ABSTRACT: In many ways, service delivery for adolescents with language/learning disorders (L/LD) differs from services provided to others. The effectiveness of service delivery largely depends on a speech-language pathologist's level of knowledge in the linguistic, physical, social, and cognitive areas of normal adolescent development. Equally, if not more important, is the relationship that is developed with the adolescent. Although we may more naturally relate to other age groups, working with adolescents can be at least just as rewarding if we can convey to these clients that we are willing to try to understand their perspective and help facilitate the acquisition of skills that will help them prepare to become successful in social and academic settings.

One thing for certain is that the adolescent client and the adult clinician often have two different perspectives and points of view about what is important, what needs to be done, and how it should be done. This article is divided into two sections. The first section discusses considerations that the clinician should make in order to understand and relate to the adolescent better. The second section addresses the skills that the adolescent should develop to communicate better with the clinician and increase successful transfer of communication skills to the real world.

KEY WORDS: adolescents with L/LD, adolescent communication, adolescent language, adolescent communication skills

Improving Communication in Adolescents with Language/Learning Disorders: Clinician Considerations and Adolescent Skills

Jean M. Novak
San Jose State University, CA

Adolescents with and without language/learning disorders (L/LD) go through a major transition period from childhood to adulthood and are faced with many challenges. These challenges are related to the changes that occur in physical, cognitive/language, and social/personal areas of development. Perhaps for many clinicians, working with adolescents requires a more concentrated effort to relate to these clients or their perspectives. Although we may more naturally relate to other age groups, working with adolescents can be at least just as rewarding if we can convey to these clients that we are willing to try to understand their perspective and help facilitate the acquisition of skills that will help them prepare to become successful in social and academic settings.

In essence, the speech-language pathologist who works with adolescents should understand that the challenge in working with this population lies partially in the ability to view the adolescent from his or her perspective. This article will present various considerations that will facilitate the clinician's ability to take the adolescent's perspective and use this perspective in treatment planning and service delivery. For the purposes of this article, the term adolescent refers to students from 11 to 18 years of age.

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ABSTRACT: In many ways, service delivery for adolescents with language/learning disorders (L/LD) differs from services provided to others. The effectiveness of service delivery largely depends on a speech-language pathologist's level of knowledge in the linguistic, physical, social, and cognitive areas of normal adolescent development. Equally, if not more important, is the relationship that is developed with the adolescent. For example, an adolescent who exhibits poor linguistic performance and is rejected by his or her peers due to cultural differences may reduce his or her interest in entering into communicative opportunities. Interestingly, older clients with similar concerns and characteristics would likely not be as negatively affected. Additionally, to the adult speech-language pathologist, issues facing the adolescent may not be viewed as overwhelming. However, when viewed from an adolescent’s perspective, perception by others, especially peers, may be one if not the most important concern.

In essence, the speech-language pathologist who works with adolescents should understand that the challenge in working with this population lies partially in the ability to view the adolescent from his or her perspective. This article will present various considerations that will facilitate the clinician’s ability to take the adolescent’s perspective and use this perspective in treatment planning and service delivery. For the purposes of this article, the term adolescent refers to students from 11 to 18 years of age.

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**CLINICIAN CONSIDERATIONS**

The clinician working with adolescents needs to take into consideration various issues related to this age group in order to have successful treatment outcomes. First, clinicians working with adolescents should become familiar with the physical, cognitive/language, and social/personal domains that are related to normal adolescent development. Next, it is important to develop an awareness of the challenges facing adolescents with and without L/LD, as well as a sensitivity to cultural differences that may influence the therapeutic process. Additionally, developing a productive therapeutic relationship within a safe and positive environmental climate for learning is an important factor to take into consideration. Providing adolescents with appropriate role models and relevant activities by using a variety of materials and natural consequences encourages adolescents to consider becoming involved in the therapeutic process. One of the most important considerations when working with adolescents is to provide them with immediate success after a specific skill is taught so that the value of the skill will not be lost. The following section will address these clinician considerations, as well as provide therapy suggestions.

**Normal Adolescent Development**

Normal adolescent development affects the physical, cognitive, and social domains (Platt & Olson, 1997). All three areas play a major role in the complex transitional period of adolescence. This is a time when there is a great deal of change occurring and variability of behaviors being observed on each of these levels. A clinician working with adolescents should be aware of the various areas affecting normal adolescent development before determining if the adolescent’s behavior is or is not within the normal range of development.

**The physical domain.** Several major physical changes occur during adolescence, including rapid acceleration in height and weight; development of sex glands; development of secondary sex characteristics such as voice changes and the growth of facial, body, and pubic hair; changes in body fat and muscle composition; and changes in the circulatory and respiratory systems (Steinberg, 1989). Physical signs of becoming a woman or a man are evident. These physical/sexual changes also influence the interest levels of adolescents (e.g., a heightened awareness of and an increased interest in the other sex and dating, or simply just talking to and spending more time with the other sex).

It is during adolescence that future career plans such as area of athletics, sports, and other trades/professions may be seriously considered. For example, a female must have just the right body type to be a ballerina, and a male must have the physical ability, strength, and build to become a football player or a fireman. The many physical changes, which are or are not manifested, occur at different times for males and females, and can cause adolescents much distress and concern as they come to realize that their body type may prevent them from realizing their vocational or avocational dreams (Platt & Olson, 1997).

**The cognitive/language domain.** The ability to use abstract thinking improves during adolescence within the cognitive/language domain (Nippold, 1998). Adolescents expand their ability for introspection (thinking about their own thoughts), meta-cognition (the ability to regulate thinking), abstract thinking skills related to time and space, logical thinking, perspective taking (thinking about what someone else is thinking about), and hypothetical reasoning (making decisions for “what if” situations) (Rice, 1990).

