



DEVELOPMENT OF A PRELIMINARY COUNSELLING READINESS SCALE FOR HEARING AID USERS

Psychology

Ms. Shabnam Shafi*

Msc Psychology student, JAIN (Deemed-to-be University), Bangalore, India*Corresponding Author

Dr. Hemanth Babu.R

Assistant Professor, JAIN (Deemed-to-be University) Bangalore, India

ABSTRACT

Background: Many adults with hearing loss do not use hearing aids, and psychological readiness is one reason. Audiologists have few short tools to judge readiness in routine appointments. The objective of the study is to develop a pool of items on counselling readiness for hearing aid users and obtain preliminary expert evidence of content validity. An expert panel rated 28 items covering seven psychological domains for relevance and clarity on a five-point agreement scale. Of 58 responses, 53 eligible responses were included in the analysis. An adapted item-level content validity index (I-CVI) was the proportion of Agree and Strongly Agree ratings. Item reduction was guided by relevance rating, clarity, conceptual relevance and representation of proposed domain. The I-CVI ranged from 0.340 to 0.868 (scale-level S-CVI/Ave 0.51). Ten items were retained (S-CVI/Ave 0.70), covering value, pressure, motivation, autonomy, self-efficacy, technology confidence, patience and readiness for a trial. Only three items reached an I-CVI of 0.78. No stigma, minimization or self-disclosure items were retained. The study resulted in a preliminary 10-item Counselling Readiness Scale supported by expert-based content evaluation, providing an initial structured framework for assessing psychological and emotional readiness related to hearing-aid rehabilitation. Further research involving the intended adult population is required to examine the scale's psychometric properties, including reliability and construct validity.

KEYWORDS

Counselling Readiness, Hearing Aids, Scale Development, Content Validity

INTRODUCTION

Hearing loss is common in adults, and many people who could benefit from hearing aids do not use them. Seeking help is not one decision. It involves admitting the problem, facing stigma, building confidence with the device and committing to regular use. A counselling session that does not match the patient's readiness is less effective, yet audiologists have few short tools for judging readiness in a routine appointment.

The Transtheoretical Model describes behaviour change in five stages: precontemplation, contemplation, preparation, action and maintenance (Prochaska & DiClemente, 1983). A review of its use in audiology found that later stages are linked to help-seeking and hearing aid uptake (Manchaiah et al., 2018). Existing tools measure attitudes to hearing loss and hearing aids, such as the Hearing Attitudes in Rehabilitation Questionnaire (Hallam & Brooks, 1996), or behaviour-specific stages of change (Pronk et al., 2024). Some of these are long for routine use, and they give clinicians little guidance on what to do with the result.

This study took a first step towards a short counselling readiness tool. We wrote a pool of items across seven domains, asked an expert panel to rate their relevance and clarity, and used the ratings to select a preliminary set.

METHOD

Design and participants. This was a quantitative scale-development study using expert content ratings. Experts were recruited by purposive sampling and completed an online form. Eligible experts held a qualification or role in audiology or psychology. Of 58 responses, five responses outside this field were excluded, leaving 43 audiologists and 10 psychologists.

Items. A 28-item pool was written from the literature across seven domains: stigma and ageism (items 1–5), minimization and denial (6–10), perceived benefit, expectations and cost (11–15), external pressure versus internal motivation (16–20), self-efficacy and technical confidence (21–24), situational readiness (25–27) and communication self-disclosure (28). Experts rated each item for relevance and clarity on a five-point agreement scale (1 = Strongly Disagree, 5 = Strongly Agree).

Analysis. The adapted item-level content validity index (I-CVI) was the number of Agree and Strongly Agree ratings divided by 53. The scale-level index (S-CVI/Ave) was the mean of the I-CVIs (Polit & Beck, 2006). Items with stronger quantitative support were prioritised for retention. Items with moderate quantitative support were

considered when they represented an important aspect of the construct or contributed to domain coverage. Items with low relevance, limited conceptual contribution or substantial redundancy were considered for removal.

Ethics. The form's introduction stated the purpose of the study, research-only use, voluntary participation and that giving a name was optional. Submitting the form was taken as consent. No patient data were collected.

RESULTS

The adapted Relevance I-CVI ranged from 0.340 to 0.868, and relevance means from 2.57 to 4.15. S-CVI/Ave was 0.507 across all 28 items. Item 17 scored highest value (I-CVI 0.868), followed by items 23 (0.811) and 22 (0.792). Ten items met the retention rule (Table 1), with an S-CVI/Ave of 0.70. Only items 17, 22 and 23 reached an I-CVI of 0.78.

Table 1. Retained items (N = 53)

Item	Statement	Mean	Clarity mean	I-CVI
15	I believe that hearing aids are worth the financial investment.	3.57	3.68	0.623
16	I am here today mostly because my spouse/children insisted on it.	3.57	3.62	0.585
17	I want to improve my hearing because I'm tired of missing out on life.	4.15	4.13	0.868
19	Getting a hearing aid is my own choice, not anyone else's.	3.72	3.77	0.623
22	I am confident I can learn to put the hearing aids in correctly every day.	4.09	4.15	0.792
23	I feel comfortable using a smartphone app to control my hearing aids.	4.06	4.13	0.811
24	I believe I have the patience to get used to the new sounds.	3.79	3.89	0.679
25	I am ready to start a 30-day trial of hearing aids right now.	3.79	3.79	0.717
26	I am prepared to wear hearing aids all day, every day.	3.92	3.94	0.717
27	I am just here to gather information, not to make a decision.	3.53	3.70	0.547

The retained items came from four of the seven domains: perceived benefit (1 item), external pressure versus internal motivation (3), self-efficacy and technical confidence (3) and situational readiness (3). No stigma, minimization or self-disclosure items were retained. I-CVI for the stigma items ranged from 0.340 to 0.491 and for the minimization items from 0.358 to 0.434.

DISCUSSION

Experts rated motivation, confidence with the device and readiness to act most highly. Item 17, which assessed the desire to improve hearing because of missing out on life, demonstrated the highest relevance mean and adapted I-CVI (mean 4.15, 86.8% positive). Items 22 and 23 also demonstrated strong endorsement (79.2% and 81.1%). These items addressed confidence in learning hearing-aid handling and comfort with technology. Items 16 and 27 describe a patient who attends for someone else's sake or only to gather information. Their support was moderate (58.5% and 54.7%), but they identify patients who need different counselling from those who have already decided. No stigma, minimization or self-disclosure items were retained. This does not show these factors are unimportant, as they are well-known barriers (Hallam & Brooks, 1996). The wording may not match clinical experience, or the rating format may have affected the results.

Limitations

The ratings reflect expert judgement only. Psychometric properties such as internal consistency, test-retest reliability, construct validity and criterion-related validity were beyond the scope of the present study. The preliminary scale may require further evaluation with the intended population of adults undergoing hearing rehabilitation to examine the applicability and functioning of the items in clinical settings.

CONCLUSION

The study produced a ten-item preliminary set questionnaire with moderate expert support. The findings provide initial expert-based information about the content of the proposed items. The outcome of the study is a preliminary expert-reviewed and content-evaluated item set. It should not be interpreted as a fully validated or reliable clinical instrument, as further evaluation with the intended population is required to establish its psychometric properties.

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