Outcome Survey of Auditory-Verbal Graduates: Study of Clinical Efficacy

Donald M. Goldberg*
Carol Flexer†

Abstract

Audiologists must be knowledgeable about the efficacy of aural habilitation practices because we are often the first professionals to inform parents about their child's hearing impairment. The purpose of this investigation was to document the status of graduates of one aural habilitation option; auditory-verbal. A consumer survey was completed by graduates from auditory-verbal programs in the United States and Canada. Graduates were queried regarding degree and etiology of hearing loss, age of onset, amplification, and educational and employment history, among other topics. Results indicated that the majority of the respondents were integrated into regular learning and living environments.

Key Words: Auditory-verbal, aural (re)habilitation, clinical efficacy, clinical outcomes, hearing impairment

Whether or not they provide aural habilitative programming themselves, audiologists are often central to each family's decision regarding selection of intervention methodologies (Luterman, 1991) for children with hearing impairment. How families are told about their child's hearing impairment, and how they are subsequently informed about the plethora of aural habilitative options, often heavily influences the parents' decision (Martin et al, 1987). Therefore, audiologists must be knowledgeable about the effectiveness of the treatment strategies that they recommend.

If our ultimate goal is to provide persons with hearing problems opportunities to improve their quality of life, then we are ethically obligated to determine if our intervention is effective. Indeed, the investigation of clinical efficacy is a primary responsibility for all aspects of our profession of audiology (Perkins, 1990). Child aural habilitation is an important component of audiology's scope of practice. Therefore, aural habilitation practices are subject to examination for treatment effectiveness.

One important way of evaluating the efficacy of a treatment strategy is to examine that treatment's social validity; is the desired long-range outcome of an intervention approach actually achieved (Wolf, 1978; Test et al, 1987; Halpern, 1990)? For example, if a targeted outcome of intervention procedures for children with hearing impairment is that those children would be independent, contributing adults in mainstream society, then the test of the social validity of that intervention procedure would be to determine if those children actually grew up to achieve the specified goal. Moreover, it could be argued that a meaningful measure of outcome is the evaluation of that outcome as perceived by the recipients of the service.

Anecdotal accounts of the communicative abilities and subsequent adult status of children with hearing impairments abound, regardless of the intervention methodology chosen and followed. Indeed, there are many intervention options, each one distinct in philosophy, methodology, programming, expectations, and assumptions. “Debates in the past have centered on the issue of oralism versus manualism. Today, issues are more complex. Present controversy pits morphosyntactic approaches against semantic/pragmatic approaches, ASL/ESL against various manually coded forms of English as philosophies, and naturalistic pedagogy against metacognition, among others.” (Easterbrooks, 1987, p. 188).
The purpose of this investigation was to descriptively document, through the use of a consumer survey, the status of graduates from only one type of program; auditory-verbal. Such documentation is critical because there are no known published data about the outcome of the auditory-verbal approach. This project was not designed to determine if one particular philosophy, method or outcome of aural habilitation is superior to any other; nor was this paper developed as a treatise to compare and contrast all habilitative intervention methods. Rather, this project looked only at the social validity of auditory-verbal principles; can auditory-verbal practice, in fact, reach its stated goals as reported by its recipients?

In order to determine if the auditory-verbal approach can fulfill its intent, a brief definition and description must be included about what auditory-verbal purports to be and to accomplish. As defined by a position paper published by Auditory-Verbal International, the auditory-verbal philosophy is a logical and critical set of guiding principles (AVI, 1991). These principles outline the essential requirements needed to realize the expectation that young children with hearing impairments can be educated to use even minimal amounts of amplified residual hearing. Use of amplified residual hearing in turn permits children with hearing impairments to learn to listen, to process verbal language, and to speak. The goal of auditory-verbal practice is that children with hearing impairments can grow up in regular learning and living environments that enable them to become independent, participating, and contributing citizens in mainstream society.

Auditory-verbal is a model of intervention that incorporates the principles outlined in Table 1 (adapted from Pollack, 1970, 1985). Note that auditory-verbal is not merely a “technique” to be delivered 2 hours per week, but rather a way of life to be practiced on a daily basis. Consequently, professionals require specialized training to deliver auditory-verbal services (Caleffe-Schenck, 1992).

