Counseling: An Approach for Speech-Language Pathologists

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Van Riper often told his students, “It is not enough to know the kind of disorder a person has, one must know the kind of person who has the disorder.”

Knowing the kind of person who has the disorder is part of being a speech-language pathologist. The ideas presented here are to help you get to know the client better in order to facilitate change. Of course, this also requires that clinicians know themselves. Counseling in the field of speech-language pathology is similar to counseling in any type of disorder. Counseling is not psychotherapy in which mental or emotional disorders are treated (Crowe, 1997). There are many different theories of counseling. Crowe provided a comprehensive review of clinical approaches, including cognitive–behavioral and experiential. Luterman (1991) also reviewed various counseling directions for speech-language pathologists. Egan (1998) described a basic approach concerning problem management for the skilled helper. He gave step-by-step instructions in the progression of counseling. An outstanding review is provided by Manning (2000) on the characteristics needed in a clinician, including the ability to use humor.

ABSTRACT: This article is a description of an approach to counseling that focuses on the client–clinician relationship. The basic assumption presented is that clients have the ability to find their own solutions in an accepting, empathic environment (C. Rogers, 1951, 1961). A process is described in which the importance of the qualities of the clinician is related to the counseling. These qualities are caring, self-awareness, observation, and active listening. With the help of an empathic environment, the client can become self-aware and grow toward self-acceptance. These dynamics can help clients with communication disorders to recognize and confront faulty perceptions, making them freer to make realistic choices (A. T. Beck, 1976; A. Ellis, 1984; A. Ellis & R. Harper, 1975; D. Meichenbaum, 1977). The effects of developmental ages/stages in children and the role of temperaments are also addressed.

KEY WORDS: counseling, communication disorder, speech-language pathologists

Each clinician has his or her own unique personality and an attraction to certain approaches. It is recommended that every clinician who is considering counseling a client with a communication disorder review the counseling literature and become familiar with the different approaches. Choosing the approach that is compatible with your own personality and interests will be much more effective for the client than using an approach that is inconsistent with your views. In this article, I will describe my approach to counseling as a speech-language pathologist. It is one that has been influenced by the person-centered work of Rogers (1951) and the cognitive restructuring approach of Beck (1976), Ellis (1984), Ellis and Harper (1975), and Meichenbaum (1977). The goal in counseling as presented here is to facilitate individuals to find their own answers, experience an internal sense of control, and leave with new perspectives and the confidence that they can continue to care for themselves.

At the beginning of the counseling process, it is important for the clinician to explain the process to be used in counseling to the client. The clinician gives the client information about the goals and the approach that will be used to reach them. It can be described in the following manner.

> I understand that this is a difficult time for you. There must be many different emotions taking place in you concerning your communication problem and what it means in your life. I am here to be with you during this time and help you through it. I

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> will help you find your own answers and solutions. We will work together to remove obstacles that are keeping you stuck. At some point, we will explore a different way of looking at things. The goal is for you to leave counseling with a feeling of internal strength, self-control, and self-confidence that will continue to help you problem solve.

The client is encouraged to ask questions and to think things through before making a decision to commit to the process described. The client is given as much time as needed to make a decision to begin counseling. The client's choice to take the counseling journey with the clinician is a commitment to be invested in the process.

There is an emphasis in this article on the clinician as counselor, connecting with the client, guiding the client to feel independent and self-confident in solving problems. Rogers (1951, 1961) stated that the self-actualizing individual is open to and aware of experiences, is free of defense responses, lives in harmony with others, can perceive experiences realistically, has self-esteem, and can adapt to new situations. There is a congruence that develops between reality and the individual's perception. The individual is basically good, rational, and goal directed. The clinician provides an environment of unconditional acceptance and respect for the client. Empathy by the clinician is a genuine, real caring for the client and an ability to identify with the client's feelings. The basic premise is that the client knows the best answers for him- or herself. The clinician provides the environment and feedback that allows the client to find resolution and, finally, be freer to change perspectives. The client feels such emotions of sadness, anger, fear, and hurt, with the clinician being empathic and nonjudgmental. The client is provided with an environment that facilitates an opportunity to progress toward self-actualization. The client then can move beyond these feelings to a more rational place where perspectives change and different options are available. This is accomplished through helping the client to restructure his or her way of thinking cognitively. Faulty assumptions are questioned and replaced with perceptions that are closer to reality.

