Use of a Self-Assessment Technique in Counseling Adolescents with Hearing Loss: From Theory to Practice

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Adolescents with impaired hearing often feel isolated, receiving little support from peers or audiologists. This tutorial describes how educational and pediatric audiologists can use a recently developed self-assessment tool as a counseling strategy when working with the adolescent population. The reader is provided with literature reviews in three topics: Counseling and its application to audiologic practices, the developmental issues of adolescents and the impact of hearing loss during this time in life, and the use of self-assessments as a counseling tool. The final section integrates these topics to demonstrate how a self-assessment designed for teens with hearing loss can provide a counseling framework for educational and pediatric audiologists interested in providing counseling support. Hypothetical scenarios are included in the Appendix to illustrate the use of the self-assessment instrument.

Introduction

Audiologists are trained to assess a person's auditory status and provide appropriate recommendations that correlate with the diagnosis. Many audiologists feel comfortable discussing the technical aspects of hearing loss and of amplification, but may not be as comfortable when discussing the psychosocial aspects of a person's hearing loss. This kind of discussion involves a different kind of support, often called counseling. Why would an audiologist need to be trained in counseling? Audiologists understand the limitations a person with hearing loss can experience communicating with others in social situations, at home with spouses, children, and/or siblings, and at school or work. Knowing that a person struggles in these situations and counseling them towards communicative independence to lessen the struggle are two different competencies. This tutorial will review literature in three areas: Counseling and its application to audiologic practices, the developmental issues of adolescents and the impact of hearing loss during this time in life, and the use of self-assessments as a counseling tool. The final section will integrate these topics to demonstrate how a self-assessment designed for teens with hearing loss can provide a counseling framework for audiologists interested in providing counseling support.

Counseling in Audiology

Definition of counseling duties for the audiologist

The 2002 edition of the American Speech-Language Hearing Association's (ASHA) Desk Reference includes a set of preferred practice patterns for audiology, which includes a description of counseling. Specifically, the expected outcome of counseling is to develop goals for recovery from, adjustment to, or prevention of a communication or related disorder by encouraging change and growth in which patients/clients become more autonomous, more self-advocating, and more responsible for achieving their potential and realizing their goals to communicate effectively. Guralnik (1984, p 143) in Webster's dictionary defines counseling as "1) the mutual exchange of ideas, etc. discussion; 2) advice; 3) to consult together." Counseling is the mutual exchange of ideas that allows one or both of the parties to leave the discussion feeling more confident and prepared to handle the discussed situation. Counseling is an active process that encompasses teaching and learning on the part of both or all the members engaged in the discussion. To facilitate autonomy and encourage patients to realize and fulfill their individual goals, the audiologist needs to understand and participate in patient-driven intervention.

The Audiologist as the non-professional counselor

How does this definition apply to the field of audiology? Developing goals that promote autonomy, self-advocacy, and responsibility of one's communication goals, as defined by the 2002 edition of the American Speech-Language Hearing Association's Preferred Practice Patterns for the profession of Audiology, requires audiologists to engage in counseling with the patient, actively dialoguing and facilitating communication that inspires the patient's own self-awareness and self-reliance to tackle personal communication difficulties. Counseling means working in collaboration to achieve the patient's goals, not the audiologist's goals.

Historically, training in audiology has focused on providing patients and their families accurate information about the technical aspects of hearing loss and amplification. Clark (1994) defines this type of interaction as informational counseling. In this model, the audiologist tends to dominate the conversation, concentrating on the degree of hearing loss, amplification considerations, implications for language development, and accessibility to auditory information. Audiologists are uniquely suited to deal with issues of disordered communication that affect every area of the patient's life and yet most professionals have a difficult time recognizing patients' concerns. These concerns often manifest themselves in the form of an affective statement or comment; for example, "I refuse to wear my FM system. Everyone stares at me and calls me names. Yesterday someone called me a 'retard'." An audiologist who is not in tune with the emotional cues in the student's comments might reply, "You need to wear your FM system in order to get good grades in school." The student was commenting on the emotional component of having a hearing loss (feelings of isolation, dealing with attitudes of intolerance) not the technical aspects (auditory accessibility that facilitates academic success). Clark (1994) describes effectively listening for emotional cues or affective statements and responding accordingly as personal adjustment counseling.

Counseling training in audiology programs

Culpepper, Mendel, and McCarthy (1994) surveyed ESB-accredited programs looking for advancements in counseling content and increased opportunities for learning the art of counseling as compared to their similar survey conducted in 1986. The authors found a limited number of counseling courses and counseling opportunities offered to students. The authors' findings demonstrated minimal change in educational trends, specific to counseling, over an eight-year span. This lack of preparation likely accounts for results obtained from Martin, Barr, and Bernstein (1992), who reported that approximately half of the audiologists surveyed did not feel prepared to counsel people with hearing loss and their families. Recently, a few academic institutions have made an effort to provide counseling courses designed to address the emotional component of hearing loss rather than focusing on the informational elements of counseling, (e.g., type of hearing loss, amplification). English, Mendel, Rojeski, and Hornak (1999) noted an improvement in audiology students' abilities to 1) distinguish between content messages (need for information) and affective messages (expressing an emotional con-

cern) and 2) respond appropriately to the identified message after taking a counseling course that directly focused on these skills. Identical outcomes were obtained from master's-level audiologists enrolled in a distance education course (English, Rojeski, & Branham, 2000). Although more research is needed in the area of audiology counseling course effectiveness, these two studies suggest that one way to becoming a successful non-professional counselor is to obtain training specifically designed to address the intricacies of counseling individuals with hearing loss and their families.

Counseling approaches

One way audiologists can learn to respond more appropriately and effectively to their patients' concerns is by familiarizing themselves with the basic theories of counseling. The three theories most frequently applied to the practice of audiology are behavioral counseling theory, rational-emotive counseling theory, and person-centered theory of counseling.

