Why Didn't I Say That? Techniques for Counseling Clients and Their Families

Pourquoi n'y ai-je pas pensé? Le counseling des clients et des membres de leur famille

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Abstract

Counseling skills are considered an essential component in the clinical repertoire of speech-language pathologists and audiologists. Ongoing attention to this aspect of clinical intervention is believed to increase the quality of the therapeutic process. This article defines the counseling role for communication disorder professionals, describes the psychological needs of families, and provides a framework for counseling interactions. The article presents five strategies to assist clinicians in counseling clients and their families: a) be with the one you're with, b) listen actively, c) watch your "but", d) use behaviour description, and e) be yourself.

Abrégé

Le counseling est un instrument essentiel de la panoplie des orthophonistes et des audiologistes. En portant constamment attention à cet aspect de l'intervention clinique, on devrait accroître la qualité du traitement. Le présent article explique l'importance du counseling pour les professionnels qui traitent les troubles de communication, décrit les besoins psychologiques de la famille et propose un cadre pour les interventions. Cinq stratégies devraient aider le clinicien à conseiller ses clients et les membres de sa famille : a) ne pas mélanger les cartes, b) pratiquer l'écoute active, c) proscrire le «mais», d) recourir à la description du comportement, et e) laisser le naturel agir.

Counseling is an integral part of the practice of speech-language pathology. It cuts across disorder areas, client ages, and work settings. We engage in aspects of counseling whenever we interview clients for the purposes of taking a case history, when we relay diagnostic and treatment information, and when we listen to our clients and their families discuss their communication disorder and its effect on their lives. This was expressed by Luterman (1991) when he said "Counseling skills permeate everything I do" (p. 179).

Why is it then, that speech-language pathologists and audiologists, like many other health care professionals (Bernstein, Bernstein, & Dana, 1974), feel a lack of confidence in their counseling skills? One explanation is the minimal academic preparation most training institutions provide in the area of interpersonal communication and counseling (Culpepper, Mendel, & McCarthy, 1994; McCarthy, Culpepper, & Lucks, 1986). Clark and Martin (1994) also suggest that clinicians may have unreasonably high expectations for their counseling interactions with clients, and may be unsure of how to assess their skills. We may also be unsure of our role as counselors, and fearful about crossing into the domain of psychotherapy for which we are not prepared (Stone & Olswang, 1989). Finally, we may feel that the family dynamics and emotions surrounding the diagnosis and treatment of a significant communication disorder are beyond our skills. This article will address counseling as a necessary and important tool in the clinical repertoire of speech-language pathologists and audiologists. It will define the counseling role, describe the psychological needs of families and provide a framework for counseling interactions.

Role Definition

Counseling is a recognized component of the clinical process in speech-language pathology and audiology. ASHA (1993) includes counseling in its practice patterns and defines counseling as "procedures to facilitate the patient's/client's recovery from, or adjustment to, a communication disorder." The counseling needs of most individuals with communication disorders and their families can be met by clinicians as a part of the therapeutic process. "Fortunately, the vast majority of our clients and their family members are ordinary people experiencing a normal reaction to a stressful and unfamiliar situation" (Luterman, 1991, p. IX). As professionals, our counseling role requires that we assist the client and the family in adjusting to the changes brought about by the communication disorder. These families need to make changes in such areas as role definitions, attitudes, and

expectations but don't require in-depth personality changes. Thus, the counseling task of clinicians is distinct from psychotherapy and should be focused on specific adjustment issues. As Luterman (1991) states, "...we are working with people who are emotionally upset, not necessarily emotionally disordered and, as such, we need to develop the skills to deal with emotional adjustment issues and family issues" (p. XVIII). The counseling process may facilitate behavioural changes and coping mechanisms within the family while reducing excessive levels of unhelpful emotions such as depression, anger, frustration, and guilt (Chenail, Levinson, & Muchnick, 1992; Pollin, 1987).