The counseling experience is one that is based on having a relationship that encompasses caring and connecting while maintaining objectivity in the listening and guidance process (Patterson, 1985).

CLINICAL PROCESS OVERVIEW

Caring

Caring is having empathy and a genuine concern for another's well-being, wanting whatever is good for that person. Caring for the client is the beginning of establishing a relationship with a client and perhaps the most important dynamic of counseling. Caring can be translated into having respect for the client's ability to discern how to achieve an internal sense of control. It means accepting the client's point of view even though it may differ significantly from the clinician's. The client and clinician begin relating in a "dance" that has a patterned rhythm and a flow of exchanges. When there are miscommunications, they can be addressed and resolved, often strengthening the relationship.

Self-Awareness

The counseling process starts with the clinician. The clinician needs to be self-aware. Awareness of one's own distractions and prejudices is essential in order to put them aside and be fully "present," emotionally and mentally, with the client. Self-awareness can be facilitated in the client. Awareness is overlapped with observing. Awareness allows the clinician to be present fully with the client; observation is taking in information while being present.

Observation

Learning to observe in an objective manner will provide necessary information for the clinician. It takes practice to learn to observe in this objective way. The observation experience is an ongoing process throughout counseling. The clinician learns to notice as much about the client as possible. It means recognizing nonverbal as well as verbal communication. Awareness and observation are intricate aspects of active listening.

Active Listening

Active listening refers to "hearing" the message as completely as possible, including body language, facial expression, and tone of voice, as well as the words (Ekman, Sorrenson, & Friesen, 1969). Active listening means being with the client's struggles in a collaborating resonance in the relationship. It communicates to clients that they are heard and understood. In this manner, respect is given. As clients have an environment of acceptance and being heard by the clinician, they begin to let go of emotions that were limiting. They begin to be ready for a change in perspective, a different way of viewing experiences.

New Perspectives

Once the client has become more self-aware, self-accepting, and self-confident, he or she begins to find a new way of viewing old problems. The clinician helps the client to question old assumptions as the premise of cognitive restructuring is incorporated to help the client change his or her perception (Beck, 1976; Ellis 1984; Ellis & Harper, 1975; Meichenbaum, 1977). Now, the client can begin to experience empowerment instead of powerlessness.

Special Considerations

A special consideration when counseling children or parents is knowledge of the developmental age and stage of the child (Ames & Ilg, 1976a, 1976b, 1976c; Ames & Ilg, 1979a, 1979b; Ilg, Ames, & Baker, 1981). Possessing realistic expectations of children is an important part of counseling.

The client's temperament, whether child or adult, is an important aspect of the knowledge needed by the clinician. Knowing the client's temperament contributes to the success of connecting while working within the client's framework of tolerance (Kagan, 1991). Clarifying temperament dynamics helps the clinician to understand and relate to the client better (Carey, 1996, 1997; Carey & McDevitt, 1995).

DYNAMICS OF COUNSELING

Clinical Process

Caring. Caring is considered by this author as a given for effective therapy of any kind. It differs from the other processes in that it is not a techinque. It is a state of being. It is a dynamic that is expressed in each area presented below.

Self-awareness. Self-awareness means knowing what you are thinking, feeling, and doing at any given moment. It is practicing being "present" as full attention is given to a task, a person, a thought, a feeling, as well as physical states. It is the opposite of being on automatic. Automatic is often the mode of functioning, unless attention is brought to the situation or event.