The focus of this paper is the presentation of data obtained from a survey completed by graduates of auditory-verbal programs. How do these now grown-up recipients of auditory-verbal practice and way of life describe themselves and their histories?

**METHOD**

Due to issues of confidentiality, a complete listing of individuals who had participated in auditory-verbal programs throughout the United States and Canada was not available. Therefore a list of known therapists (e.g., Doreen Pollack and Daniel Ling) and centers (e.g., Helen Beebe Speech and Hearing Center) was developed. These contact persons and sites were given the list of auditory-verbal principles (see Table 1) in order to verify that their programs would be considered auditory-verbal ones. In addition, prospective former students needed to satisfy the following criteria: (1) 18 years old or older and (2) participation in their program for at least 3 years.

It was made clear that the purpose of this investigation was not to identify “stars,” but instead, to contact as many former students as possible. The investigators were told the number

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Auditory-Verbal Principles</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Supporting and promoting programs for the early detection and identification of hearing impairment and the auditory management of infants, toddlers, and children so identified;</td>
</tr>
<tr>
<td>2.</td>
<td>Providing the earliest and most appropriate use of medical and amplification technology to achieve the maximum benefits available;</td>
</tr>
<tr>
<td>3.</td>
<td>Instructing primary caregivers in ways to provide maximal acoustic stimulation within meaningful contexts, and supporting the developing of the most favorable auditory learning environments for the acquisition of spoken language;</td>
</tr>
<tr>
<td>4.</td>
<td>Seeking to integrate listening into the child’s total personality in response to the environment;</td>
</tr>
<tr>
<td>5.</td>
<td>Supporting the view that communication is a social act, and seeking to improve spoken communication interaction within the typical social dyad of infant/child with hearing impairment and primary caregiver(s), including the use of the parents as primary models for spoken language development, and implementing one-to-one teaching;</td>
</tr>
<tr>
<td>6.</td>
<td>Seeking to establish the child’s integrated auditory system for the self-monitoring of emerging speech;</td>
</tr>
<tr>
<td>7.</td>
<td>Using natural sequential patterns of auditory, perceptual, linguistic, and cognitive stimulation to encourage the emergence of listening, speech, and language abilities;</td>
</tr>
<tr>
<td>8.</td>
<td>Making ongoing evaluation and prognosis of the development of listening skills an integral part of the (re)habilitative process; and</td>
</tr>
<tr>
<td>9.</td>
<td>Supporting the concepts of mainstreaming and integration of children with hearing impairments into regular education classes with appropriate support services and to the fullest extent possible.</td>
</tr>
</tbody>
</table>

of "graduates" by the therapists who delivered intervention and the appropriate number of questionnaires and postage-paid return envelopes were then sent to therapists and centers for distribution.

Each identified therapist served as the contact person to their former students and was encouraged to do as much as possible to ensure a high response rate. In addition, Auditory-Verbal International published an article on this project in their newsletter, The Auricle. Readers were asked to contact the researchers if they met the criteria for participation, but had not yet been contacted by their former therapist or center.

The questionnaire was seven pages in length and included both fill-in and open-ended questions (Appendix). Areas addressed included degree and etiology of hearing loss, age of onset, amplification, and educational and employment history, among others.

A total of 366 surveys were forwarded to auditory-verbal therapists and programs. A response rate of 42.9 percent was achieved with 157 usable forms returned.

A follow-up request for information was attempted; however, due to the lack of names on some returned questionnaires, therapists and centers could only be apprised of some of the names of their former students who did respond, which made it difficult to recontact the true nonrespondents.

RESULTS

Hearing Loss

Ninety-three percent of the respondents reported having a hearing loss in the severe to profound severity range (based on the pure-tone average for the better ear). Regarding age of onset, over 95 percent reported a prelingual loss (defined as 3 years of age or younger). Etiology of the hearing loss is shown in Figure 1. The largest number reported an unknown etiology (53.4%). It should be noted that of these respondents, 15.6 percent stated that the hearing loss was congenital. Because the respondents were primarily in their 20s, it was not surprising that 28.9 percent reported rubella as the etiology.

Identification and Amplification History

The average age of identification of the hearing loss was 23 months, with the average age of initial amplification 27 months, suggesting fairly immediate intervention. Binaural amplification accounted for 64.1 percent of the initial hearing aid fittings. Use of assistive devices was reported by 51.4 percent of the respondents. The most commonly mentioned device was an FM system or auditory trainer.