In addition, linguistic competence increases during this period, which involves a greater ability to use and understand the abstract meaning of words, concepts, and figurative language such as metaphors. Comprehension and use of various complex linguistic features and various rules of conversation such as adjusting speaking style to the listeners’ needs, and methods for controlling and reflecting on ideas being expressed also develop (Nippold, 1998). For example, adolescents have strong political and religious opinions and are able to discuss their beliefs and values on various topics. They are able to debate various points of view and provide different explanations for various situations and world events.

Adolescents are able to modify their communication to fit the listener’s perspective (perspective taking), although parents generally tend not to agree that their adolescent is capable of this. Typically, adolescents maintain a conversation with minimal non-topic remarks. They produce more informative narratives embedded with events that describe various actions in the story (Brinton & Fujiki, 1984; MacLachlan & Chapman, 1988; Westby, 1984).

Problem-solving skills, which deal with the ability to formulate hypotheses and provide alternative solutions to a problem, continue to develop and expand (Larson & McKinley, 1995). In essence, the increased use of abstract language and problem-solving skills is a key factor in facilitating life-changing decisions such as making choices about school settings, curricula selections, and future educational/vocational goals. For example, adolescents are capable of considering various universities and deciding which one best addresses their career goals, which educational setting meets their future expectations, and which university is within their financial means.

**The social/personal domain.** Social/personal development relates to social redefinition and the search for self-identity (Harter, 1990), which is reflected in values, plans, goals, priorities, and lifestyles. This period of development also includes an element of egocentrism where the adolescent creates an imaginary audience and feels like life is similar to performing on stage for others, where every behavior is being evaluated and scrutinized by others and where feelings of uniqueness and indestructibility emerge (Elkind, 1978; Santrock, 1987). With these feelings of indestructibility, adolescents may feel that no harm will come their way. For example, they may be aware of acquired immune deficiency syndrome (AIDS) and its risk factors, but they will continue to have unprotected sex because they do not feel that they could possibly become infected with the virus. In addition, their need for independence and autonomy is reflected in the control they exert over their own behavior (e.g., the clothes they wear, the music they listen
During this period, adolescents also develop the “no one understands me” syndrome. They shift their allegiance from their family and adults to peers, exhibiting more emotional dependency on peers than on family because they feel that peers provide social support and validate their self-worth (Petersen & Epstein, 1991). Social competence and expanding social relationships occur, and “belonging” is very important during this stage. Relationships are developed for reasons such as attachment, social integration, reassurance of self-worth, sense of reliable alliance, and the opportunity for nurturing others (Brown, 1990; Rice, 1990).

Social development at this stage involves looking for common interests and identities and overcoming loneliness. In the 1990s, social activities included dating and attending concerts in groups, roaming the malls in packs, talking on the phone endlessly, and frequently going to each other’s homes to watch videos and MTV. These behaviors have continued into the new millennium. In addition, adolescents have become technologically savvy with playing video games, surfing the net, and using e-mail.

Challenges Facing Normal Adolescents

There are many major high-risk behaviors that confront adolescents on a daily basis. These include substance abuse, suicide, unsafe sex, teen pregnancy, AIDS, eating disorders, teen violence, school underachievement, delinquency (Toch, Gest, & Guttmann, 1993), and, most recently, the fear of terrorism. Substance abuse, which includes alcohol, cigarettes, and drugs, has been found in adolescents at an increasingly higher rate each year. Adolescents who are substance abusers are more likely to be in auto accidents, commit crimes, drop out of school, contract AIDS, attempt suicide, and have emotional disorders (Platt & Olson, 1997). Unsafe sex and AIDS have been found to occur in adolescents, especially in those who have difficulty making decisions about their personal behaviors (Center for Disease Control and Prevention, 1995). Higher rates of unsafe sex and teen pregnancy in females have been found in adolescents who have poor basic skills, lowered educational expectations, and limited life options (Rotheram-Borus & Koopman, 1991).

Suicide ranks as a leading cause of death in adolescents (Smith, 1990). Adolescents with schizophrenia, depression, psychoses, and conduct disorders are at higher risk for committing suicide than those without these emotional/mental disorders (Gottesman, 1991; Guetzkoe, 1991). Eating disorders such as anorexia and bulimia are also found in the adolescent population in increasing numbers (Harvill, 1992; Hoffman, 1994). Speech-language pathologists should increase their awareness of the signs of these and other disorders common to adolescents and make appropriate referrals as needed.

Due to the growing rate of teenage crime, school violence (i.e., handguns, gang fights, and shootings), and the threat of terrorism (Burbach, 1995), many adolescents experience a high degree of apprehension and/or fear throughout their typical day. Various crimes are found among adolescents who conform to peer pressure and engage in antisocial behaviors (Rice, 1990). School underachievement, delinquency, and dropouts are also found among the adolescent age group. A higher percentage of poor school performance, minimal school involvement, and negative school experiences has been found in adolescents with emotional/behavioral disorders and depression (Hebbeler, 1993).

Finally, unstable and dysfunctional families that do not provide adolescents with a secure and stable home environment may lead the adolescents to become involved in high-risk behaviors or develop severe anxiety (Platt & Olson, 1997). It may be difficult for parents to find time to spend with their adolescent children due to overloaded work schedules, single-parent households, or just because they don’t understand their almost-adult children. This is quite an interesting phenomenon, especially because all parents have gone through the period of adolescence themselves and yet still find it difficult, frustrating, if not impossible to communicate with their own adolescent children.

All adults have walked in the shoes of an adolescent, yet apparently those shoes drastically change with each generation, or maybe adults have simply developed a different frame of reference over time, known as the “older yet wiser” perspective. Is it possible that adults have forgotten what it was like to be an adolescent, or do they just not want to remember this challenging transitional period? Is it possible that some clinicians also experience the same difficulties in dealing with adolescents? Some speech-language pathologists may not view their adolescent clients as they do their own adolescent children, whereas other speech-language pathologists may not have children when working with this population. Some speech-language pathologists who have adolescents on their caseload may find that they are unsure of how to deal with these clients. Speech-language pathologists who find themselves in this situation should consider attending some psychology classes on normal and abnormal adolescent development, enrolling in workshops that deal with adolescent behavior, volunteering in settings where there are adolescents, or becoming involved in youth group activities. These speech-language pathologists can benefit greatly from observing and having firsthand experiences with adolescents.