The clinician should be aware of what personal thoughts and feelings are in contrast to the thoughts and feelings of the client. Unless this difference is recognized, it is difficult to know if personal ideas are being presented or if the client's ideas are being encouraged. If the goal is to help the client find ways of solving problems and becoming empowered in self-sufficiency, then self-awareness by the clinician is necessary. Also, in order for the clinician to be able to provide full attention to the client, he or she must be available to the client. Being available means that there are few internal distractions (the clinician's thoughts and feelings concerning him- or herself) to interfere with the nonverbal clues and the words of the client as he or she is talking. The clinician is freer to notice possible tension in the client, embarrassment, discomfort, happiness, enthusiasm, reticence, and so forth. Unless the unspoken and spoken information is recognized, the clinician is limited in working with the client. Clinicians beginning counseling with a client may recognize their own anxiety and feel unsure of themselves. There may be a tendency to talk excessively in order to relieve tension. If there is self-awareness, then observation can take place. By being present, the clinician will have more of a choice to either keep talking to relieve anxiety or to focus on the client. Clinicians can eventually become comfortable with themselves and can then concentrate on the client.

Increased awareness on the part of the clinician aids in remembering information that the client presents. When the clinician is mentally/emotionally present, moment by moment, what is seen and what is heard is taken in and tied together. By giving this level of attention to the client, memory of the interaction is significantly improved. During one session, the client may mention that he has no friends; later, the client may discuss a group he enjoys getting together with each week. The clinician remembers these conversations and is aware of the client possibly feeling alone even when in a group. More information as the sessions proceed will let the clinician tie this possibility together or discard it.

Clinicians absorb the data that will help them know the client, enabling them to understand what the client wants and needs. The job then becomes one of "clearing the weeds off the path" the client desires to travel. For example, the client may be distracted from working on anger and grief by worrying about what others think. The clinician can guide the client to work on anger and grief by putting what others think into perspective. That is, the clinician can facilitate the client getting to the chosen goal. Unless clinicians have acquired the ability to free their minds, they are limited in their ability to aid the client in this endeavor.

For example, the client expresses to the clinician that because of stuttering, he has not had as fair a chance to compete as other people have and he is angry. If the clinician is not aware of personal feelings about unfairness, there may be a tendency to agree with the client, reinforcing the anger, joining him in his anger, or attempting to "fix it" by telling him in so many words not to feel that way (similar to what the clinician may tell herself). Neither response helps the client first, to have his anger heard, and second, to move toward his own resolution of his feelings. In instances such as this, the client's problem is being perpetuated. The clinician who is aware of personal issues can recognize which is her anger and which is the client's. Unless the clinician is aware of personal thoughts and feelings, solutions may be imposed that are not best for the client. The clinician needs to be aware of the thoughts that are present when a client is struggling with a problem in order to discern whether a "solution" or an option is being presented.

The clinician can work toward the goal of self-awareness by beginning to attend to tasks that are often done automatically, such as brushing teeth, making coffee, or eating (Kabat-Zinn, 1990). One simple exercise to increase awareness may be as easy as peeling an orange while being fully present to take in the feel of it, the smell, the taste, and so forth. As the clinician begins this new way of thinking and noticing, it will be easier to notice what contributes to feeling anxious, angry, sad, and so on. This is a step toward better recognizing what is a personal feeling and what is being heard from the client. The questions that could be asked are: What were my thoughts just before I felt anxious? What do I feel in my stomach, neck, and shoulders? What do I do with my anxiety—distract myself, stay with the feeling, or talk myself out of it? The clinician's ability to recognize personal, internal processes is a prerequisite to helping the client recognize and deal with anxiety.

The client can be encouraged to shift from thinking, feeling, and doing primarily on automatic to an aware state. The client can experience awareness that can provide choices that were unrealized before counseling. For example, the client with a communication disorder may realize that fears have limited the socialization process. As

the client realizes that power is given to the fears, there is a choice to continue to give into the fears or to take the risk of getting into a social situation. Even if the choice is to give into fear, the fact that it is a choice is a more powerful place than feeling that there is no choice. The client is beginning to take responsibility related to making a choice because there is an awareness of options.

