AUDITORY (ORAL) METHODS

The goal of the auditory methods is to teach a child how to use his residual hearing so that he may have access to spoken language. “Most deaf children have some residual (remaining) hearing. The brain, which develops rapidly in the first few years of life, needs rich language input during that time.”52 The speech signal is redundant. Since it carries excess information, it is not necessary to hear every sound to understand a message.53 Additionally, there is also a great emphasis on speech and speechreading. The ultimate educational goal is to place the child in a mainstream school environment.

No one method can unilaterally guarantee success for every individual. Parents that decide to pursue an auditory method need to understand that there are four critical factors that can make the difference between success and failure.

Early intervention is key. “For language to be successful with deaf children (no matter what the educational approach), programs of early intervention must take place during the critical language-learning years of birth through 6.”54 In fact, if children start auditory stimulation after age 3, the process is progressively more difficult. Listening is a “use it or lose it” skill.55

It is imperative that the parents obtain the services of an excellent pediatric audiologist for their child. The audiologist must know how to set the child’s hearing aid for speech. The child will need audiological testing every 6 months. The importance of aggressive treatment should not be underestimated.56

Good training is a must. If the parents pursue the auditory option, they must be willing to find people capable of training their child. The U.S. is, traditionally, a signing nation. Since the 1970s, there has been a decline in the number of pure oral programs. About thirty percent of the programs in the U.S. are oral programs and there are three oral residential schools. It is conceivable that parents wishing to pursue this option will have to deal with availability issues. They may also need to invest in private schools and speech therapists, since many school programs do not have pure oral programs.

There is a need for high-level parental involvement. “Learning spoken language requires more effort and is a slow process. It requires a lot of work.”57 Parents are urged to talk to their kids as much as possible. Language doesn’t just happen in therapy a few times a week. Language happens all day long and the primary teacher is the parent.58

There are two major types of auditory training. Auditory/oral training not only stresses auditory training, but also trains a child to use speechreading and contextual clues to receive information. Children that have auditory/oral training tend to pick up sign as a second language so that they can communicate with signing peers.59

Auditory/verbal (AV) training only trains the child to use his residual hearing. Children that have successful AV training tend to be completely mainstreamed into hearing society.

Auditory/oral training is the more traditional of the two approaches. The main focus of this type of training is to teach the child how to use his residual hearing. The earlier a child is given hearing aids, the better. Humans are uniquely programmed neurologically to develop the auditory pathways for language usage in the early years. Once this brief window of opportunity is missed, the neurolinguistic capabilities will forever be diminished due to retrograde auditory deterioration.”60 In addition to training residual hearing, the child is also trained to speechread. Speechreading is challenging for several reasons. “Only about 30 percent of English sounds are visible on the lips, and 50 percent are homophonic, that is, they look like something else. Look in a mirror and ‘say’ without voice the words ‘kite’, ‘height’, and ‘night’. You’ll see almost no changes on your lips to distinguish among those three words. Then say the following three words—‘maybe,’ ‘baby,’ ‘pay me.’ They look exactly alike on the lips.”61 In order to speechread well, the individual must use high level mental gymnastics. He must make an educated guess on much of what he sees, using situation and context. This almost always requires an excellent grasp of the target language. Many prelingually, late-diagnosed deaf simply do not have the exposure to English to pull these gymnastics off. Most deaf individuals do some speechreading. Some individuals truly have a knack for this skill. Since the goal in auditory/oral training is for the individual to both understand speech and communicate through speech, speech therapy is a necessary component in the training process. Speech therapy involves one-on-one interaction for many years and a great deal of repetition is involved.62 The immediate benefit of this method is the ability to communicate with the wider hearing world. There are some studies which “support the notion that the emphasis on the English language as the mode of communication results in higher reading levels than with signing approaches.”63 One talented college student shared that going to Oral Day School was “an awesome experience. I learned to be confident and to be a leader.”64

Each method has its own type of challenges and the auditory/oral method is not different. The method is one that requires many, many years of hard work on the part of the child, his parents and his teachers. Often, there is little gain for many years. “For a deaf child to benefit from amplification (if this is, in fact, possible), it will take time and effort.”65 One deaf respondent shared these thoughts: “Today, with my hearing loss I probably would have been taught Total Communication. I would have understood things at an earlier age, but I’m convinced I would not be speaking as well as I am today. I really did not speak intelligible speech until fourth grade.”66 Another respondent that was deafened by meningitis shared this: “I think that if I had to learn sign after losing my hearing, this would have seriously interfered with my ability to pick up sign as a second language so that I could communicate with signing peers.”

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about three years to re-learn how to understand English." Hard work aside, there is also the issue of cost. Quality oral programs are not always available. Quality speech therapy and private schools may be required. “With few exceptions, the successful implementation of the Oral approach has been achieved in private school settings for an array of possible reasons.” All deaf oral respondents shared a combination benefit /disadvantage to this method. They all had extraordinary study habits and developed an impressive work ethic. In order to succeed in the mainstream, they all had to study harder, and in greater depth than their hearing peers. Many were unable to speechread their teachers because they constantly moved about the classroom or faced the blackboard. They compensated by reading other material on the subject. One respondent shared this: “Because I could never understand my teachers in the classroom, I am largely self-taught. I missed (and craved) classroom interaction and participation. But I think the skills I learned to succeed in school are ones that have helped me throughout my adult life—love of learning, self-discipline, resourcefulness, learning to depend on myself, ability to research all sides of an issue.” A number of adults, especially ones that were raised orally and learned to sign later, felt that they missed a lot of information. Group and noisy situations were considered particularly challenging. One respondent felt that this method is not recommended for profoundly deaf children. He shared this insight: “The oral approach rarely succeeds for a profoundly deaf child. By the age of five a child might know a handful of words, but would have missed the most important years for acquiring language.”

The auditory/verbal method (AV) is totally reliant on a child learning to use his residual hearing. “The auditory/verbal philosophy is based upon the belief that children with all levels of hearing loss have the basic human right to the opportunity to develop the ability to listen and use verbal communication.” No effort is expended on honing speechreading skills. As a matter of fact, if a child tries to speechread during therapy, the therapist covers her mouth to hide visual clues. Speech training is a part of AV therapy. AV Therapy requires one-on-one interaction. It is very intensive. The goal for these kids is to go straight into the mainstream. They usually do not go into any deaf education programs. AV Therapy is not widely available. This method is only for children that are aided young. In addition, these children must have some residual hearing when they are aided. Absence of cochleas contraindicates this method. Specialists, called auditory verbal therapists, train these children.

The benefits of this type of approach are that if the therapy and the child work together well, the child can go straight into mainstream education. Drawbacks connected with dependence on speechreading are eliminated.

One of the method’s biggest drawbacks is lack of availability. There are only 50 –100 AV therapists in the US and Canada. Another potential drawback is the question of whether distorted sound is a good basis for establishing the native language and, if so, is language gained early enough to be useful?