Educational History

Perhaps the most telling data relate to the educational history of the auditory-verbal graduates. The degree of mainstreaming (defined as fully integrated in "normal" schools) was impressively high (Fig. 2).

Furthermore, 152 respondents stated that they had completed high school and one reported receiving a GED degree. Approximately 70 percent of the respondents reported their age at graduation from high school to be between 16 through 18 years. Not surprisingly, over 95 percent of the students continued with some form of post-secondary education. Of the 139 respondents reportedly continuing education after high school, 124 attended or were enrolled in college or university settings. Of the individuals attending colleges or universities, only 12.1 percent (N = 15) stated that they attended or were enrolled at National Technical Institute for the Deaf or Gallaudet University. The rest
attended post-secondary programs that were not dedicated to working specifically with persons with hearing impairment.

Auditory-Verbal Therapy

The average number of years of enrollment in auditory-verbal therapy was 11. Respondents noted the range of therapy time from 3 to 23 years (for several, their entire lifespan equaled years of therapy), suggesting that auditory-verbal intervention is a long-range commitment.

Familial History

Table 2 details a variety of familial issues related to the auditory-verbal graduates. It should be noted that the respondents ranged in age from 18 to 47 years old, with the majority in their 20s, which might account for the relatively low marriage rates.

Questions were posited regarding the graduates' family involvement in therapy and their education. With the exception of one individual, all (N = 152) stated that their mothers were actively involved. Of the 150 persons who answered the question about their mother's occupation, over three-quarters (76.7%) reported that during their preschool years, their mother stayed at home. Some of the responses about their mother's involvement included the following: "Mother was always present at my speech lessons with Miss Crawford. She watched and listened and then continued to teach me at home. Every day there was constant teaching of words. She gave formal lessons at home and treated me just like everyone else... normally!"; "She worked with me every single day until her illness made it difficult to work with me. When she was unable to assist me she asked friends to take turns to give me lessons at home."; "Almost every waking hour was some form of education. When going to school it became more tutoring, helping fill some gaps and encouraging."; and "Mom took me for whatever I needed! P.S. Thanks Mom."

Over 80 percent reported involvement of their fathers with approximately two-thirds (66.9%) of their siblings also participating. The respondents perceived the nature of their father's participation to include financial provisions as well as other support and encouragement. When direct involvement was described, often the participation was in the form of homework assistance. Siblings were typically described as providing moral support and serving in the role of appropriate speech and language models. When the siblings were noted as not helping, typically the explanation of the siblings being significantly younger was offered.

Telephone Communication

Over three-quarters (77.6%) of the respondents stated that they made use of the telephone, with varying degrees of success. Approximately one-half (49%) of the graduates made use of a TDD.

Societal Integration

More than half of the respondents (56.1%) reported early and continuing involvement in community activities. Activities were varied, including teaching CPR, holding office or membership in clubs and committees, coaching, and church and synagogue involvement. Examples of some of the organizations participants were involved in or affiliated with included, The Boy Scouts, YMCA, YWCA, sororities, and fraternities. When no activities were reported, the explanation of being too busy and working full-time was noted.
Work History

Because many of the graduates were still enrolled in post-secondary educational programs, job titles and settings and income levels were reported by only 92 participants. Table 3 outlines these results.

The jobs reported were varied, including blue collar positions such as bus and truck driver, courier, house painter, packer, factory worker, dairy farmer, and repairman; office positions such as administrative assistant, computer programmer and analyst, finance manager and analyst, bank vice-president, secretary, and clerk; and other professional positions such as social worker, graphic artist and designer, counselor, engineer (two respondents), teacher (four respondents including three in special education), attorney (three graduates), professor, entomologist, dentist, and physician (an E.N.T. and a pediatrician).

Additional Disabilities

Approximately one-third (36.7%) of the graduates reported having disabilities in addition to their hearing impairment. The most commonly reported problems were vision and learning disabilities (Fig. 3). It should be noted that some of the respondents reported a vision problem based on their usage of glasses. Questionable accuracy is suggested with the paucity of speech and language problems (3.6%) reported by the graduates.