Behavioral Counseling Theory. Behavioral counseling is based on the work of noted behaviorists John Watson, Ivan Pavlov, and B.F. Skinner (Ivey, Ivey & Simek-Morgan, 1993). Skinner believed it was more important to study observable behavior while depending less on one's thoughts and feelings (Miller, 1993). He proposed that if one's behavior was positively reinforced, the behavior would continue. If a behavior was punished or ignored, the behavior would cease. In its purest form, behavioral therapy is designed to help control the consequences of our behavior that will lead us to change our actions. For example, a child throws a tantrum every time his parents deny his request. If the parents ignore his tantrum, despite its longevity, the tantrum will stop. If the parents give in to his request in order to stop his tantrum, the child will continue to use tantrums to get what he wants.

A behavioral approach requires the audiologist to guide the patient through several small steps that eventually leads to the larger goal (Clark, 1994). As with all counseling approaches, audiologists need to work in concert with the patient to meet the individual's goal. Behavioral techniques should not be used to coerce a patient; behavior shaping needs to benefit the patient. The reinforcement should be intrinsic and therefore practical and realistic for the individual (Nichols & Schwartz, 2001).

Rational Emotive Behavioral Therapy. Rational Emotive Behavioral Therapy (REBT) is a form of cognitive behavioral therapy that states that thought, behavior, and emotion are interrelated (Kelly, 1992). REBT was conceived by Albert Ellis in the mid-1950's. As Ellis was working with patients, he began to realize that he was taking a more active role in therapy, attacking the patient's logic, and recommending behavioral activities for patients to complete upon leaving the therapy session (Ivey, Ivey, & Simek-Morgan, 1993). REBT differentiates between practical problems (e.g., not attaining one's goals or failure at tasks) and emotional problems (e.g., "No one will like me if I make a mistake"). A person's emotional problems may be related to or separate from the practical problems that are experienced. Most people have a difficult time separating what is an emotional problem or a practical problem because they typically hold irrational

beliefs regarding the situation (DiGiuseppe, 1991). In 1962, Ellis reported eleven irrational beliefs; Kelly (1992, p. 45) outlined four of the most common irrational beliefs:

1. A person cannot imagine a situation being worse than it already is. The situation or circumstance in question is virtually intolerable.
2. A person cannot imagine enduring a particular situation, much less being happy in this situation.
3. A person will likely be highly self-critical and critical of others, and ungenerous or unforgiving of mistakes.
4. A person will likely think only in absolutes (e.g., "I must be right all the time", "Everything must be perfect", "Life must always go the way I had planned").

Attacking irrational thought does not imply disregarding one's emotional response to a situation. Bringing to light the emotional aspects helps the patient navigate through the situation without becoming so entrenched in the emotion that day-to-day functioning becomes impossible. Once patients become perceptive in identifying irrational thought stemming from emotion, they become prepared to execute a rational plan that enables them to achieve their ultimate communicative goal (Linscott & DiGiuseppe, 1994).

Person Centered Counseling. In 1959, Carl Rogers defined a philosophy, the person-centered approach, which was unique and foreign to most working in the area of psychology. The central tenet of the person-centered approach is "that the individual has within him or herself vast resources for self-understanding, for altering the self-concept, basic attitudes, and his or her self-directed behavior-and that these resources can be tapped if only a definable climate of facilitative psychological attitudes can be provided" (Rogers, 1979, p. 98). Rogers identified three components necessary for implementing the person-centered approach: 1) congruence of self, 2) unconditional positive regard, and 3) empathetic understanding.

Congruence of self means that the professional is communicating with and relating to the patient in a way that conveys a message of interest in the patient's concerns, and preparedness to experience the emotional concerns of the patient without a sterile professional barrier. Communication between the audiologist and patient would remain fluid and both parties would feel a sense of openness.

Unconditional regard defines the audiologist's positive acknowledgement and acceptance of the variety of emotional states the patient might project. For the patient to feel unconditional regard from the audiologist, the audiologist needs to be willing to convey a positive environment that facilitates uncensored expression on the part of the patient.

The final component, empathetic understanding, challenges the audiologist to perceive and reflect back to the patient a clear message of the patient's thoughts, emotions, or concerns. Empathetic understanding requires active listening by the audiologist: a skill that takes practice and repeated implementation to feel comfortable and at ease (Clark, 1994; English, 2002; Rogers, 1979).

All three counseling theories are applicable to the field of audiology. Each theory provides useful information that ultimately will benefit patients and their families. Combining the theories is possible, practical and highly likely given the diversity of patient's communicative needs. Patterson (1986) cites seven commonalities among counseling approaches supporting the practicality of integrating different counseling theories. They are:

1) Agreement that humans can change or be changed;
2) Agreement that some behaviors are undesirable, inadequate, or harmful or result in dissatisfaction, unhappiness, or limitations that warrant change;
3) Expectation that clients change as a result of their particular techniques and intervention;
4) Agreement that those who seek counseling experience a need for help;
5) Agreement that clients believe change can and will occur;
6) Expectation that clients will be active participants; and
7) Use of interventions that characteristically include persuasion, encouragement, advice, support, and instruction.

The goal for the practicing audiologist is to become familiar with the theories so they are routinely implemented in order to enhance the service provided to patients and their families.

The Adolescent Years
Adolescence occurs between ages 10 and 19 with three stages of development: early adolescence (ages 10-13), middle adolescence (ages 14-16), and late adolescence (ages 17-19). Early adolescence entails significant physical/sexual maturation, intense concerns with body image, concrete thinking, emerging independence in decision-making, increasing peer influence, feeling attracted to others, and experimenting with new ways of behaving. Middle adolescence involves continuing physical/sexual changes, less concern with body image, emerging ability for abstract thinking, development of a sense of identity, exploration of romantic interests, enormous influence of peers/school environment, increase in sexual interest, and experimentation with risk-taking behavior. Late adolescence usually means a cessation of physical/sexual changes, greater acceptance of physical appearance, and increased capacity for abstract thought and realistic risk assessment. A sense of identity is established, family influence is balanced with peer influence, and serious intimate relationships begin to develop. Persons in later adolescence contend with transition to work, college and/or independent living. (McCoy & Wibbelsman, 1999; Ponton, 1997). Autonomy, identity development, peer group affiliation, physiologic changes, occupation preparation, and transition to adulthood are a few of the issues facing teenagers that will be discussed further in this tutorial.