Family Needs

It has long been argued (Caroff & Mailick, 1985; Vargo, 1987) that families are the "forgotten element" in rehabilitation. "A communication disorder always exists within a *family* " (Luterman, 1991, p. XVIII). Instead of a purely client-focused perspective, intervention and counseling should be viewed within the perspective of a "therapeutic triad" composed of the clinician, the client, and the family. Much more work needs to be done in the area of helping families cope with the day-to-day realities and frustrations of living with a person with a disability. Some families require assistance in one or more areas in order to come to terms with the communication problem. Here is an illustrative, but not exhaustive, list of what many families need to assist them in their transition from unproductive emotions, such as pity and guilt, to productive behaviours such as coping and sharing.

Catharsis

Family members need to tell their story, often many times. To the listener, including the clinician, this may seem redundant and nonproductive. Often it is quite the contrary. For many families it is a necessary first step to desensitize what they consider to be a catastrophic event in their lives. Clinicians see individuals with communication disorders every day and realize that clients and families can lead fully functional productive lives. Families, on the other hand, usually have only one experience with a communication disorder. This is at best upsetting and at worst catastrophic. Therefore, they may need to retell their story, thus neutralizing the negative emotional charge that the experience has for them and thereby making it more benign. There is a caveat here. There exists a point at which constant retelling becomes wallowing, and the clinician must be sensitive to this boundary. Unfortunately, there is no definitive guideline as to when the line is crossed. Most experienced clinicians will quickly recognize when families are telling their story because they need to come to terms with the situation and when the recounting is used unproductively, for example to avoid the demands of therapy. One index of the healthfulness of the story-telling is whether it makes the family feel better or worse. Helpful recounting of a series of events provides an emotional release that assists families to better come to terms with their situation. If the recounting only makes them feel worse, they are probably wallowing. This should be discouraged. Luterman (1991) rightfully cautions that catharsis in and of itself does not "cure" because expressing feelings is not enough for a person to grow emotionally. However, emotional expression facilitates the separation of negative feelings from nonproductive behavior.

Family Sharing

Families also need to get their "emotional house" in order. This usually means expressing feelings of grief and loss with all family members, including children. Children often find this process painful, but they must be included. Shielding them may seem the kind thing to do in the short term. However, delays in acceptance may result in behaviours such as acting out or withdrawal.

For example, it is not uncommon for siblings of children with communication disorders to experience jealousy because of the time and attention devoted to the child in treatment. This jealousy is sometimes exhibited by modification of their own speech patterns in nonfunctional or regressive ways. When family sharing is part of the therapeutic process, these sorts of behaviours can be recognized early and often averted entirely. Family sharing also will increase awareness of the impact of the communication disorder on other family members and thus assist the primary caregiver in balancing the needs of the family with the needs of the patient.

Friends and Support Groups

The speech-language pathologist cannot be expected to provide all of the emotional support that a family requires. Some of these needs can better be met by friends and support groups. Friends and support groups meet different needs. Friends are best suited to provide nonjudgemental listening, empathy, and respite care if needed. Support groups, on the other hand, provide an organized mechanism for group members to share day-to-day coping strategies with others in similar circumstances. Not all families need support groups, but for some, support groups can be one of the most beneficial components of the adjustment process. Luterman (1991) believes "we can give no greater gift to the families we are helping than providing them with a support group" (p. 143).

Time for Self

Many parents or spouses need to have a brief respite from the family member with a communication disorder. Caregiving can be extremely taxing on patience and energy.

Often the primary caregiver needs only a few hours respite in order for energy and psychological resources to be renewed. Speech-language pathologists sometimes increase the care-giving demands by assigning "homework". Home practice is often an essential component of treatment, but treatment will be better if clinicians remain aware of the increased demands associated with home practice and balance their assignments with the need for family members to have *time for self.* It is often true that family members who take time to care for themselves will be best prepared to care for others (Luterman, 1991).