Perceptions

The respondents were queried as to their perceptions of their current participation in the "hearing," "deaf," or both worlds (Fig. 4). Approximately three-quarters (72.7%) stated that they were part of the "hearing" world. Within this group, 13.3 percent specifically described being offered the opportunity to be part of the hearing world due to the choices afforded them (e.g., "I am a hearing-impaired person who has succeeded beyond reasonable doubts to adjust in the hearing world."); "I participate in the hearing world; obviously there are some things I can't do, but that doesn't prevent me from..."
having a full, rich, wonderful life!"; and "I fully participate in the hearing world. My greatest problem is the limitations I face in occupational choices. Education became very difficult at the college level and many jobs depend on ease with the telephone and communications."). Only one respondent stated being in the “deaf” world; this person did not elaborate. Approximately one-quarter (26.7%) of the respondents reported being part of both the “hearing and deaf worlds.”

The researchers searched for any negative responses to balance the positive results and self-reported perceptions of the graduates. The only listed responses which could be considered less positive were the following: “I am a person with a hearing loss who primarily participates in the hearing world but can miss many social contacts and opportunities. On the other hand I don’t fit in the deaf world because I sign very little.”; “I am a person with a hearing loss who participates completely in the hearing world, but sometimes circumstances depress me and I feel left out.”; and “I consider myself an aberration (not a representative sample) of my peers. I still encounter subtle discrimination at all levels and in all environments. But once I establish myself (over time) I am able to compete successfully in virtually all settings.”

**DISCUSSION**

The purpose of this survey was not to compare approaches to aural habilitation nor to debate philosophical differences between methods, but rather to determine for the first time, if the auditory-verbal model of intervention is capable of reaching its targeted outcome. Arguably, a significant demonstration of clinical efficacy is the actual performance and self-perception of graduates of a particular approach. This paper is a first step in documenting that.

Audiologists are often the first professionals to inform parents that their child experiences a hearing impairment. Therefore, it is imperative that audiologists are knowledgeable about all aural habilitative practices and further, that audiologists are concerned about the clinical efficacy of available methods.

The importance of family commitment was emphasized as respondents described the level of their mother’s and father’s involvement in the aural habilitation process. Specifically, 76.7 percent of the mothers chose to stay home with the child during the preschool years, and 81.3 percent of the fathers had personal involvement. One of the graduates recognized the pivotal role of her family by writing: “It was through my family that I have accomplished positive results. My parents, at the time when they were told I was deaf became immediately involved with the auditory training programs and speech lessons which has helped me to motivate myself in succeeding well enough to cope with the hearing world. At the time of my detection (9 months), my family accepted me with loving care, despite the deafness. They knew that I was a normal child, just as any child was and that it was just a small part of me that was different.”

If the goal is independent function in the community, then measures of that function could include mainstreaming in local schools, attendance at post-secondary institutions that are not specifically designated for persons with hearing loss, and involvement in typical community activities. The majority of respondents of this survey identified themselves as successfully functioning in all three areas.

A very telling point is the self-perception and identities of the graduates themselves. Have they chosen, as adults, to participate in the “hearing” world, the “deaf” world, or in both? Approximately three-quarters of the group stated that they perceived themselves as being part of the “hearing” world. One-fourth of the graduates reported being participants in both the “hearing” and “deaf” worlds.

Audiologists are often the first professionals to inform parents that their child experiences a hearing impairment. Therefore, it is imperative that audiologists are knowledgeable about all aural habilitative practices and further, that audiologists are concerned about the clinical efficacy of available methods.

The purpose of this survey was not to compare approaches to aural habilitation nor to debate philosophical differences between methods, but rather to determine for the first time, if the auditory-verbal model of intervention is capable of reaching its targeted outcome. Arguably, a significant demonstration of clinical efficacy is the actual performance and self-perception of graduates of a particular approach. This paper is a first step in documenting that, for the majority of consumers who responded to this survey, auditory-verbal practice did indeed provide them the opportunity to grow up in regular learning and living environments that enabled them to become independent persons in mainstream society.
Outcome Survey of Auditory-Verbal Graduates/Goldberg and Flexer

Acknowledgment. Oral presentations of this study have been given at the following professional meetings.

REFERENCES


APPENDIX

Copy of survey forwarded to graduates of auditory-verbal programs in the United States and Canada.