Challenges Facing Adolescents With L/LD

Many adolescents with L/LD experience deficits in the social/personal, language/cognitive, and physical domains of normal adolescent development (Mercer & Mercer, 1993). Problems with peer relationships and social skills have been predominately identified in addition to other language and personal difficulties (Haager & Vaughn, 1995; Polloway & Smith, 2000). Unlike normal adolescents, those with L/LD are unable to adjust their style of communication to address the needs of the listener (Bergman, 1987). They may have difficulties negotiating, interpreting nonverbal communication, and processing/expressing more abstract language concepts (Gallagher, 1993). Adolescents with L/LD exhibit poor problem-solving abilities, demonstrate weak skills when dealing with new social situations, and have lower...
overall communication abilities. As a result, they frequently experience social rejection (Kimmel & Weiner, 1995).

Problems with executive functioning are evident when the adolescent has difficulty applying a strategy to solve a problem, organize a task like writing a term paper, or put pieces of information in a logical and sequential order when asked to present an oral narrative (Singer & Bashir, 1999). For example, attentional deficits may create a passive learner who is distracted by irrelevant stimuli such as background noise and cannot focus on relevant information. It may also be during adolescence that a diagnosis of attention deficit disorder (ADD) is made for the first time. This may be a difficult diagnosis for the adolescent to accept, even though this label may now explain why there were so many problems with learning in the academic setting. Attention difficulties may have affected the adolescent’s ability to solve problems, listen and follow directions, reason abstractly, and comprehend and organize information, as well as develop social competency (Ylvisaker & DeBonis, 2000). Metacognitive/metalinguistic difficulties can also exist that do not allow adolescents with L/LD to understand or analyze why certain things are difficult for them to do (Brown, 1978; Larson & McKinley, 1995). These difficulties affect the cognitive/language domain of normal adolescent development.

Challenges in listening, following directions, and organizing information, and a lack of success during social interactions, also have a profound impact on performance in academic areas (Bashir & Scavuzzo, 1992). Consequently, adolescents with L/LD often perform as many as 3–5 years below their grade level in reading and math (Platt & Olson, 1997). Reading difficulties include problems with word recognition, vocabulary, reading comprehension, and reading rate, which are very likely related to problems with memory, language, thinking, and reasoning (Masters, Mori, & Mori, 1993). For example, difficulty with understanding abstract material may affect adolescents’ ability to understand and interpret poetry.

Problems in mathematics are reflected in difficulties with computation, numerical reasoning, and solving mathematical work problems. Many adolescents with L/LD also struggle to recall math facts and sequences of mathematical operations to solve multiplication and word problems (Mercer & Mercer, 1993). They may also have difficulty comprehending math concepts that involve directionality or spatial relationships (Ehren, 1994).

Lack of motivation, experience, and self-esteem, as well as low achievement, have been identified in adolescents with language difficulties (Platt & Olson, 1997). As a result, adolescents with L/LD may have difficulties adjusting in various settings such as school, work, and the community. Social and language competence required in any profession or vocation escapes adolescents with L/LD. Building personal relationships, making career choices, interacting effectively with parents and peers, and avoiding high-risk behaviors and other health problems are all challenges facing adolescents with L/LD due to their communication and social competency difficulties. Awareness of these challenges and appropriate referrals when necessary should always be considered. Addressing these challenges in a team approach can also provide information and explanations of why an adolescent is behaving in a certain manner.

A speech-language pathologist should observe adolescents and become familiar with characteristics that define certain behaviors. For example, a delinquent adolescent usually has a temperament that is restless, energetic, impulsive, extroverted, aggressive, and destructive. This same adolescent may also exhibit a hostile, defiant, resentful, and stubborn attitude. He or she may be a concrete thinker and have difficulties with problem-solving strategies. The home environment may be abusive, providing little understanding, affection, and stability, with lower moral standards. Additionally, this adolescent may exhibit characteristics of depression in addition to being delinquent. Working only on problem-solving strategies may not be enough or effective without first or jointly addressing the other areas. This adolescent may be beyond a speech-language pathologist’s reach, without other professional help. Therefore, if an adolescent with L/LD exhibits various types and degrees of high-risk behaviors, a psychologist/psychiatrist may need to be consulted.

Cultural Differences

Immigrant adolescents, like other age groups, are influenced by their culture (Hyun & Fowler, 1995). Adolescents from different cultures face various challenges inherent to their background. Cultural differences may include child-rearing and socialization practices, learning and communication styles, political and religious beliefs, and school achievement expectations (Adgar, Wolfram, & Detwyler, 1993). These factors influence adolescents’ behavior and need to be considered when working with this age group.

Adolescent immigrants are more closely tied to their traditional culture than those who left their homeland at a younger age or those who were born in the adopted country of their parents (Platt & Olson, 1997). In addition to the possibility of having underlying language/learning difficulties, adolescents coming from different countries may also have language barriers and other emotional problems related to adjustment and assimilation into a new and different country. For example, school achievement may be largely due to non-school-related factors such as school achievement expectations from a cultural perspective, family educational background, or the socioeconomic status of the family.

A Therapeutic Relationship

Developing a trusting and open relationship is one of the most important considerations when working with adolescents (Larson & McKinley, 1995). Being actively involved in adolescent activities and participating in their interests shows adolescents that they are being treated as worthwhile individuals. Knowing the adolescent on a personal level is the key ingredient to show that someone cares, and that the adolescent is valued as a human being who has something important to contribute to society. Therefore, being attentive
and interested in the adolescent without ridiculing or embarrassing the adolescent publicly or privately, as well as avoiding sarcasm, are important considerations when trying to establish a trusting relationship. This is especially important with the adolescent with L/LD who already feels that he or she has been “let down” by professionals from various disciplines for many years.

