Counseling in Communication Disorders

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Stuck Inside
I'm in here.
Doesn't seem like it,
but, I'm in here.
Won't you help me out?
Won't you help me find myself again?
I think I came from over there....
Or, maybe it was over there,
or,
or,
or....
Guide me back.
I got lost...
and
I can't find my way back.
I am in here!
I am.

by Madeline Hopkins Harbinger, 1996

ABSTRACT: The intent of this article is not to make counselors of speech-language pathologists and audiologists, but instead to provide information that will increase the insight and awareness of clinicians when they communicate with patients and their families. This article will highlight the behavioral, humanistic, and existential models of counseling; considerations when counseling spouses and parents; stages of crisis (e.g., shock, realization, retreat, acknowledgment); issues in cultural diversity; and, finally, the status of counseling in the field of communication disorders.

The poem to the left was written by Madeline Hopkins, a 32-year-old, newly married woman who suffered a cerebral bleed when she was 7 months pregnant. Years later upon recovery, she wrote her thought-provoking memoirs entitled Harbinger (Hopkins, 1996), in which she reveals her feelings and experiences of the rehabilitation process and, in particular, what it was like being a patient receiving therapy. I had the privilege of working with Madeline, her husband, and her family. The rehabilitation process was not a typical, run-of-the-mill language therapy program, but an experience that required skills in communication and counseling that were not provided in any of my graduate school classes or fellowship training.

We, as practicing speech-language pathologists and audiologists, are certainly well equipped to take a thorough case history, administer appropriate diagnostic tests, communicate results of the diagnostic workup, and provide treatment to remediate the deviant behaviors. However, in addition to the professional content, there are numerous emotional factors to consider when working with patients and their families. We have a responsibility not only to be knowledgeable and competent in our area of expertise, but also to consider the manner in which we communicate with clients and their families as well as to provide counseling when needed.

The purpose of this article is not to make counselors of speech-language pathologists and audiologists, but to provide knowledge to speech-language pathologists and audiologists that will ultimately increase their insight and effectiveness when communicating with patients and families. To this end, the models of counseling, considerations when counseling spouses and parents, issues in
cultural diversity and counseling, and counseling in the field of communication disorders will be discussed.

MODELS OF COUNSELING

Counseling has been defined as a process that assists individuals in their exploration and clarification of thoughts and feelings so that they may see difficulties more objectively and make their own decisions (Parkinson & Rae, 1996). The task of the counselor is to help individuals work toward an understanding of themselves in order to learn new ways of coping with negative life situations (Rollin, 1987). More often than not, the type of counseling that occurs in the field of communication disorders stems from a foundation of information counseling in which case test results and/or treatment progress are conveyed to the patient as concrete facts, instead of approaching the patient from a personal adjustment perspective.

Although there are numerous models on counseling, applying this literature to the field of communication disorders is not common. Luterman (1991) and Rollin (1987) offered great insight into the role of counseling in the field of communication disorders using models of counseling from the field of psychology. The behavioral, humanistic, and existentalist models will be discussed here not with the goal of making professional counselors out of audiologists and speech-language pathologists, but to offer insight into various methods of counseling that will increase effectiveness when communicating with clients and families.

Behavioral Model

The behavioral model of counseling is based on the notion that human behavior can be shaped by the environment (Skinner, 1953). This approach provides a structured framework that can be applied to the specific behavior that is to be changed. In this model, the task is broken down into a series of successive steps where progress at each stage can be measured and reinforced. The principles of behavior modification are easy to teach to students and the inexperienced clinician likes the structured framework. An example of this model that is used frequently in pediatric speech therapy is to offer tokens such as stars or stickers to positively reinforce a correct behavior. Although this approach is effective in modifying a behavior inside the therapy room, it provides a narrow view of our role as speech-language pathologists. In addition, issues commonly associated with communication disorders such as loss, independence, and self-esteem, which also effect communication disorders, are not addressed in this particular model.