When most adults think back on their adolescent years, a flood of memories and emotions come racing back. For some, it is a time of great joy and excitement; for others a time of loneliness and despair. Adolescents can find themselves in a tug of war, not wanting to leave their childhood but, at the same time,

longing to enter the world of adulthood. In this transitional time, developing a strong sense of "who you are" is imperative to the ultimate goal of autonomy - the right or power to self-govern. Autonomy carries with it a tremendous responsibility for making decisions that can have a lasting impact. For example, choosing to be active sexually can result in a teenage pregnancy or a sexually transmitted disease, both of which have implications for the future. For the adolescent, developing a strong sense of self can facilitate independence and the capacity to have healthy relationships with friends and family (McCoy & Wibbelsman, 1999). Adolescence is a time to cultivate one's identity with the support of the adults around them. Maturing cognitive abilities allow adolescents an opportunity to reflect on who they are and what makes them unique. Adults can support teenagers by engaging them with non-threatening questions that facilitate conversation (e.g., Who do you admire? What do you consider your strengths? What have you done in your life that you are proud of?) Other methods of support can include discussing how a friend defined a problem, generated options, anticipated outcomes, and made a decision, and/or discussing ethical and moral problems that are in the news. In this time of self-discovery, adolescents begin to ask themselves four basic abstract questions: 1) Who am I? 2) Am I normal? 3) Am I competent? and 4) Am I lovable and loving? (Roth & Brooks-Gunn, 2000). Adults need to recognize that these questions are central to the concerns of adolescents and should give them a chance to explore their own beliefs and find their own answers.

Peer relationships

One way that adolescents find answers is by consulting their peers. Their peers are age mates who are dealing with the same issues; thus, they are considered experts in navigating the daily concerns of adolescent life. By identifying with peers, adolescents can start to develop moral judgments and values, and to explore how they differ from their parents [American Psychological Association (APA), 2002].

By the time the adolescent reaches 14 or 15 years of age, the same-sex peer groups begin to merge into larger, more loosely defined mixed-sex groups. By identifying with peers, adolescents can start to develop moral judgments and values, and to explore how they differ from their parents (APA, 2002). Belonging to a group can have many positive effects that in turn may bolster the adolescent's self-esteem. Peer groups are safe environments for adolescents to practice interpersonal skills, such as communication, cooperation, and compromise, which will be important in the workplace and in future adult relationships.

Sometimes being part of a group can have a negative impact on an adolescent. Exclusion from a group can be painful and unpleasant for the adolescent who so desperately wants to "fit in." Sometimes acceptance by a group can be damaging as the group may encourage destructive behavior that is contrary to the adolescent's values. This desire to fit in and be accepted by a peer group can influence adolescents to engage in behavior that they would not normally consider.

By middle adolescence, the involvement with peers intensifies, branching out into more intimate friendships and romances.

The parent-child relationship ultimately changes due to the adolescent's active participation in the peer social circle. This change is not necessarily a negative change; parents need to remember that peers are an integral part of their adolescent's life. Family closeness has been considered the most important protective factor against high-risk behaviors such as smoking, alcohol/drug use, and early initiation of sexual intercourse (Resnick, Bearman, & Blum, 1997). Increasing conflicts between adolescents and parents heighten as the adolescent expresses a desire for independence. Minor conflicts and bickering are considered normal as teens and parents adjust to their changing relationship. Many physiological changes occur in adolescence. It is not unusual for adolescent girls and boys to have mixed feelings about their changing bodies. There is often a sense of pleasure and pride in their growing strength and adult-like appearance along with a feeling of self-consciousness about noticeable physical changes (i.e. breast development). Knowing and understanding the normal process of puberty will alleviate many of the concerns and fears adolescents may have.

Along with the physical changes of puberty, there are also emotional changes. Adolescence is a time of feeling a wide range of emotions. Emotional fluctuations may be due to changing hormone levels or because adolescence encompasses many changes. Body changes, school changes (e.g., transitioning from junior high to senior high), changes in the family as the adolescent becomes more independent, and changes in the adolescent's social life are all significant in isolation and can often be overwhelming when they happen simultaneously (Stefoff, 1990). Often, adolescents can feel a sense of loss that their childhood, and the security it provided, is ending.

The adolescent's self-image and self-concept can be tested during puberty. It is important that the adults in the adolescent's life watch for signs of a negative self-image/self-concept, including 1) constantly expressing self-defeating comments, 2) withdrawal from peers due to feelings of inadequacy, 3) not being compassionate or tolerant of others, 4) calling themselves hurtful names, and 5) strong feelings of failure when striving for perfection (McCoy & Wibbelsman, 1999).

Transitioning to adulthood is a process that starts at the beginning of adolescence and is complete when the adolescent exhibits adult behaviors. It is important that adults are aware of the skills teens need to become responsible, contributing members of society. Glen and Nelson (1989) stress seven tools or skills that an adolescent must obtain to become a responsible, contributing member of society. They are:

1) Positive perceptions of one's personal capabilities: "I am capable."
2) Positive perceptions of one's significance in primary relationships: "I contribute in meaningful ways and I am genuinely needed."
3) Positive perceptions of one's personal power or influence over life: "I can influence what happens to me".
4) Effective intrapersonal skills (e.g.., the ability to understand personal emotions, use that understanding to develop self-discipline and self-control, and learn from experience).

5) Effective interpersonal skills (e.g., the ability to work with others and develop friendships through communication, cooperation, negotiation, sharing, empathizing, and listening).

6) Effective systemic skills (e.g., the ability to respond to the limits and consequences of everyday life as responsible, adaptable, and flexible).

7) Mature judgmental skills (e.g., the ability to use wisdom and evaluate situations according to appropriate values).

The skills listed remind us of the complexity of adolescence and the transition from childhood to adulthood.

Adolescence and Hearing Loss

The complexity of adolescence is not lost upon adolescents with hearing loss. The challenges intensify with the presence of a communication disorder that often restricts ability to understand and respond to auditory information at home and at school. There also are more subtle communicative situations including phone calls, parties, or dates. Adolescence is not the time to be different from peers, yet using a hearing aid, assistive listening device, or cochlear implant is a visual reminder to teens with hearing loss that they are different from their hearing peers (Thibodeau, 1994). The potential psychosocial ramifications of having a hearing loss during the teenage years influence the adolescent's self-image, self-concept, and peer relationships. The experience of being an adolescent with a hearing loss can result in a successful transition into adulthood or mark a period in time that can adversely affect an adolescent for years to come. Audiologists who work with adolescents are called upon to facilitate a smooth transition to adulthood using counseling strategies that open the door to communication (English, 2002). The audiologist should be cognizant of the adolescent's level of linguistic or verbal conceptual competence and recognize how this may impact meaningful dialogue or expression of the adolescent's feelings.