Adolescents are concerned with their image, identity, and development of psychosocial maturity (Apel & Swank, 1999). Establishing a relationship with adolescents that allows for an open dialogue can help adolescents understand themselves better and dismantle their negativity and indifference to learning, which is often accompanied by the “I don’t care” attitude. Acceptance and recognition provide adolescents with positive communicative experiences. The clinician should show a genuine interest in the adolescent by discussing anything the adolescent desires to talk about. These discussions should involve explaining in clear, nonemotional, non-judgmental terms the nature and dimension of the problems the adolescent is experiencing.

The clinician should also be in touch with his or her own feelings about certain topics discussed with adolescents. It is important for clinicians to recognize that negative personal behaviors can lead to maladaptive interactions with their clients. Personal counseling may help the clinician understand his or her own reactions to various issues raised by adolescents. As in any therapeutic relationship, it is important to understand one’s own biases and not impose them directly on the client, who in this case may be an adolescent. For example, a clinician may like classical music, whereas the adolescent likes hip-hop. It would be important for the clinician not to tell the adolescent to switch to classical music; instead, the clinician should listen to some hip-hop music in order to understand this form of music better, taking into consideration the perspective of the adolescent. Sometimes, asking the adolescent to talk about the type of music he or she likes to listen to without being judgmental establishes an open dialogue.

It is important not to talk down to adolescents but to discuss realistic expectations and to challenge adolescents with realistic goals by helping them discover their strengths and weaknesses. Research has demonstrated that students who have positive, secure relationships with their teachers engage more highly in their work (Larson & McKinley, 1995). The clinician’s level of involvement with the adolescent increases the clinician’s understanding of the adolescent’s perspective.

Gaining access to an adolescent client’s perspective and his or her experiences can be accomplished by talking and doing things with the student (Paul, 2001). Acting on the information that the adolescent provides, negotiating conditions and requirements, making accommodations, and responding to the learning and affective needs of the adolescent should also be considered. Another important consideration when trying to establish a genuine relationship with an adolescent is to treat him or her almost as an adult, to allow as much independence and freedom as he or she can handle and to give respect. A delicate balance between “I accept and respect who you are; however, I will not allow you to do anything and everything you want” needs to be established.

**A Positive Learning Climate**

Not only should clinicians develop relationships directly with each adolescent client, but they should also establish in the therapy room a social climate that is conducive to learning. A culture of respect, caring, and trust should be fostered, as should a sense of community with others. Providing a supportive environment has been found to affect student values. In order to cultivate empathy and understanding, clinicians should model empathy toward their adolescent clients. When the adolescent sees that the clinician is compassionate and understanding, a genuine atmosphere of acceptance is created (Platt & Olson, 1997).

A responsive culture should be created that enhances adolescent ownership and thereby alleviates feelings of anger, anxiety, alienation, and powerlessness. If an adolescent who has difficulty participating in group discussions contributes information that is not quite accurate, the clinician does not need to say directly that the answer is wrong. The clinician could find some angle that makes the answer right. For example, if the clinician asks, “What is the weather like outside?” and the adolescent with linguistic processing difficulties and slow rise time says, “I went to the store on my bicycle today,” the clinician can ask another question such as, “Do you ride your bicycle in the rain?” If the student says, “No,” then the clinician can say that in that case, it must not be raining outside, and continue the weather discussion with the others in the group. In this way, the student is validated for contributing an answer, and the answer was brought into the topic of discussion. Finding the “rightness” of a wrong answer is the responsibility of the clinician, thereby establishing a safe and accepting environment for adolescents with L/LD.

Establishing a climate of fairness, consistency, and clear expectations with rules, respect, and open dialogue has been found to help adolescents with academic and motivational difficulties. Creating contexts that promote success and establishing an environment of trust and risk taking enhances the overall responsiveness and abilities of adolescents (Larson & McKinley, 1995).

**Role Models**

Adolescents need to be mentored by appropriate role models. Parents and primary caregivers play an important role in educating and teaching their children (Whitmire, 2000). Adolescents need adult guidance and they need to know that their parents care about them and that they can work on solving problems together. When an adolescent has to go home to an alcoholic parent, it may be very difficult to discuss the negative aspects of alcoholism during a therapy session. If appropriate modeling is not provided in the home setting, it is crucial that the teacher and clinician in the school or educational setting provide appropriate modeling for the adolescent. The clinician should always present the adolescent with a rationale for all the activities
that the adolescent is expected to participate in. This type of “thinking aloud” technique will help the adolescent understand the importance and value of a particular assignment and the effect this assignment will have in the near future.

Adolescents also need to observe clinicians with enthusiasm who exhibit a compassion for the work they do (Platt & Olson, 1997). Enthusiasm for learning is developed by modeling enthusiasm for teaching. It is important to model what adolescents are expected to do and say. For example, if it is agreed that rudeness is not going to be tolerated, it would be important not to interrupt the adolescent while he or she is trying to get a point across during a group discussion. It is important to remember that the best way to teach respect is by respecting. Various modeling techniques have also been found to be effective in modeling appropriate group discourse skills. Researchers have suggested dialogic mentoring (Silliman & Wilkinson, 1991), reciprocal teaching (Brown & Campione, 1990), and postscript modeling (Hoskins, 1990).

However, one must also remember that adolescents are strongly influenced by their peers (Rice, 1990). Peer group influence and peer modeling may overpower the modeling of the best clinicians and teachers (Stevens & Slavin, 1991). Schoolwork usually loses out when juvenile gangs offer more reinforcement and more love/attention than parents do.