Humanistic Model

The humanistic model, on the other hand, addresses more of the underlying feelings that could accompany a communication disorder. Carl Rogers (1951) introduced the humanistic or self-theory model, which focuses on the notion that people are in the center of an ever-changing environment and the way in which the person responds to the changes depends on how he or she perceives reality. An example in the case of an adult aphasic, if he or she perceives his or her disability as the only reality, is the possibility that the client will remain focused only on the disability and react negatively. On the other hand, if the client has the ability to perceive that there are possible assets of the disability, there would be a greater chance of positive personal outcome (Rollin, 1987).

Luterman (1991) also applied this model to speech-language pathology and audiology and described that in order for a positive change to occur, the clinician must develop an attitude of unconditional regard so that the client may feel free to openly discuss all aspects of the disability. In order for the client and his or her family to receive this unconditional regard, they should feel total acceptance from the clinician and never be labeled as "pathetic" or "sad." Instead, the client should be accepted for who he or she is despite the communication impairment. In the case of acquired disorders, the client should be given respect for who he or she was prior to entering the office.

Madeline Hopkins, the patient discussed earlier, describes in her book, Harbinger, the feeling of disregard during morning rounds by the physicians.

They would make the rounds at 5:30 am, like clockwork. I was desperately trying to become cognizant, and tried to keep a sunny disposition...even at 5:30 am. I specifically recall the feeling of being under the microscope as the interns looked down on me as if I was a science project. The thing is... I was. I felt as if I didn't exist. I remember thinking, I am a person, just like you. Don't disregard me; I am important too.

When Madeline met the speech-language pathologist for the first time, it appeared as if the clinician attempted to provide unconditional regard by respecting her as an individual despite the circumstances that brought her to the hospital by asking what she did for a living or in her spare time.

I recall not quite knowing the answer. It was all so complex,... and I couldn't explain, because I could not quite remember. I didn't have anything to show for myself. I didn't remember to ask my husband where my pocketbook was either, which would have my wallet. The wallet had my business card and my "Seller's Certificate" for my art gallery. Still, it might have been too difficult to explain, or retract. There was always an unspoken identity within me. Perhaps, that was my soul.

The second quality inherent in the humanistic model is empathetic listening. Although most supervisors probably expect this trait from their students, the skill is rarely taught in graduate programs or clinical fellowships. Empathetic listening requires the clinician to listen closely to the client and family and give the information back to them, in a slightly different manner. However, as Luterman (1991) pointed out, "empathetic listening is often abused and comes across as parroting and mechanical in the hands of someone who has learned the form but not the substance of the humanistic approach" (p. 91). But if used correctly, the patient and family will feel as if their own needs, desires, and fears are heard.
Existentialism

The third model of counseling that has been applied to communication disorders is existentialism (Luterman, 1991). Existential notions are related to the facts of existence, which are described as death, freedom, loneliness, and the meaning of life (Yalom, 1980). These notions have been used in psychotherapy in which the therapy is focused on the present and the client’s behavior is viewed as a conflict with one of the existentialist notions, which results in anxiety.

Existentialism can also be applied to communication disorders (Luterman, 1991). We are dealing with patients and families who are experiencing a loss that can be perceived as a death, which is the first notion of existentialism. Such losses can be speaking, comprehending, hearing, or the loss of having a “normal” child in the case of parents of an infant who is deaf or brain-injured. Grief of the “old self” is the person who they were prior to the injury or deficit. Clinicians should be aware of the existence of this type of loss when delivering the results of the clinical evaluation, or throughout the course of therapy and even upon discharge from services. Madeline Hopkins (1996) concludes with reflections on losing herself: “That day, December 27, 1992, everything changed in my life, for a long time. Forever. I lost myself but slowly found a different version of me. It seems more than anyone could have hoped for.”

The second fact of the existential model is freedom, and this is vital to any therapeutic relationship. Freedom can be defined as allowing the client and family to assume responsibility for choice and change in the client’s behavior. As discussed earlier, we as clinicians feel the need to be the information provider in the white lab coat and often we want to be the rescuer. The result of this type of approach leaves the client and his or her family feeling powerless, such that any change that will occur will come from an external source rather than from within. Clients and their families must be empowered to assume responsibility for their own behavior and subsequent recovery so that continual improvement will occur long after the formal therapy relationship has dissolved.