Amplification

Hearing aids are the communicative lifeline for many adolescents with hearing loss if they depend on their residual hearing to understand the auditory world around them. However, using these devices can challenge a person's sense of self. For example, a study by Doggett, Stein, and Gans (1998) revealed that adult females wearing non-visible hearing aids were perceived as having less confidence, friendliness, and intelligence in their behavioral characteristics, signifying a negative self-image. It seems that, even when not visible, hearing aids can affect a person's self-confidence and self-esteem. Elkayam and English (2003) reported that, when adolescents did a cost/benefit analysis of hearing aid use and communicative difficulties, some of the adolescents' comments implied that they felt that the high social/emotional cost of wearing hearing aids was not worth the obvious communicative benefit. The adolescents also reported that it would be beneficial to address the social-emotional issues surrounding hearing aid use over and above the communicative benefits of amplification. Elkayam and English (2003) stated that

the "instruments may be invisible, and may help the adolescents communicate better, but they do not necessarily help them feel better about themselves" (pg. 493).

The use of an assistive listening device (ALD) can have similar undesirable consequences for the adolescent with hearing loss. Visibly identifying oneself as a person with a disability and needing technological assistance can be an unacceptable option to the adolescent with hearing loss. Manufacturers have designed microphones that the student can control (similar to a remote control), with the rationale that students would prefer the less conspicuous technological approach. Despite manufacturers' attempts at making a small, inconspicuous product, many students reject the use of assistive technology for some of the same reasons they reject the use of hearing aids.

Communication

Adolescents with hearing loss have choices with regard to the communication strategies they may use, including auditory-oral, auditory-verbal, cued speech, total communication, and American Sign Language. Altman (1994) pointed out that adolescents with hearing loss attempting various communicative modes require "a strong sense of self to risk the inconsideration, impatience, and/or indifference of one's peers and adults" (pg. 201). Reed, McLeod, and McAllister (1999) examined adolescents' perceptions of necessary communication skills needed for interaction between peers. The three skills rated as crucial for peer interaction were nonverbal comprehension, perspective taking, and vocal tone interpretation. Henry, Reed, and McAllister (1995) defined these skills as characteristics of empathy. Empathy is important for peer acceptance and is a key component of adolescents' friendships (Donahue & Bryan, 1984; Reisman and Shorr, 1978). Regardless of the communication modality an adolescent with hearing loss chooses, any missed opportunity to display the three characteristics of empathy can be costly when trying to make and maintain friendships.

Some of the communicative situations that are difficult for adolescents with hearing loss are those that contain background noise, multiple speakers, distance, and reverberant acoustical conditions. Background noise can be found during extracurricular activities (e.g., sporting events), restaurants, or in the school hallways (e.g., before or after school, transitional times between classes). Situations with multiple speakers, such as small group discussions, science labs, or family gatherings during the holidays, make it difficult for the adolescent with hearing loss to follow along in the conversations through both listening and watching. Classes such as physical education or large lecture courses can have detrimental elements of distance or reverberation depending on how teachers lecture (e.g. moves around the classroom) or where they teach (e.g., large gymnasium). Sometimes situations that are difficult for the adolescent with hearing loss (e.g. a soft-spoken teacher, communication outdoors) are difficult for their peers with normal hearing as well (Elkayam & English, 2003).

Psychosocial development

Self-image. An adolescent's self-image is a reflection of oneself that often is defined by one's peer group. Often one is judged

by external characteristics or cosmetic factors (e.g., designer clothing, hairstyle, body shape/size and overall appearance). For the adolescent with hearing loss, the hearing aid is symbolic of a difference that other adolescents cannot comprehend (Elkayam & English, 2003; Mann, 1991). Most authors agree that the strongest method of preparing the adolescent for this type of self-image turbulence is by counseling his or her parents during the child's younger years with regard to positively accepting their child's hearing loss and use of amplification. Adolescents need their parents' support to foster their own acceptance of the hearing aid, and to realize that the aid is crucial to their ability to access and participate in the communicative world around them. When a positive environment is created and fostered by the parents, adolescents have a safe support system in which to retreat from the negative environment they can encounter at school, work, or in social situations (Altman, 1994; Briggs, 1975; English, 2002; Mann, 1991).

Self-concept. A recent study by Elkayam and English (2003) found that the majority of the adolescents interviewed experienced the "hearing aid effect" as originally described by Blood, Blood, and Danhauer (1977). In a more recent study by Stein, Gill and Gans (2000), 80 adolescents with normal hearing were asked a series of questions regarding their attitudes toward the appearance, achievement, and socialization ability of students with hearing loss. In general, the responses were more favorable than past, similar studies. Interestingly, the responses of the male students were more negative than the female students on questions targeting appearance (e.g. use of hearing aids). The majority of the students felt that wearing a hearing aid did not diminish the attractiveness or appearance of the adolescent with hearing loss but many felt that wearing a hearing aid would affect their own appearance.

Elkayam and English (2003) reported that adolescents identified several reasons for their negative feelings towards hearing aids, including physical discomfort, day-to-day amplification management, limited communicative benefit, and the constant barrage of questions regarding their hearing aids. The authors also found that adolescents with hearing loss felt others were judging them negatively if they wore their hearings aids or if there were communication obstacles inherent to hearing loss. Many were certain that if they repeatedly asked for clarification, their communicative partners would become frustrated which they witnessed by "weird looks" or being ignored by the communicative partners.