Relevant Activities Reflecting Adolescent Interests

Clinicians should educate themselves about what adolescents are interested in (Kaywell, 1992; Platt & Olson, 1997). Adolescents are interested in materials that include people and events that differ greatly from adult interests. Adolescents frequently talk about a wide variety of topics such as the use of drugs (i.e., ecstasy and pot), the opposite sex, sex, suicide, learning to drive, shopping and fashion (especially for female adolescents), concerts, MTV and CD releases, movies, video games, body piercing, and tattoos. Last year, branding was added to the list.

The interests of adolescents vary greatly depending on the group they “hang” with. There is no set fashion or style of dress for adolescents as an age group. It is easier to have an adolescent tell you what hair style is “not the do” and which piece of clothing is “not the look” then to find out what clothing or hair style is “in.” Pragmatically speaking, eclectic would be the best word to describe what adolescents are currently wearing. Some wear down-to-earth clothes (t-shirts and jeans), whereas others wear more of the 1960’s look (tie-dyes and bell-bottoms); still others will wear anything to look “way” different. Clothes and hair styles may be determined by body type (i.e., what looks good on the particular adolescent) or the type of group the adolescent hangs with (i.e., the retro look vs. the gothic look).

The same applies to music appreciation. Adolescent interests in music vary from rhythm and blues (R&B), hip-hop, alternative, hard rock, and rap, to heavy metal. Just as there are rules in a classroom, there are different rules adhered to during various types of concerts attended by adolescents. For example, if an adolescent attends an “Alien Ant Farm” concert, the adolescent would know that dressing down and wearing jeans and a t-shirt is acceptable. The behavior expected to see at such a hard rock concert could include a “mosh” pit, crowd surfing, and possibly stage diving, in addition to a lot of head nodding and knee bending to the beat of the music. Although the words of the songs being sung at the concert are unintelligible and distorted due to the excessive loudness level, most adolescents know the words and sing along with the vocal artists. This is very different from the clothing, dancing, and behavior exhibited at a hip-hop concert.

A clinician should consider experiencing the different music forms that adolescents are interested in. A speech-language pathologist should evaluate his or her knowledge about certain terms related to the adolescent music culture. For example, can the speech-language pathologist treating adolescents answer the following questions, “What is the purpose of a ‘mosh pit?’ What is the difference between heavy metal and alternative music?” Interestingly, when a speech-language pathologist works with young children, the speech-language pathologist does not think twice about going to a Disney movie and watching “Bambi,” “Monsters, Inc.,” or “Harry Potter.”

Popular adolescent music forms can easily be incorporated into a language lesson on classification strategies. Different forms of music can be put into subcategories and then the different music forms can be compared and contrasted. Words from the songs can be used for a writing assignment and discussed in terms of meaning and significance. Debates on which music form is better can also be planned and presented. Developing language lessons that are directly related and relevant to the adolescent has been proven to be an effective method for teaching various language skills to adolescents (Platt & Olson, 1997). Semantic maps (Ehren, 1994) can be used to distinguish various music forms and to help an adolescent organize the information about different music styles in order to present the information verbally in a cohesive narrative.

Many years ago when break dancing was popular, I had an adolescent client write a booklet on the different dance moves, in which he described moves that were safe and simple, moves that required more skill and practice, and moves that would not be recommended because they were dangerous. I was told that this adolescent had great difficulty with reading and did not want to write anything. However, after identifying his interest and extreme talent in break dancing, he agreed to work on the manual. After completing the booklet, he asked if he could make a presentation to his class and give a copy of the booklet to each of his classmates. He actually demonstrated each move and helped to teach some of his classmates how to move their bodies in certain ways so that they could also work on the steps.

In order to relate to adolescents, it is important to understand the interests of adolescents, which means to some degree experiencing some of these interests. This does not mean that the speech-language pathologist needs to get a tattoo; however, taking a trip to a tattoo parlor can
provide some interesting insights. Reading about the art of tattooing can also be informative and can be incorporated into a language activity. For example, I remember one day putting a fake rose tattoo above my ankle before doing a problem-solving activity about the pros and cons of tattoos. I found that the adolescents were more open to discussing their reasons for getting their tattoos and showing off their tattoos, especially when I explained that I would be afraid of the pain I would have to go through to get a tattoo. I also explained that I felt more comfortable with the fake tattoo because I could wash it off and put it on whenever I felt like it.

Use of relevant materials is a key to successful therapy when working with adolescents (Novak, 2000). Use of driver’s training manuals, sports and fashion magazines, newspapers, TV programs, movies, videodiscs, and CD-ROMs can be related to various curricular topics and can provide a more interesting and motivating way of presenting information to the adolescent. For example, if an adolescent with L/LD has difficulty with reading, using newspapers or magazines that reflect his or her topics of interest instead of traditional reading materials that follow a given curriculum can be beneficial. For example, reading an article written by a teenage actor about his or her personal feelings about his or her parents going through a divorce may be more relevant than reading a professional article by a psychologist that is not targeted for an adolescent audience. The use of newspapers, the Internet, or phone books can be helpful in obtaining information on various academically related topics, as well as information about jobs, classified advertisements, and survival skills.

Adolescents with L/LD should be encouraged to read developmentally appropriate materials. Easier to read books that are used for younger students should be avoided. Written materials that have a high interest level and low vocabulary or materials with basic survival information are suggested. Adolescents need to understand the usefulness of the information they are asked to read, as well as be guided to what information they need to know (i.e., relevant vs. irrelevant information). Adolescents should also be asked what they want to know and what topics are of interest to them so that relevant materials and assignments can be made. Assignments that are related to the interests of the adolescents will allow them to express their opinions and respond personally from their own experiences.

Adolescents may have difficulties with understanding information due to a lack of experiential background and an inability to relate to the information that is being presented. This may occur with adolescents from different cultural backgrounds or limited world knowledge who are unfamiliar with information that is being presented or when the adolescent has difficulty with comprehending the information that is being taught. Films, television programs, and educational CD-ROMs can help enlarge the experience and supply vocabulary for a student who has had limited experiences. Relevant information can be obtained from computer software programs that are easy to use and have step-by-step explanations for following directions (Platt & Olson, 1997). These tasks need to be challenging as well as enriching, yet linked to the interests of the adolescent.