The third notion in the counseling model of existentialism is the feeling of loneliness. This is intimately related to audiologists and speech-language pathologists because the communication disorder could result in isolation from family, friends, coworkers and, at times, the rest of the world. The child who is deaf who is integrated into a hearing school system, the youngster with aphasia who cannot return to work, the person with a laryngectomy who refuses to use his electrolarynx in public, or the grandmother who is progressively deaf who cannot hear her grandchildren are all isolated in some sense.

Jean-Dominique Bauby (1997), 43-year-old editor of French Elle magazine, wrote poignantly about his own isolation after he suffered a severe brainstem stroke that left him with a locked-in syndrome. “My heels hurt, my head weighs a ton, and something like a giant invisible diving bell holds my whole body prisoner.” He described being paralyzed from head to toe with his mind intact, imprisoned inside his own body, unable to speak or move while blinking his left eye as his only means of communication. However, his feeling of loneliness was lessened, albeit briefly, during his daily visits with his speech-language pathologist. He writes, “The identity badge pinned to Sandrine’s white tunic says ‘Speech Therapist,’ but it should read ‘Guardian Angel.’ She is the one who set up the communication code without which I would be cut off from the rest of the world” (p. 39). Jean goes on to describe the feeling of isolation and loneliness in relation to those who interact with him daily, “As the weeks go by, this forced solitude has allowed me to acquire a certain stoicism and to realize that the hospital staff are of two kinds: the majority, who would not dream of leaving the room without first attempting to decipher my SOS messages; and the less conscientious minority, who make their getaway pretending not to notice my distress signals” (p. 39).

The fourth notion in the existential model of counseling refers to the issue of meaning of life. This is the idea that there is meaning or a specific order to the universe and that there has to be an underlying reason for tragedy or illness. Some see this underlying meaning as negative, such that God punishes the bad and when crises such as trauma, stroke, or deafness befall an individual, the crisis was deserved. On the other hand, there are patients and families who see the underlying meaning as positive and feel that one must rise above, meet the challenge, and try to understand why the tragedy fell onto their paths. From this tragedy, they may learn from the experience and become stronger individuals.

This idea of crisis and the meaning of life were described clearly by Madeline Hopkins (1996) in her memoirs of recovery.

As I was completing this story in the hope that it would serve as inspiration for others, suddenly I realized what that something was. I began to make connections of the moments in my life when I was left in the dark…a life without meaning. I began to understand what the gift of life is. It was something that was given to me when I was sick, but I think it had always been there. All the hard times I had experienced in my own life, had lead me to this place. Just like a clearing in the forest…and I found it.

In this case, the discovery of life’s meaning has led Madeleine to write about her illness and recovery and to provide hope and inspiration to others who have experienced similar events in their lives.

Although the behavioral, humanistic, and existentialist counseling models have much relevance to the field of communication disorders, there is no empirical evidence to support the use of one of these approaches over another. In general, the three approaches described above are very different from one another and there is an appropriate use for certain aspects of all three models throughout the diagnostic and therapeutic process. It is the responsibility of the clinician to become more aware, more knowledgeable, and, ultimately, more effective when communicating with patients and their families.
Counseling and Spouses

The wedding vow states “in sickness and in health.” Every newly married couple has a dream about their new life together. The dream is filled with many possibilities including love, happiness, building a new home together, and starting a family. Unless one or both of the individuals has a disability before they marry, the couple typically does not focus on how to prepare for such a situation. The newlyweds proceed with life and, when and if a disability befalls one of the individuals, the spouse of the disabled is severely impacted.

At this point, the dream has been altered. And, at some level, the nondisabled spouse could be angry that the contract was permanently violated and feel cheated. The spouse could be grieving the loss of the dream that was once shared and now is faced with the possibility of losing the person they once loved.

Depending on the nature of the disability, roles in the relationship could be altered. For example, if the husband works outside of the home and becomes disabled, the wife is now faced with the reality of having to work. If the wife stays at home full-time raising the children, while the husband works outside of the home and she suffers an injury that renders her disabled, then the burden of running the household, raising the children, and working outside of the home becomes the husband’s responsibility. The situation may be much more traumatic if the person who is in charge of the finances suddenly suffers a stroke, is unable to do arithmetic, and the spouse must now resume financial responsibility.