Peer relationships. Relationships are built on communication. Mann (1991) describes an intensely overwhelming feeling of frustration that, if not dealt with, can result in aggression, behavioral problems, or withdrawal from all relationships. Henggeler, Watson, and Whelan (1990) found that mothers of adolescents with hearing loss viewed their children to be less bonded to friends and felt the friendships tended to be aggressive in nature. Stinson, Whitmore, and Kluwin (1996) found that most of the mainstreamed students with hearing loss they interviewed preferred spending time with other students with hearing loss,

describing these as deeper and more satisfying relationships. One reason these relationships are more successful could be the ability to understand and better navigate through the communication difficulties, on the part of both communicators, making conversations less stressful. Elkayam and English (2003) found that many adolescents with hearing loss feel left out of conversations and view that as a normal part of having a hearing loss. Feelings of isolation felt by adolescents with hearing loss were expressed in two ways: "1) the limited ability of others to understand the experience of being hard of hearing and 2) the limited ability of the adolescents to participate fully in conversations" (pg. 490). Limited participation and limited access to communicative information reduces opportunities to make and maintain friendships or relationships with peers, the group by which adolescents define themselves. For the adolescent with hearing loss, a great amount of effort and patience is required to have relationships with peers that do not share the same communicative concerns.

The previous sections defined counseling and its application to audiologic practices, and described the developmental issues of adolescents and the impact of hearing loss during this time in life. The following section will describe how audiologists can use self-assessments as counseling tools, highlighting a new self-assessment designed for teens with impaired hearing.

Using Self-Assessments as Counseling Tools

An audiogram provides a graphic depiction of the physical characteristics of a person's hearing sensitivity. In comparison, a self-assessment tool is the perceptual documentation of how diminished hearing sensitivity might impact one's life, specifically in communicative situations. This tool may be in written or interview format, and it may be an inventory, scale, questionnaire, or profile. Often, patients find the technical information of an audiogram difficult to apply to their real-life auditory experiences. A self-assessment tool can bridge the gap between technical audiological measurements and perceived auditory struggles for the patient by reporting information in a user-friendly manner. An audiologist can use self-assessment tools to ascertain the person's communicative expectations, amplification expectations, future counseling and audiologic (re)habilitation needs, and to assess the audiologist's practice patterns (Geier, 1997).
The ultimate goal of self-assessments is to change a targeted behavior that will influence positively a person's functioning in real-life situations. For an adult, the goal may be to be more productive and interactive in work and social settings. For a child, the goal may be to make speech audible with amplification to facilitate academic, language, and social growth (Weinstein, 2000). There are several self-assessment tools geared towards adults but few for children. Most assessments for children require responses only from an adult, teacher, or parent(s) rather than from the child and, therefore, cannot be considered self-assessments (Elkayam & English, 2003).

Self-Assessments for Adults

The World Health Organization (2002) classified all health-related disorders and conditions using three categories: impairment, disability, and handicap. Figure 1 demonstrates the impact

Figure 1. Relationships among health condition, body functions and structures, activity, and participation (World Health Organization, 2002)
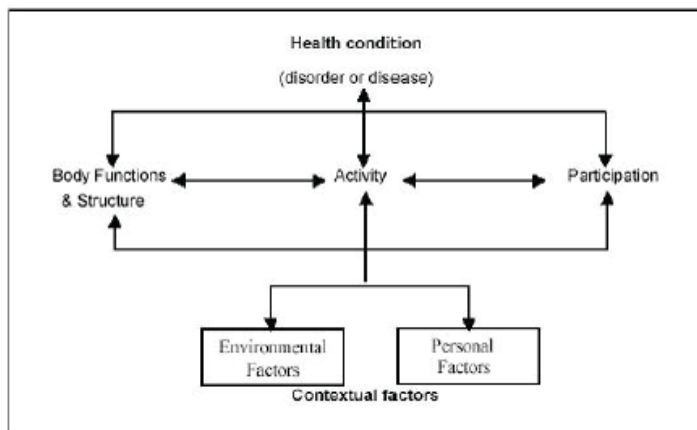
a disease or disorder can have on all areas of a person's life

In audiology, the domains of Body Functions, Body Structures, and Impairment are assessed using traditional medical and audiological evaluations. The domains of Activity, Participation, and Environmental factors can be assessed using any number of self-assessment tools designed for adults, such as:

- *Hearing Handicap Inventory for Adults* - HHIA (Newman, Weinstein & Jacobson, 1990)
- *Hearing Handicap Inventory for the Elderly* - HHIE (Ventry & Weinstein, 1982)
- *Abbreviated Profile for Hearing Aid Benefit* – APHAB (Cox & Alexander, 1995)
- *Hearing Aid Performance Inventory* – HAPI (Walden, Demorest, & Hepler, 1984)
- *Client Oriented Scale of Improvement* – COSI (Dillon, James & Ginis, 1997)
- *Glasgow Hearing Aid Benefit Profile* – GHAPB (Gatehouse, 1997)

Most of these self-assessments satisfy the requirements for all three domains of Activity, Participation, and Environmental factors, making it difficult to sort them into specific categories.

Self-Assessments for Children

Most assessment tools for children require input from adults, parents, and/or teachers regarding how children use their auditory/listening skills in a variety of age-appropriate communicative situations (e.g. home, school, social situations). Examples include the *Children's Auditory Performance Scale* (CHAPS) (Smoski et al., 1998), *Screening Instrument for Targeting Educational Risk* (S.I.F.T.E.R.) (Anderson & Matkin, 1989), and *Children's Home Inventory for Listening Difficulties* [(CHILD), Anderson & Smaldino, 2000]. Instruments that obtain information directly from the elementary school-aged child include *The Listening Inventory for Education* (LIFE): *Student Appraisal of Listening Difficulty* (Anderson and Smaldino, 1998) and the *Children's Peer Relationship (CPR) Scale* (English, 2001).

Self-Assessment for Adolescents

Adolescents with hearing loss face the day-to-day struggles that affect most teenagers including autonomy, self-identification, and peer group relationships with the added stressor of communicative difficulties intrinsic to life with a hearing loss (Altman, 1994). Audiologists are capable of providing counseling to this age group with the help of a self-assessment tool specifically designed for adolescents. In 1999, Elkayam and English modified the Self-Assessment of Communication (SAC) and the Significant Other Assessment of Communication (SOAC) (Schow & Nerbonne, 1982) into a version suitable for adolescents (the SAC-A/SOAC-A). The SAC/SOAC proved to be an excellent choice due to its Significant-Other questionnaire that could be altered to provide input from the teenager's friend regarding communicative behaviors of the teenager with hearing loss. The feedback from the SOAC-A satisfies the need teens often have to define themselves by the perceptions of their peers (Altman, 1994).