Opportunity To Express Feelings

Clients with a communication disorder and their families will experience strong emotions. This is natural and to be expected. Perhaps the most common mistake of new clinicians is the idea that our role is to keep our clients from feeling bad. To the contrary, our role is to provide emotional support and to marshal the resources for the client to work productively in spite of the strong emotions. Some of the more common emotions experienced by families are grief, anger, guilt, and depression. Probably the most long-lasting of these is guilt. Guilt is difficult to overcome because it is often not overtly acknowledged. Nonetheless, it can be extremely destructive to family functioning and often makes itself known to the clinician at unexpected times. A recent parent interview highlighted the power and longevity of guilt. Two students and their supervisor were conducting a pre-assessment interview with the parents of a twelve year-old boy with global delay. His delay was diagnosed at the age of two years and he received extensive intervention from a variety of professionals during the last ten years. The interview opened by stating the general purpose of the meeting and then asking the parents if there were any topics they particularly wanted to cover. The mother responded "Do you know what might have caused his problems?" The ensuing discussion revealed that, ten years after the original diagnosis, the parents still worried that something they had done, or not done, had contributed to their son's disability. The mother was invited to express her concerns and assured that the purpose of the interview was not to identify etiology for the purpose of attaching blame, but to learn about current functioning and plan treatment accordingly. The opportunity to voice her fears seemed to defray her anxiety and allow her to focus on the intervention process. When dealing with discussions of guilt, a focus on nonjudgemental listening and acceptance is important. Family involvement in intervention is optimized if the emotions surrounding guilt are attended to.

Professional Counseling

Occasionally, families may require services from trained psychotherapists such as psychologists, social workers, or psychiatrists (Vargo, 1987). Family members may require assistance in resolving interpersonal and intrapsychic conflicts (Margalit, Raviv, & Ankonina, 1992; Padrone, 1994) or need professional help in learning skills such as stress management (Walton, 1993). It is important for clinicians to be able to identify when they are ill equipped to deal with the emotional difficulties of a client and/or family. Stone and Olswang (1989) discussed this in terms of what they call the "boundaries" of the clinician/client relationship. Referral to a mental health professional is appropriate when boundaries are crossed or challenged. As Stone and Olswang said "relationships are *beyond* the boundaries for speech-language pathologists and audiologists when the participants cannot maintain a respectful interaction..., when the client's emotional or behavioural stability fluctuates repeatedly, or when dependency is fostered that detracts from the client's self-confidence" (p.29). These boundaries are individually determined and are different for clinicians with differing levels of experience. Even very experienced clinicians will encounter therapeutic relationships that are beyond their boundaries. This does not reflect poorly on clinicians' skills. Rather, it indicates a sensitive response to client needs.

Clinicians are equipped to listen, empathize, and provide emotional support to clients and families. They are not equipped to provide in-depth psychotherapy, marriage counseling, or adjustment counseling beyond that circumscribed by the qualities described above. In order to provide appropriate and timely referrals, clinicians should be fully aware of the professional counseling resources in their area.

A Framework for Counseling Interaction

Most health professionals are well trained in diagnosis and remediation of client problems. This "solution focus" is appropriate for much of our work. However, when dealing with emotional concerns of clients and families, a solution orientation is not only unhelpful but may even be counter-productive. Instead, it is more appropriate to focus on *processes* rather than *prescriptions*. At certain points in the therapeutic process, what clients need most is to feel that their experience is truly understood by the health professional. At this point they want empathy, not suggestions. Clients are often talked to but rarely heard. This is what is meant by focusing on process and is the framework that is presented in our discussion of counseling techniques for speech-language pathologists and audiologists. However, it is important first to recognize the different types and purposes of interviews with clients.

Shipley (1992) divides interviews into three types: (a) the information-getting interview, the purpose of which is to secure information, (b) the information-giving interview, the purpose of which is to provide information, and (c) the

counseling interview, the purpose of which is to change behaviour and attitudes. Although Shipley distinguishes among these three types of interview, it must be acknowledged that the skills used for one type of interview are also used for the others. For example, each type of interview may use open and closed questions, provide the client and family members with information on assessment and diagnostic results, and provide support and direction for modifying future behaviour and attitudes.