Cultural relevancy is also important to take into consideration (Banks, 1991). A history assignment that requires the students to write about the congress in the United States could be altered by having the student write about the governmental structure of his or her native country, which then could be used to compare and contrast to the U.S. government structure. Emphasizing the reasons and importance for studying a particular topic and how it relates to the world and to the future of the students highlights the relevance of the content as it relates to each student personally and to experiences the adolescent had.

**Variety of Materials and Techniques**

The use of a wide variety of teaching materials and techniques assists in meeting the needs of students of all ages, including adolescents with varying learning abilities. Any medium that stimulates interest and involvement in the adolescent is worthy of consideration (Meier, 1995). The presentation of information should be novel, with an element of surprise in order to capture the interest of the adolescent. Adolescents are in therapy because they did not have much of a choice, so it is up to the clinician to provide the information in an interesting fashion. The student should feel that attending therapy is going to be worthwhile.

Multi-modality techniques using visual, tactile, and auditory channels should be considered (Lazear, 1991). For example, a visual representation of achieving a goal of wanting to lose weight can be used as a visual reminder of what the student is trying to reach. If an adolescent wants to lose weight, cutting out pictures that show the benefits of weight loss is helpful (i.e., pictures of people at a dance, people having a good time at a party, wearing a bathing suit.). Visual imagery techniques of having the adolescent visualize what it looks like to be thin and what the steps are to lose weight may help to avoid pitfalls. Computerized photos that show the individual after losing 20 pounds can also be used to motivate the adolescent. Contracts that specifically outline a timeline on how and when tasks will be completed can be put in writing and serve to closely monitor and permanently keep a verbal agreement that many times can be forgotten.

Students should be allowed to make choices on designing academic tasks. In addition, adolescents should be provided with choices that represent a variety of formats to measure their ability to learn and with choices on how they are to be evaluated on the material and information being taught. Adolescents should also be provided with multidimensional tasks and adaptations of assignments. For example, written directions can be adapted by highlighting or underlining the important words in the directions, writing the directions in steps, adding examples or pictures to the directions, simplifying the directions, and going over the directions orally in class (Platt & Olson, 1997).

Alternative assignments for specific information that needs to be understood can include giving the adolescent choices on either taking a test, designing a report, making up a test, writing a summary, discussing the major points on a tape recorder or videotape, writing relevant points in a journal, creating a poster highlighting definitions of major terms, or...
offering another option or suggestion. This variety provides the adolescent with choices on how to discuss the content information that needs to be evaluated by the teacher. Tasks should be novel and have an element of surprise.

Functional and adolescent-specific relevant materials that can be integrated into the curriculum should be used. If an adolescent has difficulty with oral narratives and with putting information in sequential order, but likes to cook and eat out, then materials such as menus or recipes can be used. These materials enable the student to express needs or follow a sequence.

When working with adolescents from various cultural backgrounds, the above strategies should be implemented in addition to some other strategies. Materials used in therapy, such as books, should represent cultural differences in the areas of customs, traditions, history, literature, and music. Materials should also reflect the specific interests of adolescents from a particular cultural background. The use of materials that highlight contributions of individuals from an adolescent’s cultural background allows that adolescent to be proud of his or her heritage and gives the adolescent an opportunity to express him- or herself in a positive manner. It also provides the adolescent with the ability to discuss something he or she is familiar with in a nonthreatening environment. Adding information that reflects various cultural viewpoints (i.e., comparisons and contrasts of other historical events) also provides cultural enrichment and identity and a better understanding of the new culture.

**Reinforcements and Natural Consequences**

Although rewards should be based on the quality of the work the adolescent produces, not simply the act of engaging in an activity (Emmer, Evertson, Clements, & Worsham, 1994), adolescents with L/LD need to be supported for trying, regardless of the outcome of their efforts. Adolescents should also be held accountable for their work so that they also experience consequences for failure.

Natural consequences provide real-life experiences for the adolescents. For example, a student who is learning how to give directions will be expected to give the directions to someone to see if the person can get to the place where he or she will be able to buy something the student wants. If the person is not able to get to the store with the directions the student gave, then the purchase cannot be made. Use of extrinsic rewards should be as little as possible and only when necessary.

Natural consequences teach adolescents about cause and effect. For example, an adolescent wants to get a driver’s license, but does not study for the written test. The adolescent takes the test and does not pass. Working with the adolescent on learning the information in the driver’s training manual to understand the rules and regulations may also be a motivating language activity. The adolescent is already intrinsically motivated to want to get the license and realizes that the information needs to be learned in order to pass the test. If the adolescent experiences a natural consequence, it usually is directly related to the task and therefore is more meaningful than if the adolescent is simply given a punishment.

**Successful Experiences**

As adolescents move from childhood to adulthood, they need to learn to make adult decisions, decide about careers, make personal value judgments, learn how to get along at work, and manage households (Larson & McKinley, 1995). The speech-language pathologist should provide adolescents with immediate successful experiences whenever working on a particular skill.

The most important task in working with an adolescent with L/LD is breaking the cycle of failure, which requires that an adolescent experience success immediately. Adolescents who have experienced the cycle of failure do not expect to succeed and may feel that success is beyond their control; in turn, they lack motivation to be involved in various tasks or even in the therapeutic process itself. They may have the attitude of “why bother” because they have not been successful for so many years. Therefore, it is important that as an adolescent acquires a particular skill, he or she practices the skill in a real-life situation so that the adolescent can benefit from environmental feedback and most of all experience success (Dohm & Bryan, 1994). The only way to speak better is to speak and to practice speaking. Immediate generalization and carryover enhances intrinsic motivation and mastery goals.