The client can be helped to achieve awareness by the clinician asking at obvious times of excitement, anxiety, sadness, and so forth what the client is aware of feeling at that time. At other times, the clinician may notice the client being quiet and ask what thoughts are there. Assignments can be made that are realistic, with a high possibility of success. The type of assignments the clinician used to increase his or her own awareness will be helpful to pass on to the client. Specific requests to describe certain activities that are automatic are a beginning. Asking the client to bring full awareness to feelings and thoughts at various times, including coming to therapy, is also helpful. The client can be asked to observe him- or herself the next time there is anxiety. The client can be given permission to be anxious but to relate to the clinician the thoughts and any physical discomfort. During this process, it becomes difficult for the client to continue being as anxious as before because the anxiety is viewed from an aware position instead of an automatic one. The reactive or reflexive behaviors may now be a response that has begun to be observed and, at some point, the client may be able to choose to change.

The client is to be aided and encouraged in arriving at solutions. There is a movement toward exploring feelings and thoughts. An example of an overly sensitive child, here defined as a child who reacts quickly to the moods of adults with feelings that are easily hurt, might respond to the father's stern voice by thinking she has done something wrong. When her mother looks tense and worried, she is afraid something bad will happen. This child may experience fear and self-blame. If she recognizes what she is feeling when it happens and stays present with her feelings instead of going into a fearful and withdrawn place, she could learn a new way of dealing with it. The clinician could help her to become more assertive and ask her father if he is angry with her. If he says no, he's just tired, the child can begin to let go of that fear. In this process, the child is learning to be empowered instead of overwhelmed. Her temperament will remain sensitive; however, she need not be self-punitive and anxious.

Observation. Awareness is a prerequisite to observing effectively. Now that some of the "chatter" in the mind of the clinician has been reduced, he or she is able to observe. This level of observation refers to the verbal and nonverbal indicators, such as mood, facial expression, body language, vocal tone, and investment in the process. Observation is a way of getting to know the client, including understanding multicultural differences. When a clinician is not knowledgeable about the culture of the client, the clinician should ask the client to educate him or her as they proceed through the counseling process. The clinician needs to understand as much as possible about differences and similarities (Battle, 1993; Cole, 1989; Cooper & Cooper, 1993). An example might be the client's lack of eye contact during conversation. The clinician may view it as an avoidance behavior, encouraging the client to have eye contact. However, in some cultures, this is a sign of disrespect. It can be thoughtless to be uninformed about a client's culture.

Observation in this context is for the purpose of taking in as much information as possible about the client. The clinician observes how the client enters the clinic room. For example, does she smile or is she serious? Does she start talking or does she wait for the clinician to ask a question? Is she open in her comments or cautious? Does her body appear tense or relaxed? Is there appropriate eye contact or avoidance? Are her arms crossed or in a relaxed position? Is her voice tense or natural? If her voice becomes tense, what is the content being discussed? If her voice is excited or without much energy, what is the content being discussed? When she is asked what she observed about herself since the last session, how does she respond? Does she appear interested in observing herself in an objective manner? Does she follow up on assignments or does she often "forget?"

These observations are important if the client is to be helped to make progress. The clinician needs to be able to "read" as much information as possible about the client. Often, the client is not even aware of how much is being "told" to the clinician. When a clinician reflects back to the client something that is felt but the client is not aware of, there is an experience of being heard. For example, if the clinician observes tension in the client's voice and body when the discussion is about work and follows up with a statement about perhaps work being difficult, the client is often pleased and surprised, wondering how the clinician knew. The client is being faced with realities that have often been denied. Submerged attitudes begin to be brought to awareness. At times, the client should be challenged by the clinician in a gentle but honest manner (Egan, 1998). These exchanges build trust and confidence in the client–clinician relationship. Trust leads to the client experiencing freedom to share, be vulnerable, and grow.

Through observation, the clinician looks for signs of fear, anger, sadness, interest, excitement, reticence, eagerness, and so on. There is a picture being formed about the temperament of the client. The clinician looks for signs of shyness, outgoingness, hyperactivity, impulsivity, and so on. When some of the temperament dynamics are better understood, the clinician can work within the framework. For example, if a client is shy and enjoys being alone, it is not respectful to work on a change that requires spending a good portion of time with other people. A balance that the client agrees to is the most helpful.