A typical use of the information-getting interview is the case history. It is common for a written case history to be completed and followed by an interview used to clarify and obtain additional information. This is often the first contact between clinician and client and, as such, can have a profound effect on the relationship to follow. According to Shipley (1992), speech and hearing clinicians are sometimes inadvertently responsible for engendering feelings of guilt. Clinicians must be careful, particularly in the opening interview, not to question parents in such a way that the parents feel they are getting "the third degree." Most case history questionnaires for children include detailed questions about birth history and ask for information about other disabilities in the family. These sorts of questions may unintentionally cause the parents to feel that there is something in the history to explain the disorder and that they may be at fault. Instead, it is important to provide reassurance to help counter parents' feelings of guilt and to bring them onside in the therapeutic process. "Individuals experiencing guilt often benefit when they are made to feel part of the *solution* rather than the *problem*" (p. 63).

Information-giving interviews are common in our profession. Diagnostic and treatment information is most often exchanged in this format (Luterman, 1991). Information-giving alone, however, is not satisfactory for clients and their families. Care must be taken to ensure that families are active and equal partners in the process. Research has indicated that this may not be the case. Turnbull and Olswang (1989) analyzed tape-recorded samples of parent counseling sessions conducted by speech-language clinicians. They found that most of the interactions were characterized by clinicians giving information to relatively passive recipients.

This type of interaction may be common in our professions because of the influence of the medical model on our treatment and assessment procedures. The medical model, which is clinician-centered, is being replaced by a consumer-centered model. In the consumer-centered model, the clinician relinquishes the role of "parent" and becomes a consultant to the client and family. Table 1 provides a contrast between these models of intervention.

The final category of interviews is the counseling interview of which the focus is changing behaviours or attitudes. The following guidelines and strategies may assist clinicians in their counseling interviews.

TABLE 1. Traditional Versus Consumer Models in Rehabilitation

TRADITIONAL MODEL	CONSUMER MODEL
1. Professional assumes role of parent.	1. Professional assumes role of consultant.
2. Patient assumes role of child.	2. Patient assumes role of consumer.
3. Professional tells patient what is in patient's best interest.	3. Patient has equal voice in treatment goals
4. Listening to the patient is viewed as unproductive use of treatment time.	4. Listening to the patient is viewed as necessary in order to determine what "rehabilitation" means for that particular person.
5. Treatment goals are prescribed by some external (usually "normal") standard controlled by therapist.	5. Treatment goals are tailored to patient's unique lifestyle with major input from patient.
6. Difficulties related to treatment are blamed on the patient, e.g., patient is labelled "noncompliant", "manipulative", etc.	6. Difficulties related to treatment are viewed as an interaction between therapist, patient, treatment modality, and environment.
7. Focus is solely on cure, or on reducing the impairment to the reducing the impairment to the maximum extent possible. The gold standard is "normality".	7. Focus is on function consistent with patient's lifestyle. "Normality" may or may not be relevant.
8. Rehabilitation is primarily medical.	8. Rehabilitation involves medical, social, psychological, and vocational functioning (WHO, 1980).

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Be with the one you're with. Give your client your total attention. It is important that clients perceive you to be focused solely on them. Interruptions and distractions only serve to make clients feel that they are a less important part of the therapeutic process. Divided attention is non-therapeutic attention. Total attention increases motivation and enhances the probability of the client being "onside".

This is easy to say and difficult to do, because it may mean changing habitual behaviours such as answering the telephone. Whenever possible it is advisable to hold telephone calls and all other interruptions with the understanding that exceptions exist in the case of emergencies.

Listen actively. To help some people, all you have to do is listen. Active listening means being involved and absorbed in what the client is attempting to communicate. The acid test of active listening is whether you can describe in your own words both what the client is saying and feeling. This is often referred to as "empathy". It is a crucial part of the active listening process. "The concept of empathy receives attention in clinical literature but is easily misunderstood; in essence it involves knowing patients well enough - caring enough for them - that the [clinician] better perceives the world as patients see it and thus better appreciates how they experience their pain" (p. 267).