In addition to the severity of the disability, the length of the marriage prior to onset will impact how the couple faces and weather adversity. If the couple is newly married and has not been exposed to difficult situations together, they may have a more difficult time than a couple who has been married for 50 years. The disability could cause excessive marital stress and expose preexisting weaknesses and, with some marriages, the weaknesses may be so deep that the marriage will crumble. On the other hand, the adversity may prove to be an opportunity for strengthening the weaknesses and mending old wounds.

I have treated a number of adults who suffered severe cerebral injuries who were newly married and appeared to weather the storm quite well. For example, D.T. had been married 2 years when she suffered a cerebral bleed at the age of 24 during childbirth. The injury left her severely aphasic, apraxic, dyslexic, and dysgraphic. She remained at home full-time raising their son while her husband worked outside of the home and she never received therapy because there was no time, transportation, or money. D.T. and her husband walked into my office after 50+ years of marriage, holding hands. On the initial case history, they explained that despite the devastation the stroke had on their lives initially, they had a lot of family support to help out with their new baby. Later, they learned how to live with the disability, and they laughed as they shared anecdotes of D.T. trying to discipline their young son when she could not speak. The couple is now enjoying their retirement with golf, family, friends, and travel.

The communication disorders professional needs to give considerable attention to the nondisabled spouse during the diagnostic and therapeutic process (Luterman, 1991; Rollin, 1987). The success of any rehabilitation program depends on the active participation of the family (Rollin, 1987). The spouses need to be included in the diagnostic workup and the therapeutic goals should be agreed on between the clinician, client, and spouse. The spouse needs to be educated regarding the nature of the communication impairment and given ideas on how to best communicate with his or her partner. The therapist needs to begin each session with the client and the spouse (if possible) and ask open-ended questions regarding communication in the home. For example, “How are things going at home?” Or “What kind of difficulties are you having communicating with Joe?” The purpose of this is to provide an open forum for the nondisabled spouse to voice his or her frustrations. Hopefully, the clinician can provide some ideas to alleviate the situation.

As the therapeutic process progresses, the nondisabled spouse could experience a range of emotions from anger to grief, realization, perhaps depression, and, hopefully, acceptance. Again, each person will not traverse the stages similarly, nor will each person experience every stage. But the clinician should be aware of and vigilant to the nondisabled spouse and provide an open environment and support whenever possible. Rollin (1987) defined two goals when working with families with aphasia: a reeducation process in which the family assists the patient and participates in activities and an opportunity for family members to cope with their own emotional responses to the trauma modifying previous behaviors and establishing a different mode of living. Finally, introducing spouses to other spouses in similar circumstances can be beneficial.

Counseling and Parents

Mark and Lynne had their first child, Moriah, 6 years ago. Moriah was born with bilateral vocal fold paralysis, general hypotonia, and curvature of the spine. She currently is in school full time, receives physical therapy, has a tracheostomy, and wears a back brace 20 hours per day. Prior to delivery, Lynne was working full-time as a speech-language pathologist with infants and children with special needs. Lynne was interviewed and asked to talk about what it was like having and raising a child with a disability.

Right after I gave birth, the doctor told me that the baby was having trouble breathing. I remember feeling very sad, because I knew she might have a slight chance of having vocal fold paralysis since I have one vocal fold that is paralyzed. I remember apologizing to my husband because I felt very guilty that I was responsible that I gave her this condition. I could not bring her home from the hospital with me initially because she needed additional care and finally 4 weeks later she got to come home. After one week at home, she had to go back in the hospital because she was having difficulty breathing and needed a tracheostomy. That was when the shock of the situation hit me. Because I realized that it was much more serious than my own vocal fold paralysis.
Upon bringing her home from the hospital the second time, we went through all the normal stuff that all new parents go through when bringing a baby home like sleeplessness, upheaval in the routine etc., but I had additional responsibilities. I had to take care of her tracheostomy, oxygen, medications and then she developed difficulty eating (later she needed a gastric tube). After the routine kicked in, around 10 months later, it finally sunk in that what had happened was not going to change anytime soon. At that time I became angry and frustrated that I could not be like all the other new moms and just pick up their baby and diaper bag and head off to the store or see the grandparents. I really could not leave the house with her because I had a suction machine, oxygen and I was concerned about her getting infections. I was overprotective and felt responsibility for her overall wellness and health and particularly concerned who would take care of her if I got sick. I rationalized that she was doing so well because I have been providing such extensive care.

