

Webinar 1 – Q&A

1. **I have a new child on my caseload who has a severe hearing impairment and a diagnosis of autism. Our school's staff uses only the most basic sign. What do you think about using picture symbols, speech, and minimal sign to begin?**

Answer: *Diagnosis of autism is likely to be more primary to communication delays than hearing loss. You do not mention the age, intervention history, or communication level of the student, and all of these details are important to individual development. An essential beginning point is to make sure that access to language is optimized. I would begin by ensuring that the student is fitted with optimal sensory devices (consult the managing audiologist), and in good working condition on a daily basis (look for in-service training on managing and troubleshooting). All of the accommodations you mention can be helpful in providing access and building conceptual understanding as a bridge toward expressive language. However, a key to the development of communication when there is a diagnosis of autism is also methodology, and so it would be essential to consult with autism specialists for planning educational programming and approaches such as Applied Behavior Therapy. I would suggest having a Teacher of the Deaf provide services within a program that specializes in services for autism.*

2. **At what age can accurate and reliable audiograms begin to take place?**

Answer: *An accurate and reliable audiogram is based on behavioral responses from the child. It is possible to test a child behaviorally as soon as a child has head and neck control, which can be as early as 4 months of age, but is more reliable sometime between 4 and 6 months of age. The procedure is called “Visual Reinforcement Audiometry,” and the results would be put onto an audiogram. Prior to that, it is also possible to use*

ABR and/or ASSR results to plot approximate thresholds on an audiogram.

3. Does a hearing device correct the hearing problem completely?

Answer: No, hearing devices do not correct the child's hearing loss the way that glasses correct visual problems. Hearing aids amplify the intensity (loudness) of the sound, and digital hearing aids can be set to emphasize particular frequencies (pitches) more than others in order to make speech more accessible to the wearer. However, even with excellently fit hearing aids, the individual will be hearing speech "softer" than a normally hearing person, and is likely to have more trouble listening and understanding in noise or at a distance from the speaker. In addition, the individual's hearing problems may not "just" be related to a lack of intensity. There could be additional problems with clarity, and hearing aids are not equipped to address clarity problems.

Cochlear implants also do not correct the hearing problem completely. They provide electro-acoustic stimulation to the neural fibers in the cochlea, which –with time, effort and usually with therapy--provides stimulation that the brain can learn to interpret as sound. However, the person wearing a cochlear implant does not hear speech in exactly the same way as a normally hearing person. And again, it will not be as intense for the cochlear implant wearer as it is for a normally hearing listener. The amazing thing is, though, that with the right professional management and device, both hearing aids and cochlear implants can help most children to hear, understand, and produce clear and fluent spoken language.

4. How long does the LSLS certification process take?

Answer: Beyond the Master's degree, it typically requires 3 years of employment with at least 15 hours per week doing auditory-verbal

therapy or education. The requirements for mentoring, supervision, and professional development can take place during that time. It is only after all of the pre-requirements are fulfilled that the candidate is allowed to sit for the examination. Please contact the A.G.Bell Academy for more detailed information. (agbellacademy.org)

5. What are good strategies to use with an infant with a UHL?

***Answer:** Unilateral Hearing Loss can be of any degree, and can have a variety of etiologies which could influence the kind of technology that would be recommended by the child's pediatric audiologist. Regardless of other factors, it will be important to be aware that the child will have trouble understanding speech in the presence of noise, and determining where sound is coming from (localizing). The family will need to be vigilant about controlling noise in the child's environment, and will need to provide a linguistically rich environment—all of which will be easier with the support of knowledgeable professionals.*

6. What is the prognosis for a child for which one of the legs of your stool is missing?

***Answer:** To review: slide #34 uses a 3-legged stool as a model of those factors that support the development of early spoken language in children whose hearing status puts them at risk for developing language. The seat of the stool represents the child's ability to fulfill his or her potential for spoken language. One leg represents appropriate technology, another leg represents professional expertise, and, the third represents parent engagement. The model suggests that the deaf and hard-of-hearing child in a hearing family, is most likely to reach his or her full potential for developing spoken language when all three components are in place*

within the first six months of life.

In other words, a deaf child who has consistent access to the sound of their parents' voice, and parents who are confident in their ability to nurture, provide and teach their child will follow a course of development that is adaptive for both short and long-term growth. Skills across domains will present synchronously and provide a foundation for the complex behaviors that are needed later in development.

The human species, however, is very adaptive and deaf children who have hearing parents will make all kinds of adjustments to maintain an emotional, social and communicative connection to their parents whether or not they have adequate sensory access to their environment. The danger is that while those early adaptations made without sufficient sensory information may serve them for the short term, they will not serve them well later in development. So we might say short-term adaptation with inadequate support is maladaptive for long-term development. The likelihood of these children reaching their potential for developing spoken language skills is ultimately compromised.

The stool serves as an instructional or conceptual model. Fortunately children and families are infinitely more complex, resilient and resourceful than our stool. Each of our speakers has case testimonies to support the success of those deaf and hard-of-hearing children who with great effort have managed to acquire spoken language skills in spite of an uneven foundation.

7. What problems are occurring with unilateral losses besides difficulty

hearing in noise?

Answer:

*The American Speech and Hearing Association (ASHA) has an excellent summary that will answer your question about unilateral hearing loss:
<http://www.asha.org/public/hearing/Unilateral-Hearing-Loss-in-Children/>*

Additionally, for a more in depth answer, this comprehensive paper has a lot of information about the challenges that someone with a unilateral hearing loss might face:

<https://successforkidswithhearingloss.com/wp-content/uploads/2011/08/The-Developing-Child-with-Unilateral-Hearing-Loss.pdf>

- 8. When I was an itinerant teacher years ago, I had an incident or two where the HHPD teacher was pregnant and would refuse to have a cmv student in her class? Is that transmitted?**

Answer: *Here is a link to a website that will provide you with complete information in response to your question:*

<http://www.cdc.gov/cmvt/transmission.html>