I. Hearing Loss and Amplification

Degree of hearing loss:

<table>
<thead>
<tr>
<th>250</th>
<th>500</th>
<th>1000</th>
<th>2000</th>
<th>4000</th>
<th>8000 Hz</th>
</tr>
</thead>
<tbody>
<tr>
<td>RE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>dB HL</td>
</tr>
<tr>
<td>LE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>dB HL</td>
</tr>
</tbody>
</table>

Aided (with hearing aids) thresholds:

<table>
<thead>
<tr>
<th>500</th>
<th>1000</th>
<th>2000 Hz</th>
</tr>
</thead>
<tbody>
<tr>
<td>dB HL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Aided Speech Recognition Threshold (SRT): dB HL

Aided Word Recognition (Discrimination) Score: %

Word list used:

<table>
<thead>
<tr>
<th>Presentation level: dB HL</th>
</tr>
</thead>
</table>

Age of onset of hearing loss:

Cause of hearing loss:

Did you or your mother have any of the following?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
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<td></td>
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</table>

1. Asphyxia

2. Bacterial meningitis

3. Congenital perinatal infections
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4. Defects of the head or neck
5. Elevated bilirubin (jaundice)
6. Family history of childhood hearing impairment
7. Low birth weights

Age of identification of hearing loss: __________________________________________
How frequently did you experience middle ear problems? ________________________
_________________________________________________________________________
_________________________________________________________________________
Age first amplified/provided with hearing aid(s): ________________________________
One hearing aid or two hearing aids? ________
How consistently did you wear your hearing aids as a child? ______________________
_________________________________________________________________________
_________________________________________________________________________
Has your hearing loss been progressive?
   __ Yes   __ No
If yes, describe: __________________________________________________________
_________________________________________________________________________
_________________________________________________________________________
Have you ever made use of assistive listening devices (ALDs) such as an FM system? If so, please describe, including ages/grades when ALDs were used. Describe their benefits, if any:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

II. School History

Briefly describe your educational program as you were growing up. Be specific, for example, if you were mainstreamed for all or part of your classes, list the grade, which courses, etc.:  
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Did you receive any special services while in elementary and/or secondary school, for example, speech-language therapy, teacher of the hearing impaired, occupational therapy, tutoring, reading assistance, learning disability assistance, counseling, etc.?

Please describe the ages/grades and the extent of the special services you received:

How would you describe your elementary school?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully mainstreamed “normal” school</td>
<td></td>
</tr>
<tr>
<td>Partially mainstreamed “normal” school</td>
<td></td>
</tr>
<tr>
<td>Oral day school/classroom</td>
<td></td>
</tr>
<tr>
<td>Oral residential school</td>
<td></td>
</tr>
<tr>
<td>TC day school/classroom</td>
<td></td>
</tr>
<tr>
<td>TC residential school</td>
<td></td>
</tr>
<tr>
<td>Manual school/classroom</td>
<td></td>
</tr>
<tr>
<td>Other (please describe)</td>
<td></td>
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</tbody>
</table>

How would you describe your middle school?

<table>
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<tr>
<th>Option</th>
<th>Description</th>
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<tbody>
<tr>
<td>Fully mainstreamed “normal” school</td>
<td></td>
</tr>
<tr>
<td>Partially mainstreamed “normal” school</td>
<td></td>
</tr>
<tr>
<td>Oral day school/classroom</td>
<td></td>
</tr>
<tr>
<td>Oral residential school</td>
<td></td>
</tr>
<tr>
<td>TC day school/classroom</td>
<td></td>
</tr>
<tr>
<td>TC residential school</td>
<td></td>
</tr>
<tr>
<td>Manual school/classroom</td>
<td></td>
</tr>
<tr>
<td>Other (please describe)</td>
<td></td>
</tr>
</tbody>
</table>
How would you describe your high school?
Fully mainstreamed "normal" school
Partially mainstreamed "normal" school
Oral day school/classroom
Oral residential school
TC day school/classroom
TC residential school
Manual school/classroom
Other (please describe)

Did you complete high school?  ____ Yes  ____ No
How old were you when you completed high school? ______
Did you continue your education after high school?  ____ Yes  ____ No
Did you enter a vocational school, college, or university?  ____ Yes  ____ No
If so, please name and describe:

Did you receive a degree?  ____ Yes  ____ No
If yes, what type?