By around 2 years, she began to stabilize and did not need to be suctioned as frequently or require as much care however, I found I could not decrease the medical attention I was giving her. I became anxious and thought that somehow if I gave any less, that she would become ill. It took time for me to be comfortable, but I gradually learned and decreased the level of care I was providing. My husband and I realized then that we must get on with our lives and establish a normal routine.

Moriah now is doing great. She is enrolled in school full time, receives physical therapy for her curvature of her spine, eats everything by mouth and uses a speaking valve to communicate.

The relationship between clinicians and parents of children with communication disorders is vital to the diagnostic and therapeutic process. Parents bring their children to see specialists in communication disorders because they either suspect that something is wrong with their child’s ability to communicate or because another professional referred them. In order for a clinician to effectively communicate and counsel these parents, he or she must understand the path the parents have traveled prior to walking into the speech and hearing clinic and what their daily lives entail when caring for a child with special needs. The journey often begins at the time of the diagnosis, with a myriad of emotions to follow.

The emotions frequently reported by parents when describing their first reaction to receiving the diagnosis is one of a crisis. The stages of a crisis reaction are described as shock, realization, retreat, and acknowledgment (Webster & Ward, 1993). Although these constructs are useful as a general framework from which to understand crisis, not all parents experience all stages, nor will each parent traverse the stages similarly.

Shock. Shock is one of the first reactions to a traumatic situation in the case of learning there may be something wrong with a child. The parent may panic, and panic results in feeling helpless and powerless. Parents may lash out in anger to the physician, other medical professionals, or even God. As discussed earlier, the psychological model of existentialism can be effectively applied to this situation. If you recall, the notion of death was the first fact of existence and, in this situation, parents are experiencing a loss of having a normal child, which can be perceived as the death of a dream.

In the case example provided earlier, Lynne described her initial reaction as sadness and not shock. This is probably because Lynne herself had unilateral vocal fold paralysis and knew there was a possibility that she might pass it along to her baby. However, at 4 weeks of age, when Moriah needed to return to the hospital for a tracheostomy, Lynne felt shock at that time because Moriah’s paralysis was much worse than hers and the severity of the situation quickly became apparent.

Realization. Following shock is the stage that the situation is not going to change and must be dealt with. The realization that the disorder will not simply “go away” could create anxiety. Inability to sleep, depression, tears, panic, and irritability can all be symptoms of anxiety. Anxiety may diminish the parents’ ability to communicate and collaborate with the medical professionals who are attempting to provide care for the child and family. As Webster and Ward (1993) pointed out, the parents may be unable to understand the information provided, which may have to be repeated by the professional time and time again. The parents may also be slow and awkward in learning how to work with the child, or they may be so sensitive that they feel that the suggestions offered by the professionals are criticisms. In addition, anxiety could be perceived as anger or confusion to the clinician.

As discussed earlier in the section reviewing models of counseling, the humanistic approach outlines the need for the patient and family to receive unconditional regard, such that they should feel total acceptance from the clinician and never be labeled as emotionally unstable or angry. The clinician can best deal with this situation by understanding that the parents could be anxious and provide a safe, respectful environment for which they can be given time to accept and learn to cope with the enormous situation that has just been placed before them.

Retreat. Rearing a child with a disability is an overwhelming task, and most parents will admit that they would like to retreat or run away from it all. In addition, the feeling of not being able to handle the situation flawlessly can induce feelings of guilt. The behaviors of retreat can be seen by the clinicians as parents who are not participating with their children in the therapy sessions or who do not want to become actively involved in the treatment planning. If the clinician realizes that the parents may be just temporarily retreating, the clinician can ask the parents to select the home tasks that are easiest for them and to reinforce each effort made by the parents (Webster & Ward, 1993).