The SAC-A/SOAC-A has many of the same characteristics as other self-assessment tools. The twelve-question format assesses communicative difficulties by incorporating six questions directly addressing situational communicative problems, three questions that discuss feelings associated with communicative problems, and three questions addressing how adolescents perceive they are viewed by others. As with any self-assessment tool, the SAC-A and SOAC-A instruments are designed to facilitate a counseling environment between the audiologist and adolescent with hearing loss, in hopes that the communicative door will be opened, allowing the adolescent to express any concerns he or she may have related to life with a hearing loss. Once the door to communication is open, the audiologist can implement his or her counseling strategies to help the adolescent examine how communicative choices, good or bad, affect interpersonal relationships and communicative lifestyle (Elkayam & English, 1999, 2003).

What makes the SAC-A/SOAC-A combination a unique self-assessment tool is its use of language that is respectful to the experiences of an adolescent. Questions are phrased in the context of an adolescent's life. Communicative situations are relevant to their experiences (e.g., language or science lab, school assemblies, and in the hallways at school). There are no other self-assessment tools designed specifically for the adolescent population. Another unique feature is the Significant-Other questionnaire (SOAC-A). Very few assessment tools are designed from the significant other's perspective, or in this case, a peer or friend's perspective. As stated earlier, peer feedback and peer perceptions are crucial for most adolescents. They use peers as a means of gauging their behaviors, attitudes, and actions. Peer feedback is equally essential to the development of adolescents with hearing loss. The SAC-A and SOAC-A use peer comments and/or feedback to provide reflection and insight on the targeted adolescent's communicative behaviors. Elkayam and English (2003) felt that the Significant-Other component of a self-assessment questionnaire for adolescents facilitates "the counseling process, since comparison of responses was frequently an incentive for discussion" (pg. 494).

Conclusion

An audiologist's willingness to counsel adolescents on the complex issues surrounding their hearing loss is crucial to their achieving communicative independence and communicative autonomy. Pediatric and educational audiologists need access to a self-assessment tool designed for adolescents and instruction on counseling theories that will facilitate communication between the audiologist and the adolescent. Using a systematic framework, such as a self-assessment tool, in conjunction with one or more of the counseling theories discussed in this tutorial will provide a platform for discussion between the audiologist and the adolescent.

The SAC-A and SOAC-A are currently undergoing evaluation for test-retest reliability (Elkayam, English, Crowell, & Lambert, in progress). Because these assessments were modified only slightly from existing standardized assessments, it is expected that they will be found to be reliable; however, until final data are analyzed, readers are cautioned not to use these tools until reliability is confirmed and published. If these self-assessments are found to meet psychometric criteria, audiologists should consider using the SAC-A and SOAC-A as a framework or platform for counseling adolescents. A variety of other counseling techniques can be utilized to take the focus off the audiologist and place it on the adolescent, who often has a rich and intricate story to tell. Audiologists are called to respond appropriately and effectively to the adolescent's concerns by familiarizing themselves with the SAC-A and SOAC-A self-assessments and basic theories of counseling.

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Appendix A
Counseling Scenarios for Educational Audiologists

Hypothetical Scenario #1:
Brandon

Brandon is a fourteen-year-old male with a moderate to severe sensorineural hearing loss in both ears. He is an excellent student and high achiever, taking courses two or three grade levels above his chronological grade. Brandon perceives himself to be excelling academically and enjoying a social life. Brandon's parents attend all IEP meetings. Brandon's father contributes minimally to the discussion while Brandon's mother tends to monopolize the discussion. Brandon's mother has a hearing loss and often mentions her struggles as an adolescent during IEP meetings. She views Brandon as struggling both academically and socially and she repeatedly vocalizes this at IEP meetings, in front of Brandon. Brandon tends to be less self-assured with each meeting often agreeing with his mother's assessment of his skills. Brandon's mother wants him to use an FM system during school hours but he refuses without giving any reasons. Brandon and his parents agree to the use of the SAC-A and SOAC-A to shed light on some of the perceptive discrepancies between them.

Brandon, along with his friend Mark who has normal hearing, completed the SAC-A and SOAC-A. Overall, Mark rated Brandon as having more difficulty in all communicative situations than Brandon did. Brandon's scores did reveal elevated concern in the social domain (i.e. communicating in small groups, hearing loss interfering with social life, hearing loss prohibits him from doing things that might be fun, feeling left out of conversations, and people getting the wrong impression when they first meet him).
After reviewing the SAC-A and SOAC-A, the audiologist engages in a conversation with Brandon to discuss his concerns, ascertain his motivation for making changes, and mutually devise a plan that is compatible with Brandon's needs. The conversation might look like this:

BRANDON: "Did Mark write down the same answers as I did on the questionnaire?"
AUDIOLOGIST: "How do you think he answered?"
BRANDON: "I am not sure. I think the questions were hard and he doesn't really know me that well. I picked him because we are neighbors; we sit together on the bus."
AUDIOLOGIST: "Do you think you should have picked someone else?"
BRANDON: "I really can't think of anyone else I would pick. (PAUSE) Did Mark answer the same as I did?"
AUDIOLOGIST: "You both answered fine. (PAUSE with EYE CONTACT) Brandon, on the checklist you said your hearing loss interferes with your social life. Tell me more about that."
BRANDON: "Well, I am not invited to parties. Mark is invited to every party. No one likes to hang around me."
AUDIOLOGIST: (PAUSE) "What makes you think that no one likes to hang around you?"
BRANDON: "I am not sure. (LONG PAUSE) I don't fit in here. People think that I am weird. They either ignore me or talk to me like I am stupid. They talk so loud and slow, like I am dumb. I get better grades than anyone else in my classes."
AUDIOLOGIST: "Do you want to feel like you fit in at this school?"
BRANDON: "I want to have friends and I want to be invited to parties."
AUDIOLOGIST: "Building friendships can take a lot of work. Are you committed to working towards making more friends?"
BRANDON: "Yes I want to make more friends."
AUDIOLOGIST: "Okay. Is there someone you would like to get to know better?"
BRANDON: "Yeah, Travis seems cool. Sometimes we talk about motorcycles. Maybe I could start with Travis."

