envision a contractual working relationship with private practice audiologists or with audiology practices in hearing and speech centers, other applications are being considered. Several participants hope to put their skills to work as employees in community-funded agencies for deaf and hard of hearing people. Others hope to use this learning in coaching businesses. There is little doubt that other applications will emerge over time.

Conclusions

Although the program is very new, the Gallaudet University Peer Mentor Training Program offers the possibility that the unmet AR needs of both consumers with hearing loss and hearing-health professionals can be at least partially met by the use of peer mentoring. As persons with hearing loss, peer

mentors will have an insider perspective on coping. Mentors can provide AR services that communication professionals lack sufficient time to provide, including greater emphasis on facilitating communication and addressing the psychosocial effects of hearing loss on persons with loss and their families. Initial anecdotal evidence has been encouraging in that the student feedback has been largely positive and both consumers and professionals appear to be willing to consider the use of peer mentors as adjuncts to professional services for people with hearing loss. It is hoped that future graduates of the Gallaudet Peer Mentor Training Program will contribute to the development of more comprehensive models of AR service delivery.

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