There are two techniques that can assist clinicians to listen actively. The first is the perception check. Often as clinicians we think, feel, or sense that clients are experiencing a certain emotion. Perception-checking simply means asking the client to validate our perceptions. For example, if a client looks sad to us, we might say "You seem sad today. Are you?". It is then up to the client to confirm our perceptions or to offer alternate explanations. Behaviours which may be perceived as "sadness" may indicate other things such as fatigue, distraction, boredom, or any number of other emotions.

The second technique to help clinicians listen actively is the paraphrase. Paraphrasing means stating in your own words what you understand the client to mean. This can be done for thoughts or feelings. Clinicians should be cautioned that paraphrasing can be overdone to the point where it is counterproductive. However, there is no doubt that in most current clinical interactions the paraphrase is under-utilized rather than the opposite. Too often we think we understand what a client is thinking or feeling when, in reality, we don't. The paraphrase is a simple way to decrease the chance of misunderstanding and to communicate your genuine interest to the client. This has the added effect of reinforcing the client for self-disclosure and assists the client in exploring thoughts and feelings at a deeper level. The paraphrase may be considered a verbal mirror.

Watch your "but". Many clinicians are taught that in order to decrease the impact of negative feedback, they should always precede the negative statement with a positive one followed by "but". For example, it is counter-productive to say "You have certainly progressed in your treatment, but we still have a long way to go." Whatever follows the "but" inadvertently negates the positive reinforcement that preceded it. For instance, consider these two statements: "I really like you but sometimes you're a pain in the neck." vs. "Sometimes you're a pain in the neck, but I really like you." Which statement do you believe would be better received? We think it's the second and, as a result, have two suggestions: (a) If you're going to use "but", state the positive part following the "but" ("We still have a long way to go in therapy, but you have certainly progressed in your treatment.") or (b) don't use "but" at all; use "and" instead ("You have certainly progressed in your treatment, and we still have a long way to go.").

Use behaviour description. It is easy to impute motives to others, especially when there is conflict. When this happens, evaluative labels or descriptions are often used. For example, "You're not putting in enough effort", "You're not motivated", "You don't seem concerned for your child's well-being". Evaluative labels convey a judgmental approach to the relationship and only serve to make people defensive. Instead, try objectively describing the behaviour that you observe. For example, "You have missed three treatment sessions in a row" or "You haven't completed your homework assignments." This type of feedback conveys an accepting approach and reduces defensiveness. Such feedback also encourages self-exploration on the part of the client. If, by paraphrasing, you are a verbal mirror, in using behaviour description, you are a verbal camera.

Be yourself. Whatever therapeutic strategies you use must be congruent with the person you are. Clients are sensitive and perceptive more to what clinicians are and do than to what they say. If you feel uncomfortable or "false" using a technique, it will probably show. However, a mild level of discomfort is a natural part of the learning process. So don't give up with these or other techniques until you've given them a fair chance. Once they become part of your "natural" therapeutic repertoire, they will be perceived by clients and colleagues alike as being performed effortlessly. When that's the case, don't be surprised if you're asked "How do you do that?"

Conclusion

Some readers may view the above suggestions as simply falling into the category of "common sense", and thereby discount their usefulness. However, we would like to make

two observations about common sense. First, common sense is not just knowing what to do in a given situation; it is actually doing it. Second, if we adopt this definition of common sense, it becomes apparent that common sense really isn't very common. This is the view taken by Joseph (1994) who wrote: "To say that someone has good common sense is to pay no small compliment; it implies a sharp eye for the significant, a grasp of the obvious — like seeing the emperor's new clothes — that at times makes everyone else seem color blind" (p. 1). The techniques suggested in this article are simple to understand but not easy to master. Nonetheless, through practice, they can become a valuable addition to every clinician's therapeutic repertoire. Better intervention through better counseling will benefit both clients and their families.

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