The information from the SAC-A and the SOAC-A was shared with Brandon's parents. His mother expressed mixed feelings about the results. She knew he was struggling socially more than he let on and felt badly that he had not shared his concerns with her. The use of the SAC-A/SOAC-A in this scenario starts the process of transition from parental responsibility for the hearing loss to Brandon's responsibility for his hearing loss.

The audiologist used a combination of counseling techniques with Brandon in response to Brandon's thoughts and comments. She kept "the spotlight" on Brandon, giving him time to articulate his concerns without judgment from the audiologist. Brandon demonstrated a self-awareness of the feelings he was having which is one of the first steps to making communicative changes. The audiologist used silence and eye contact to convey empathic listening, showing Brandon that his concerns were important and worthy of discussion. Brandon conveyed his commitment to making changes; the audiologist provided him the opportunity to make his desired changes.

Hypothetical Scenario #2:

Caitlin

       Caitlin is a seventeen-year-old female with a moderate, sensorineural hearing loss in the right ear and a profound, sensorineural hearing loss in the left ear. Caitlin is quite popular in school; she is in sports, school plays and various clubs/organizations. She has a dynamic personality but she has a temper that can flare instantly. She has a history of both verbal and physical altercations with peers. Her most recent altercation was both physical and verbal; she was caught fighting with a student in a school hallway. The incident was violent and those who witnessed stated that Caitlin's opponent was an aggressive young woman. Everyone but Caitlin knew to stay clear of this young woman. The speech-language pathologist immediately recognized that Caitlin's hearing loss could have contributed to this, and past, altercations. She asked for an assessment by the audiologist to ascertain Caitlin's communicative needs. Caitlin's parents agreed to the assessment but Caitlin was not as eager to discuss issues surrounding her hearing loss. She has made it clear for several years that she does not have a disability. Caitlin and her friend, Jane, completed the SAC-A and SOAC-A to see if Caitlin perceives any difficulties communicating with her hearing loss. Caitlin and Jane's responses were completely opposite from each other. Jane perceived Caitlin as having grave difficulty in all the probed communicative situations. Caitlin did not see problems with her ability to communicate in the various situations. The audiologist has a good rapport with Caitlin and decides that a conversation around Jane's perceived concerns is not only worthwhile but necessary to foster Caitlin's awareness of possible communicative struggles.

AUDIOLOGIST: "Hi Caitlin, thank you for filling out the SAC-A questionnaire. What did you think of the questions?"

CAITLIN: "They seemed easy. I don't have a lot of difficulty with my hearing. I don't know why my parents wanted me to do the questionnaire. They always think I am having trouble with my hearing."

AUDIOLOGIST: "How do you know your parents think you are having trouble?"

CAITLIN: "They are always on me to pay attention. They think I can't do anything because I wear hearing aids. They say I have a "disability". I don't have a disability, I am just fine!"

AUDIOLOGIST: "What does the word "disability" mean to you?"

CAITLIN: "It means that you can't do anything for yourself and you have to depend on other people. I am not dumb. I wish my parents would lay off me!"

AUDIOLOGIST: "It sounds like you want your parents to let you be independent. Have you told them how you feel?"

CAITLIN: "No I try not to talk to them. I feel more comfortable talking to my friends. Jane is my best friend, she really understands me."

AUDIOLOGIST: "Jane sounds like a good friend. (PAUSE) Caitlin, Jane's questionnaire looked a lot different from yours. She seems to think that you are having more trouble with your hearing loss than you do. Why do you think that is?"

CAITLIN: "She said that? Wow, what do you mean? How different were the questionnaires?"

AUDIOLOGIST: "For all the questions she said you "almost always" have difficulty. Would you like to look at the questions again so we can discuss this?"

CAITLIN: "Yes that would be great! I am surprised she thinks I am having so much trouble."

       Caitlin is like most adolescents: she values her peer's opinion and questions/rejects much of her parent's concern. The SAC-A and SOAC-A self-assessments are a key component of tapping into Jane's perceptions. In this conversation, Caitlin started out angry and resentful of what she thought her parents thought of her. Everything changed when her good friend expressed concern. The door to communication was opened; Caitlin seems ready to hear what Jane's SOAC-A assessment had to say.

       Again, in this conversation the audiologist talks little and listens carefully. Caitlin would have rejected a lecture from the audiologist; she needed to express her feelings of perceived inadequacy by her parents. The audiologist needed to hear how important her friendship with Jane was in order to reference Jane's comments. Obviously this is just the start to the conversation between Caitlin and the audiologist. Caitlin needs more counseling in the area of accepting her hearing loss and decreasing the stigma of "disability" as she defines it.

Hypothetical Scenario #3:

Theresa

Theresa is a sixteen-year-old female with a moderate, sensorineural hearing loss in both ears. She has an above average I.Q. with marginal grades. She does not participate in extra curricular activities. Theresa's parents and teachers regard her as quiet and sometimes inattentive. Her parents feel that the IEP accommodations are excessive; they feel their daughter is doing fine in school and really doesn't need any support. Theresa rarely offers or expresses an opinion about her hearing loss at her IEP meetings. Theresa's case manager has concerns about Theresa's lack of friends and social interactions. An audiological evaluation including the self-assessment tools, the SAC-A and SOAC-A, were administered to ascertain Theresa's perception of her communication abilities as they relate to her hearing loss. Her perceptions were to be compared to a peer as a means of facilitating communication.

When the evaluation date approached, the audiologist was notified that Theresa could not find a peer to complete the SOAC-A. Theresa asked if her sister Karla, age fifteen, could serve as a peer. Karla is an excellent student, taking advanced courses, participating in extra curricular activities, and very socially active. Karla has no hearing loss. She was allowed to be Theresa's peer based on her sister's request.

The SAC-A and SOAC-A questionnaires were compared and revealed that Karla felt Theresa had significant difficulty in all areas assessed. Theresa's SAC-A was identical to Karla's, in that she perceived extreme difficulty with the communicative and social-emotional aspects of her hearing loss.