Acknowledgment. Finally, after a period of time, parents will hopefully come to accept and acknowledge the fact that the disability is present. As referred to above in the existential model of counseling, this concept of acknowledgment is related to the meaning of life. This is the idea that most people would like to believe that there is meaning or a specific order to the universe, and that there has to be an underlying reason for tragedy or illness. Some parents view the underlying meaning of the disability in a negative light—that somehow God punished them because they were bad and the disability was deserved. But, on the other hand, there are parents who believe that the underlying meaning is positive and that they must rise above, meet the challenge, and try to understand why this tragedy fell onto their paths.
As Lynne eloquently explained when her 6-year-old daughter approached her with sadness, asking why she has a trach and brace and all the other kids do not, Lynne told her, “It is OK to be sad for awhile, Mommy gets sad sometimes too. But it is not OK to let it ruin your whole day or ruin the fun times. Life is learning about how to deal with the not so good things that happen to you and you are lucky you are learning that now. Some people never learn this lesson.”

Feelings of guilt. As mentioned previously, the clinician communicating with and counseling parents must be aware of the vast array of feelings that accompany a life experience such as a communication disorder. Above, the feelings associated with receiving a diagnosis were discussed and, in addition to the stages of shock, realization, retreat, and acknowledgment, feelings of guilt may be present that could profoundly affect the parents’ behavior.

Luterman (1991) proposed that next to anger, guilt is the single most pervasive feeling experienced by parents of children with disabilities; in particular, the mothers feel responsibility for the disorder as if they somehow caused it during pregnancy. A trusting, safe relationship between the clinician and the mother should be established so that she feels free to discuss feelings of guilt. Again, this ties in very closely with the humanistic approach of counseling, which can establish an environment in which feelings of guilt can be discussed.

Behaviors such as overprotectiveness, the overloving/overgiving parent, overdoing, and sometimes withdrawal are associated with guilt (Webster & Ward, 1993). Overprotectiveness stems from the fear of the parents that if they are not overly careful, they could be the cause of harm to their child. Lynne described that because she had been providing such intensive care for 2 years, Moriah had been doing well and had not gotten worse. Lynne was convinced that she could not decrease her vigilance despite her daughter’s medical improvement, because if she did, Moriah would certainly become ill. The reasoning here is that the parents think that they let something bad happen to the child once and they do not want anything else to happen. If the overprotectiveness is prolonged, the child will not have the ability to develop autonomy or initiative.

The overloving/overgiving parent is an extension of overprotection. Examples of this behavior can be seen in the parents who dedicate their lives to the child and are unwilling to allow other capable family members to provide care for the disabled child. The overdoing behavior is seen as trying to do more than is prescribed or necessary for the child (e.g., more physical therapy repetitions). This parent works very hard at all the therapies—at times, to the detriment of other relationships in the family, such as the marriage or with the other siblings.

Suggestions for Clinicians

Webster and Ward (1993) and Luterman (1991) pointed out that the most important role a professional can play when working with parents who are displaying symptoms of guilt is to offer understanding, support, and opportunities to explore and clarify their feelings. A major goal of therapy should be to disengage the parent’s guilty feelings from the nonproductive behavior. People can still feel guilty and be productive in their child’s therapy at the same time.

Webster and Ward (1993) described several responsibilities of the clinician when working with parents of young children with disabilities. The first responsibility of the professional is to give information. The information provided must be the specific type and amount that can be absorbed and comprehended at any one time. If the information is in excess and filled with too much detail, the parent will hear only fragments and will walk away feeling overwhelmed. On the other hand, if the information is brief and lacks sufficient content, the parent may walk out of the clinic feeling unfulfilled.

The second responsibility of the clinician is to obtain information from the parents. The parents have a window into the child’s daily behaviors, experiences, and interactions which is invaluable. Without this information, the clinician does not have a true picture of the child’s level of functioning. The third responsibility of the clinician is to help parents understand and clarify their own ideas, attitudes, and emotions. Parents may require assistance sorting out their own feelings and attitudes about their child’s disability, treatment options, and their own role in the therapeutic process. If the clinician provides a safe, respectful, and open forum in which the parents can discuss concerns, the parents will be able to trust the clinician and ultimately, the child will benefit from this relationship.