John was not comfortable in asking for directions and was always getting lost. Language therapy focused on providing John with various questions he could ask and strategies he could use in order to obtain appropriate directions. After the session, he was asked to obtain directions of how to get to a different building on campus where he needed to get information about the basketball games being held during the school year. He went into the main office and asked the secretary to give him directions and a map. John was able to write down the directions and follow a map that was given to him. After successfully finding the building, he was able to obtain the information he needed. He was successful in performing a task that he had always been uncomfortable doing. Immediately putting into practice the skill being taught is necessary for an adolescent to see the value in learning the skill. Using the skill effectively will also motivate the adolescent to continue using the skill and being successful.

**ADOLESCENT SKILLS**

Adolescents need to develop various skills in order to be successful in this competitive world. Developing positive thinking, problem-solving, perspective-taking, self-monitoring, and self-evaluation skills through role playing and group interactions have been found to be helpful. After many years of failed and disappointing experiences, these skills can help an adolescent develop appropriate and successful communicative interactions. The following section will address the skills that adolescents need to become effective communicators.

**Positive Thinking**

The way an adolescent thinks about a task can directly affect how the adolescent will approach the task (Stipek, 1998). Students who feel that they are not competent in
certain things may either avoid or evade assignments, whereas others may rely on extrinsic reinforcements rather than personal interest or value to complete an assignment. Some students initially lack interest before an assignment, but may change their minds depending on how the rationale and information about the task is presented. These students are able to combine completing the assignment with thinking about the possible value of the task.

Paul was a 15-year-old who refused to take vocabulary tests. It was explained to him that he did not do well on vocabulary tests because he did not understand the words, and that they were difficult for him because he could not relate to the words. However, he kept saying that he didn’t care and that he didn’t want to take any of the vocabulary tests because everyone always did better than he did, and he felt that he could never do well on such a test. Paul needed to see that his way of thinking was not necessarily correct. Paul was asked by his speech-language pathologist to develop an adolescent vocabulary test that would be given to a group of graduate students at the university. He developed a list of 20 “adolescent” words that included words like ghostee, copesthetic, scrubbed, and hongee. He also provided definitions for these words and the university graduate students were expected to match the words with the definition. A week later, the tests were brought back for Paul to grade. The answers were read and Paul marked the papers. He was shocked when the highest grade was only 70%.

Several language and academic skills were addressed with this activity. The activity focused on organizing, preparing, and formatting a task as well as on evaluating and analyzing the results of the task, listening to auditory information presented in chunks of five letters at a time, reviewing the results, calculating percentages, and creating a graph of the results. Most importantly, however, Paul realized that university students had failed the vocabulary test because they did not study the words. They also were not familiar with the words so it was only natural that they did not do well. This reality-based activity encouraged Paul to try to work on his vocabulary because he no longer felt that he was the only person who ever failed vocabulary tests. As he began to think differently about taking the test, he also began to be more successful and started receiving higher scores.

Positive thinking can also be increased if the adolescent understands the benefits of what is being taught. If the focus is on the benefits, there is a greater sense of self-determination. The responsibility of the clinician is to get the student to think about doing the assignment and experience success with its completion. Making explicit what is implicit, in addition to discussing the rationale of each task, can encourage positive thinking in the adolescent (Deci & Chandler, 1986). Discussing the importance of an assignment in terms of future implications can also be beneficial. For example, if an adolescent is told that a specific skill such as answering questions with more information and details will help him or her do well during a job interview, and will increase his or her chances of getting a job, the adolescent may be more motivated and interested in providing more complete and expanded answers instead of just one-word responses.

**Problem Solving**

Problem-solving techniques (Elias & Clabby, 1988; Larson & McKinley, 1995; McFall, 1982; Park & Gaylord-Ross, 1989; Roessler & Johnson, 1987) include being able to identify/state the problem (i.e., whether to go to a party or not), listing a variety of solutions without any judgments about the solutions (if I go I will see my friends, if I go I will not get my paper completed, if I go I will have a good time, if I go I will get a bad grade on my paper and my parents will ground me, if I go I will feel guilty about my paper, if I go I will eat some good food), identifying the positive points (seeing friends, having a good time, eating good food) and negative points (not finishing a paper, getting a bad grade, feeling guilty, getting in trouble, being grounded), making a decision by trying out a solution and explaining why it was selected (going and having a good time and trying to finish the paper later), discussing what if the solution does not work (getting home late and feeling too tired to finish the paper), and evaluating the decision selected (getting grounded for a bad grade on a paper may not be worth going to the party).

Clinicians can make up situations for adolescents to problem solve or they can encourage adolescents to make up their own situations. These situations can provide adolescents with opportunities to discuss their emotions, role play the situations, and use groups to discuss solutions to the situations. Situations such as who gets the car, why it is bad to smoke, what happens if one doesn’t sleep for a long time, how much television is good to watch, how much money is needed to buy a CD, what happens when I take a test without studying, why I can’t go to a concert where there is crowd surfing, and why using Ecstasy is dangerous, can all be situations to use with the problem-solving technique described above. Using a problem-solving technique teaches the adolescent a skill that can be used in any situation and that can be generalized to other situations. It is also a skill that is necessary for an adolescent to understand the importance of weighing all the alternatives before making a final decision. It encourages the adolescent to use reflective as opposed to impulsive thinking.

**Perspective Taking**

Working in groups allows adolescents to talk with others and helps expand their viewpoint on different things in a nonthreatening manner. Adolescents hear the opinions of their peers, which allows them an opportunity to learn that opinions about the same topic can vary greatly from person to person. Working in groups also provides opportunities to collaborate and interact with others (Mercer & Mercer, 1993).

Role playing situations can help in developing perspective taking and can be used in groups. An adolescent needs to understand what someone else is thinking in order to understand where someone is “coming from.” An adolescent who has difficulty with perspective taking may have difficulty understanding why parents or teachers behave in a certain way and say certain things, or have certain expectations. Role playing allows for role reversal and perspective taking by exchanging places. The adolescent takes on the role of someone else and starts thinking about what that person is actually feeling and thinking. Role playing helps adolescents understand the perspective of
someone else. Role playing allows the adolescent to take on the role of the other person (i.e., teacher, parent, sibling, friend) and to think about what that individual would say in a certain situation, and then to discuss why the other person would think and speak that way (Clement-Heist, Siegel, & Gaylord-Ross, 1992).