Theresa and her audiologist met to discuss the results of the SAC-A and SOAC-A.

AUDIOLOGIST: "Theresa, let's look at the questionnaires that you and Karla filled out. Tell me what you think."

THERESA: (LONG PAUSE) "They are identical. (PAUSE, TEARFULLY) I can't believe it!"

AUDIOLOGIST: "Are you surprised by Karla's responses?"

THERESA: (CRYING) "Everyone in my family thinks that I am just fine, that I don't have trouble hearing. I can't believe Karla's responses are just like mine. My parents are going to be so mad. They always say 'Why can't you be more like Karla?' I don't get good grades, I am not in soccer, and I don't have friends calling me or coming over like does Karla. I just want to be me but my parents don't think that's good enough."

AUDIOLOGIST: "Theresa your questionnaire indicates that you are having a lot of trouble communicating in a lot of situations. Why do you think you are having so much difficulty?"

THERESA: (PAUSE) "Well I think I need new hearing aids but my parents can't afford it. My parents are getting a divorce and my mom said she doesn't have any money. And when there is background noise or too many people talking I can't understand what's going on. My parents say that I am 'spacey.'" (CRYING) I feel stupid that I don't understand people talking at school and at home."

AUDIOLOGIST: "There is a lot going on in your life right now."

THERESA: "Yeah, too much! It is out of control."

AUDIOLOGIST: "Is there anything that you can control?"

THERESA: (CRYING) "I don't know."

Theresa was referred for individual counseling to deal with the feelings of loss surrounding her parents' divorce. Theresa's psychologist shared with the audiologist that Theresa had no idea why her parents were divorcing. The psychologist attributed her lack of knowledge to her hearing loss, which permitted minimal accessibility to auditory information in her home environment. Funding was provided to Theresa's family for new hearing aids. Theresa's mother thanked the audiologist for the assessment and asked that Theresa's IEP be updated reflecting additional support for her social-emotional needs.

This scenario demonstrates the complexity of life for many adolescents. Theresa had very strong needs, socially and emotionally, due to her parents' divorce and the perceived obstacles of her hearing loss. The results of the SAC-A and SOAC-A became the catalyst for Theresa to openly communicate her thoughts and feelings. The audiologist made a referral for professional counseling and offered audiological support when appropriate.

Appendix B
Self-Assessment of Communication – Adolescent

SELF ASSESSMENT OF COMMUNICATION-ADOLESCENT (SAC-A)*
　　　The purpose of this questionnaire is to identify problems your hearing loss may be causing you. You and I will compare your answers with the answers your friend gave on a similar questionnaire. Some of the things we talk about may help both of us understand how the hearing loss affects you. Our discussion may result in new ideas about how to manage some of the problems you are experiencing. The information will not become part of your school record and will have no impact on your grades, school program or hearing aid use.

Please select the appropriate number to answer the following questions.   Select only one number for each question.

1=almost never   2=occasionally   3=about half the time   4=frequently   5=almost always

Hearing and Understanding at Different Times
　　　1. Is it hard to hear and understand when you are talking with only one other person?　　　1　2　3　4　5

　　　2. Is it hard to hear and understand when you are talking with a group of people,?　　　1　2　3　4　5

　　　Is it hard to hear and understand movies, TV, the radio or CDs?　　　1　2　3　4　5

　　　4. Is it hard to hear and understand when there is noise or music in the background, or other people are talking at the same time?　　　1　2　3　4　5

　　　5. Is it hard to hear and understand in any of your classes in school?　　　1　2　3　4　5

　　　6. Do you hear better when you use hearing aids?　　　1　2　3　4　5

　　　Feelings about Communication
　　　7. Do you feel left out of conversations because it's hard to hear?　　　1　2　3　4　5

　　　8. Does anything about your hearing loss upset you?　　　1　2　3　4　5

　　　9. Do you feel different from other kids when you wear hearing aids?　　　1　2　3　4　5

　　　Other People
　　　10. Do strangers or people you don't know well notice that you have a hearing loss?　　　1　2　3　4　5

　　　11. Do other people become frustrated when they talk to you because of your hearing loss?　　　1　2　3　4　5

　　　12. Do people treat you differently when your wear hearing aids?　　　1　2　3　4　5

*Modified, with permission, from Self Assessment of Communication (Schow & Nerbonne, 1982).

Appendix C
Significant Other Assessment of Communication – Adolescent

SIGNIFICANT OTHER ASSESSMENT OF COMMUNICATION-ADOLESCENT (SOAC-A)*

The purpose of this questionnaire is to identify the problems your friend's hearing loss may be causing.
If you do not understand the meaning of any of the questions, please ask me. The information will be compared with the responses your friend gave on a similar questionnaire. Your friend and I will discuss similarities and differences between responses. The information will not become part of a school record and will have no impact on your friend's grades, school program or hearing aid use.

Please select the appropriate number to answer the following questions. Select only one number for each question.

1=almost never   2=occasionally   3=about half the time   4=frequently   5=almost always

Hearing and Understanding at Different Times

1. Is it hard for your friend to hear and understand when talking with only one other person?   1   2   3   4   5

2. Is it hard for your friend to hear and understand when talking with a group of people?   1   2   3   4   5

3. Is it hard for your friend to hear and understand movies, TV, the radio or CDs?   1   2   3   4   5

4. Is it hard for your friend to hear and understand there is noise or music in the background, or other people are talking at the same time?   1   2   3   4   5

5. Is it hard for your friend to hear and understand in in class?   1   2   3   4   5

6. Does your friend hear better when using hearing aids?   1   2   3   4   5

Feelings about Communication
7. Does your friend feel left out of conversations because it's hard to hear?   1   2   3   4   5

8. Does anything about your hearing loss upset your friend?   1   2   3   4   5

9. Does your friend feel different from other kids when wearing hearing aids?   1   2   3   4   5

Other People
10. Do strangers, or people your friend doesn't know well, notice that your friend has a hearing loss?   1   2   3   4   5

11. Do other people become frustrated when they talk to your friend because of the hearing loss?   1   2   3   4   5

12. Do people treat your friend differently when wearing hearing aids?   1   2   3   4   5

*Modified, with permission, from Self Assessment of Communication (Schow & Nerbonne, 1982).