Lynne offered her unique view as a speech-language pathologist who worked extensively with children of special needs and as a mother of a child with a disability. She provided the following suggestions for clinicians who work with children and parents:

- Ask the parents in an open-ended question why they brought their child into the clinic. Allow ample time for the parents to provide information and to just “get their concerns off their chest.” For example: “Why are you here today?” or “Please tell me about what you see at home that concerns you.”
- Do not use professional terminology but instead speak in lay terms.
- Make the parents feel valued by pointing out the good things the parents are doing with their child. Empower them. Let them know that you are there to eventually make things easier for them.
- Realize that you may not be the only professional they see on a regular basis, so keep it simple. Give them a business card and let them know that you could be a resource should they have other questions. For example, “Even though I am a professional, I do not have all the answers and I am not here to make you think that I know everything. I will do the best I can to find out information for you if you have additional questions.”
- Ask functional questions during the therapy process such as “In what situation are you finding it the most difficult to understand your child?”
- End conversations with “Do you have any questions?” And, if the parents do not have any questions,
encourage them to write them down should they think of any later or to call.

• When possible, introduce parents of children with similar disabilities to one another.

CULTURAL CONSIDERATIONS

It is important for speech-language pathologists and audiologists to be aware of intercultural differences when counseling patients and families of cultures that are different from their own. Culture is defined as any group of persons who have a common set of values and language; ethnicity is defined as the portion of cultural development that is formed through early contacts with family, neighbors, friends, and teachers, as well as with his or her immediate environment of home and neighborhood (Morsink, Thomas, & Correa, 1991). Clinicians should have an understanding of basic cultural characteristics of the diverse cultures with which they work. Moreover, the knowledge should be more substantial than generalizations the clinician has formed about cultural groups different from their own (Screen & Anderson, 1994).

In order for professionals to become more knowledgeable about beliefs and customs of a particular culture of interest, Morsink et al. (1991) offered a list of questions that can be used as a general outline when doing research. How many years has the family been in the United States? What were the family’s living conditions in their native country? Does the family accept English as a second language in the home? Do extended family members play a role in the family system? Does the family respect for elders and people in authority? How do the culturally diverse family members feel about their loved one’s disability? What does the family believe caused the handicap? Does the family accept Western values of scientific medicine and technological basis for health care?

Lynch and Hanson (1992) outlined general principles of effective cross-cultural communication. Communication in high-context cultures is when fewer words are spoken and less emphasis is placed on verbal interactions. Examples of high-context cultures are Asian, Native American, Arab, Latin American, and African American. Facial expressions, tensions, movements, speed of interaction, and location of interaction have more meaning for people from high-context cultures. Communication in low-context cultures, on the other hand, focuses on precise, direct, logical, verbal communication. This type of person is impatient with communicators who do not get to the point quickly. Examples of low-context cultures are Swiss, Anglo-European American, German, and Scandinavian.

Nonverbal communication speaks louder than words when working with culturally diverse families. A gesture or facial expression that is accepted as a compliment in one culture may be viewed as rude from another. Lynch and Hanson (1992) presented some important nonverbal cultural “do’s and don’ts.” In terms of eye contact and facial expressions, Anglo-European Americans value eye contact when communicating; however, some Asian groups view eye contact between strangers as shameful. The amount of personal space (e.g., social distance) also differs among cultures. Anglo-European Americans keep approximately an arm’s length between themselves and others when communicating; however, Latino Americans, Middle Easterners, and African Americans are comfortable with closer distances. Body language such as sitting on top of a desk or on the arm of a chair is seen as rude by many Muslims, and some Asians view standing with one’s hands on the hips as hostile. The use of hand gestures to supplement verbal communication is used moderately with Anglo-Europeans and Latin Americans; Middle Easterners and southern Europeans use large gestures when communicating.

It is important to note that cultural groups are made up of heterogeneous individuals. All members do not espouse to or practice all of the values, beliefs, and practices typically ascribed to by the culture. Additionally, educational level, socioeconomic status, and length of time in the United States are variables that impact an individual’s cultural assimilation.

COUNSELING IN SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY

Parkinson and Rae (1996) examined the understanding and use of counseling by speech-language pathologists as a function of differing levels of experience. They surveyed first year and fourth year students and new and experienced clinicians. The authors were interested in the understanding of counseling by the four groups and the extent to which counseling (or in the case of students, anticipated counseling) formed a component of their practice.