The clinician is also looking for contradictions. A client may be stating that he is enjoying therapy and the work he is doing; however, his voice is monotone and he keeps forgetting to do any suggestions he has agreed to do. Or, the client may indicate that he is not concerned about the communication disorder anymore; however, his voice may sound sad and his lack of social interaction may contradict the statement. The client may have a self-description of being confident, but the demeanor he demonstrates is fearful and cautious. The client needs to have a clinician

who does not just go by what is said but can read all the other indicators that the client is providing. The client may be putting on a brave front, but may need the clinician to know that it is a brave front and that actually the feelings are just the opposite.

In order for the clinician to notice and hear the spoken and unspoken messages, there needs to be a complete focus on the client. This level of dedicated energy and caring on the part of the clinician for the client is perhaps one of the most powerful dynamics in the counseling process. The client feels attended to and heard, but as the clinician joins the client where he is functioning, the clinician's memory significantly improves concerning details. The clinician is able to put pieces together through this in-depth ability to observe. Using information derived from the client, it becomes much easier to guide the client toward areas of resolution.

Observation of children is similar to observation of adults. Children provide a great deal of information about how they are feeling. Their body language may be more direct, with arms folded, a scowl on the face, or a smile. Often, children are told, "You don't feel...." A child may say he feels warm, but he's told, "It's cold outside, you can't feel warm." Or if he's crying, he's told, "Big boys don't cry," and if he's angry, he may be told to "put a smile on your face." To observe a child and be aware of when he's happy, sad, angry, and so forth, can be a powerful way of connecting with him as the feelings are reflected. A helpful book concerning hearing children was written by Faber and Mazlish (1980).

Knowledge concerning temperament is basic to working effectively with children. Observation of the child in conjunction with the parents' report (through interview and the use of behavioral scales) can provide this information. Working within the child's temperament framework allows the child to be "heard" and to establish trust. A child "speaks" through play. Observing the play is a way of entering the child's world. Observing the dynamics of the play provides a wealth of information. Some of the observations could be related to the following questions. Is there ongoing conflict in play or is there resolution? If there is unresolved conflict, the child may be feeling powerless and may need to find some tools to handle conflict more effectively. Is there nurturing or rejecting behavior? The child may be demonstrating feelings of security or fear. How persistent is the child in working out a solution? The child may be indicating that there is distractibility and/or a tendency to give up easily when frustrated or bored. Finding the reason for the lack of persistence can provide direction for counseling. Is the child easily frustrated? Perhaps the child is overloaded with fears and anxieties, or may be impulsive. Is the child withdrawn, overly cautious, or fearful? The child may be communicating that there are many unspoken fears or that the temperament is one of cautiously approaching new situations. Are there signs of high activity? The child may naturally have high energy, may have an attentional deficit with hyperactivity, or may be anxious. Exploring the possible meanings of the observed behavior facilitates effective counseling. Observations related to these types of questions can lead to an understanding of how children relate to their world.

It is helpful for the clinician to observe the child and parent interacting. The clinician may observe the parent being sensitive to the child and responding appropriately, or the parent may frequently ask the child questions in a teaching mode, such as, "What color is the ball?" or "What shape is this block?" instead of having a conversation related to the child's interest. The information gained through observation assists the clinician in knowing if there is a breakdown in communication between parent and child. Observing the child without the parent is also informative. For example, the child may be more talkative and more spontaneous without the parent. If so, is the child more inhibited around the parent? With a better understanding of the child and parent–child dynamics, the clinician can facilitate improved communication and interaction between parent and child.

Through the observations made of the child's temperament and areas of concern, the clinician can work toward bettering the communication between child and parents. For example, if the parents understand that their child has a temperament that includes high energy, they may be more accepting of the child and less likely to interpret the energy level as rude or rebellious. The parents may have some of the same behavior and therefore can understand and accept how the child is. Or the parents may feel threatened by the thought that the child may have some of the problems they have. Having gained understanding through observing the parents' actions and reactions, the clinician can approach clients with gentleness and acceptance. The work of improving communication between the parents and child is some of the most important work the clinician does. The art of observation is an essential step to further counseling.