Did you receive additional professional schooling?
Advanced degrees, e.g., M.A., M.S., M.B.A., Ph.D., M.D., J.D., etc.

III. Personal History
Have you ever been married?  ____ Yes  ____ No
Are you currently married?  ____ Yes  ____ No
Have you been divorced?  ____ Yes  ____ No
If you are/were married, does your spouse have a hearing loss?

Do you have children?  ____ Yes  ____ No
If yes, how many?

Do any of your children have a sensorineural (permanent) hearing loss?  ____ Yes  ____ No
If yes, describe:

If you have a child who has a hearing loss, what method(s) are you using to educate your child?
IV. Work History
What is your current job title and job setting? ____________________________________________

Briefly name and describe past jobs you have held (employment history):
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Please choose the annual income range that describes your personal (not family) earnings presently:

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Choices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $4,999</td>
<td>_____</td>
</tr>
<tr>
<td>$5,000–$9,999</td>
<td>_____</td>
</tr>
<tr>
<td>$10,000–$14,999</td>
<td>_____</td>
</tr>
<tr>
<td>$15,000–$19,999</td>
<td>_____</td>
</tr>
<tr>
<td>$20,000–$24,999</td>
<td>_____</td>
</tr>
<tr>
<td>$25,000–$29,999</td>
<td>_____</td>
</tr>
<tr>
<td>$30,000–$39,999</td>
<td>_____</td>
</tr>
<tr>
<td>$40,000–$49,000</td>
<td>_____</td>
</tr>
<tr>
<td>Above $50,000</td>
<td>_____</td>
</tr>
</tbody>
</table>

V. Therapy History

For how many years did you receive auditory-verbal (Acoupedic, unisensory, auditory training) therapy?
__________________________________________________________________________________

Who was your therapist/teacher/clinician? (If more than one, please try to list):
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Describe the schedule of your therapy (years, frequency per week, etc.):
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Describe your mother’s involvement in your therapy and education:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Estimate the number of hours per week that your mother provided home therapy:
__________________________________________________________________________________

Describe your father’s involvement in your therapy and education:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

If you have any brothers and/or sisters, describe their involvement in your therapy and education:
__________________________________________________________________________________

What was your mother’s occupation when you were a child?
__________________________________________________________________________________

What was your father’s occupation when you were a child?
__________________________________________________________________________________
VI. Miscellaneous

Are you able to use (receive and send messages) the telephone (voice)? ___ Yes ___ No
If yes, with what degree of success do you use the telephone (voice)?

______________________________________________________________

Do you make use of a TDD? ___ Yes ___ No
Do you, or did you, have any other problems in addition to your hearing loss, for example, visual problems, learning disabilities, physical disabilities, etc.? ___ Yes ___ No
If yes, describe:

______________________________________________________________

Are you involved in any community activities? ___ Yes ___ No
If yes, please describe:

______________________________________________________________

How would you describe yourself in regard to your hearing impairment? (See samples listed below)
Select one of the following and comment (if you wish) OR fill in the “OTHER” line in your own words.

i. “I am a person with a hearing loss who participates completely in the hearing world.”

ii. “I am a person with a hearing loss who participates in both the hearing and ‘deaf’ worlds.”

iii. “I am a person who is deaf who participates primarily in the deaf community.”

iv. OTHER: “I am a _____________________________

THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS SURVEY. THIS INFORMATION WILL BE HELPFUL TO PROFESSIONALS IN THE FIELD OF HEARING, PARENTS, AND OTHER PERSONS WITH A HEARING LOSS. PLEASE REMEMBER THAT YOUR IDENTITY WILL NEVER BE REVEALED IN CONNECTION WITH YOUR RESPONSES TO US.

Because we are interested in collecting additional information on adults with a hearing loss who were trained to listen as children, it would be greatly appreciated if you would complete the identifying information requested below. However, you do not have to tell us who you are if you don’t want to.

Name ________________________________
Street Address ________________________________
City, State (Province), Country ________________________________
Date of Birth ________________________________

THANK YOU AGAIN FOR YOUR COOPERATION, AND WE WISH YOU ALL THE BEST!

Donald Goldberg
Easton, Pennsylvania

Carol Flexer
Akron, Ohio

Dennis Pappas
Birmingham, Alabama