The results of their study showed that there was no significant difference in the understanding of the term counseling across career status; however, there were significant differences in the use of counseling. The use of counseling increased from the first to the fourth year students, then fell again in the first year of practice, rising later with acquired experience. These results can be interpreted that first year students expect to carry out counseling behaviors when they begin practicing, and there is a much higher increase in expectation by the fourth year. However, by the time the student becomes a new clinician, the neophyte professional is faced with a stressful work situation and perhaps adopts a more educational approach when dealing with clients and their families instead of providing counseling. This situation may be viewed as a retreat to a defensive position because dealing with the emotional component of the client and his or her family might be too overwhelming. After years of experience, this study showed that seasoned clinicians practiced more counseling techniques when compared to the other three groups.

Beyond classroom training, I believe that students do not receive adequate training on how to effectively communicate and counsel their clients and families in the clinical environment during their fellowship year. Programs typically stress the intellectual and cognitive skills of the students and not the interpersonal skills. If the supervisor
adopts the humanistic model of counseling and applies it to training students, learning will take place in a nonthreatening and respectful atmosphere. The supervisor needs to facilitate this safe learning environment and view the new clinician in a nonjudgmental light.

The most commonly used method of teaching graduate students reflects the behavioral model that emphasizes an external locus of control and external locus of evaluation. The supervisor provides the structure of what is to be learned and the student complies, learns the material, and awaits a grade from the supervisor. The same holds true when supervising a counseling session. The supervisor stands back, observes the student communicate with the client and family, and then discusses with the student after the session what he or she did wrong and kindly provides suggestions as to how to modify his or her behavior. As a result of this type of learning process, students learn to satisfy instructors (external locus of control) as opposed to working to satisfy themselves (internal locus of control). In addition, students may consider taking an applied course offered in the psychology or rehabilitative counseling departments.

Lutterman (1991) described a course that he currently teaches from a foundation of cognitive and interpersonal learning. At the beginning of the course, he provides the students with the final examination, which consists of a list of essay questions that reflect his opinion as to what content the students need to master. He also provides a bibliography containing readings that will enable them to find the answers to the questions. It is then the students' responsibility to organize their time to acquire and master the content of the class. The grade is then based on the examination performance at the end of the class. In terms of the individual class sessions, half are organized with lectures, films, videos, and guest speakers while the students are required to structure the other half of the sessions. The purpose of this format, Lutterman explained, is to provide the students with an opportunity to take control of what they learn and take responsibility for obtaining the content. A benefit of this approach to teaching will create a more self-confident, self-reliant, and assertive professional who will hopefully be more effective in working with clients with communication disorders.

This method of teaching can be applied to supervisors working with students who are in the process of learning the skills of counseling and communicating with clients and their families. One approach could be to provide the student at the beginning of the term with references regarding models of counseling and an extensive bibliography. In addition, during the first portion of the term, the student can observe the supervisor counsel and communicate with clients and their families with the primary goal of coding the supervisors' behaviors followed by in-depth discussions concerning what the student observed. Once the student begins to counsel, the sessions could be videotaped and reviewed by the student independently so he or she can evaluate his or her own performance (e.g., internal locus of control). The student could then bring the videotaped session and a list of questions or concerns to the supervisor regarding his or her behavior and together they constructively could devise a plan as to how to improve the students' skills.

Again, the goal of this type of approach to learning how to communicate and counsel is to hopefully create a more self-confident, self-reliant, and assertive professional. In this model, the student is not behaving just to please the teacher or to get a good grade, but rather the student will learn from an internal perspective and learn to evaluate his or her own skills and hopefully improve and refine them over time.

Counseling should be viewed as basic to the repertoire of services provided by speech language pathologists and audiologists. This highlights the concept of viewing and treating the whole person and not just the disorder. Each client is an individual with a history and life entirely separate from the disability. It is imperative that the clinician recognize these facets of how the client incorporates the communication impairment in his or her life and how the clinician can help the client have choices in how to respond to the impairment in a positive light.

REFERENCES


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