Role playing also provides the adolescent with the opportunity to work on a specific social skill and put it in a hypothetical situation (Olson & Platt, 1996). The adolescent is able to practice the situation as if it were happening. It also allows for others to observe and provide feedback on the effectiveness of the communicative interaction. Feedback can also provide the adolescent with what could be changed to make the interaction more effective or appropriate.

Expressing Emotions

Adolescents need to be in touch with their feelings. They should know how to express their emotions/feelings in verbally appropriate ways. They should be provided with opportunities to discuss their emotions and other issues such as what makes them angry, what makes others angry, and what are different reasons that people get angry (i.e., when someone doesn’t listen, when something is taken from someone). Adolescents need opportunities to express what they do when they get angry and what are other ways they can deal with their anger that may be more appropriate. They should also be able to express their feelings in various situations (i.e., when they are not motivated) or fill in the blank when asked, “How do you feel when you are not able to _____?” Gajewski and Mayo (1989) produced an excellent social skills workbook to use with adolescents who have difficulty in a wide variety of communication situations.

Adolescents may also experience a range of negative feelings such as anger, rebellion, anxiety, frustration, and helplessness. They may have difficulties controlling these feelings and expressing them in appropriate ways. Anger and rebellion are common when students feel like they are being denied self-determination. Adolescents have a strong desire for autonomy and do not want to do things they are told to do. Lack of perceived control from the perspective of the adolescent impairs learning ability. Adolescents who feel anxious and less competent may not understand what to do and may even experience extreme physical symptoms. Anxiety has been recognized as being negatively related to intrinsic motivation. Adolescents who experience anxiety may have difficulty expressing and controlling their negative emotions. If an adolescent is experiencing chronic anxiety and an inability to control negative feelings and emotions, intervention strategies by other professionals may be necessary.

Self-Monitoring and Self-Evaluation

Adolescents should be able to monitor their own progress and achievements. Self-monitoring, self-evaluation, and self-reflection of goals require that an adolescent participate in identifying the skill to be learned, specific goals related to the skill, characteristics that will be used to help to reach the goal, things that could hinder the adolescent from reaching the goal, and strategies for achieving the goal. The adolescent should identify a specific date when the skill will be self-evaluated, as well as how each goal is going to be self-monitored (Larson & McKinley, 1995; Platt & Olson, 1977; Stipek, 1998).

External evaluation by the clinician should be de-emphasized and the experience of what has been learned should be highlighted. Grading should be based on achievement effort and improvement over time rather than performance on a given date. Grading criteria should also be clear and fair, and be understood and discussed with the adolescent before the lesson is begun or the skill is taught (Stipek, 1998). Feedback should not only be given on a quantitative scale (right vs. wrong answers), but information on the “correctness” of an answer and why a certain answer is not acceptable or not correct should also be provided. This process helps to facilitate the adolescent’s ability to self-evaluate his or her own abilities and accomplishments (Damon, 1995). It also helps the adolescent realize that he or she has some responsibility in and control of the outcome (Deci, Hodges, Pierson, & Tomassone, 1992). An adolescent should realize that ultimately he or she has control of his or her life. The adolescent is ultimately responsible for making decisions about his or her future. Hopefully, the adults in the adolescent’s life have provided the adolescent with enough guidance and information to make this decision-making process less stressful.

CONCLUSION

It may not be necessary to actually walk in the adolescent’s shoes, but it is important to attempt to view the world from those shoes when planning and implementing speech therapy with this age group. Clinicians should try to experience firsthand the interests of an adolescent. Listening to heavy metal tapes, alternative music or other music forms; reading about fashion trends like body piercing or tattoos; watching adolescent videos; and trying to play video games can help the clinician appreciate the perspective of the adolescent. Establishing a therapeutic relationship through reflective listening allows the clinician time to assess in an authentic manner whether the adolescent can separate what is possible from what is not possible (reality testing), if the adolescent is comfortable with propositional thinking and able to deal with abstract concepts (higher level reasoning), and if the adolescent can argue and present information regarding controversial matters (problem solving).

Clinicians should then provide adolescents with L/LD with opportunities to express themselves appropriately in various situations. These adolescents need to develop listening skills to understand that they may be sending a confusing message to the listener. Helping them make important decisions by allowing them to look at various options and to problem solve the effectiveness of the different solutions should be done without imposing the correct solution on them. Clinicians should help the
students gather as much information as possible about each solution and then allow the adolescents to talk through the pros and cons of each possibility to each other before making a final decision.

It is recommended that adolescents be provided with challenging tasks that are not too easy. They should be given open-ended tasks that have more than one solution or right answer and be provided with opportunities for collaboration and working in groups in order to discuss and verbalize various solutions to each other. It is important to recognize that each student has different needs; therefore, each student should be given clear and explicit information and guidance. Student autonomy should be encouraged, and the responsibility and freedom to select and complete tasks by self-monitoring should all be taken into consideration once the adolescent has acquired strategies to deal with decision making.

In order to be successful, adolescents with L/LD need to build faith in themselves with an “I can” attitude and realize that they themselves are key change agents. Speech-language pathologists should take a facilitator role to help adolescents acquire the ability to think for themselves. Improving their ability to think for themselves builds adolescents’ self-esteem, which in turn increases their risk-taking abilities and their willingness to take on new challenges, thereby strengthening their ability to make decisions and preparing them for becoming competent and responsible adults.

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Contact author: Jean M. Novak, PhD, CCC-SLP, Department Chair, San Jose State University, Department of Communicative Disorders and Sciences, One Washington Square (SH115), San Jose CA 95192-0079. E-mail: novakjm@sjsu.edu

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