Active listening. Active listening means mentally working the entire time, not being distracted, but observing the nonverbal messages while hearing the verbal ones and putting all of this information together. During the process, the clinician is looking for "threads" of connection, consistencies, and contradictions. For example, energy-charged content is noticed, even if words deny the emotion. A client may say, "The doctor didn't come in to see me for 2 hours after my stroke, but I think he was very busy." Although the words portray acceptance, the tone of the client's voice is one of tension; physically, his face is somewhat red and his fingers are fidgety. The client is trying to sound like he understands when in fact there is a great deal of anger.

Observing a lack of energy even though words express excitement is also informative: "I can speak much more fluently when I concentrate on keeping my voice on but others seem to sound more spontaneous than I do." The lack of affect may be due to the attempt to be fluent, but the statement about others being more spontaneous provides a clue to the client's feelings. It could be that the client is angry and/or feels inferior. There may be thoughts about how unfair it is. Or the client may just be making an observation without a great deal of energy in it. The clinician needs to understand the spoken and unspoken parts of what is being said.

An example of active listening is hearing the story of how the client views the effect of the communication disorder.

> Last May, I had a stroke on the right side of my brain. I had no warning signs. Out of the blue, one morning I awoke and had a severe headache and weakness on the left side of my body. My arm was weak, my leg was weak. I was scared. After many months of therapy, I was able to walk with a cane. I consider my life over. I was a successful engineer, but now I can't do anything. I used to be able to do everything.

In this brief account, the clinician is given information concerning deep grief about his loss ("I was a successful engineer"), a feeling of hopelessness ("but now I can't do anything"), and a possible exaggerated evaluation of what he used to be able to do ("I used to be able to do everything") and what he can't do now. The theme, however, is about loss more than the fact of what he could do or cannot do. Responding to the grief is the issue in this case, not the accuracy or inaccuracy of his conceptualization of his ability before and after the stroke.

If experiencing where the client is is too painful for the clinician, the clinician may start trying to convince the client that many things can still be done. If the clinician is not aware, there may be "self"-treatment taking place. Perhaps the clinician thinks that there is a requirement to have some "answers" if the clinician joins the client in his place of grief. The clinician does not have answers, and cannot. The clinician can be with the client in that place, acknowledging the feelings and having empathy for how hard the place is for him. If the clinician has done his or her own work concerning unresolved grief, it does not have to become mixed into the counseling dynamic and the situation can be handled effectively. The self-awareness by the clinician of the associations to grief is needed. To recognize that the clinician's grief is unresolved is to provide options. One of the options would be to try to keep the personal grief separate from the client's, allowing the clinician to be as fully present and empathic as possible.

Sometimes, when a clinician is feeling anxious and unsure, he or she will begin intellectualizing, that is, talking about what is known concerning the disorder. The clinician may talk about generalities such as the percentage of people suffering from the disorder and what is known or not known about it. Another indicator of discomfort on the part of the clinician is the amount of time spent talking about oneself. The clinician may start giving examples of personal experiences and how situations were handled or about personal fears. A helpful measure is to determine what percentage of time the clinician is talking as compared to the client. Often, the more unsure and anxious a clinician is, the more talking time he or she uses. Sometimes, the client's eyes actually glaze over, but the clinician hardly notices. This is not active listening. Keeping personal stories brief while focusing on the client's story is a basic requirement with this type of counseling.

The client, in order to find different options to deal with the problems presented, needs to have the story heard. Someone actually hearing it and reflecting it back may make it possible for the client to hear it for the first time. Usually, the client may have known bits and pieces of the story, but perhaps had never experienced viewing it from another's perspective and hearing the story in a cohesive way. Looking at a puzzle that forms a more complete picture is very different from viewing many loose pieces, not knowing how they fit together. The importance of the more complete picture is found in the client's understanding of him- or herself, an understanding that leads to greater congruence between thoughts, emotions, and reality.

Rogers (1951) described the congruence as being between internal awareness and external experience. Congruence is being able to experience a balance, a homeostasis, but also being able to recognize when feeling off balance or a lack of homeostasis. Congruence is being able to view areas in life that may not be fully understood, with acceptance instead of anxiety—the ability to be open to uncertainty without being overwhelmed by fear of the unknown. An ability to self-regulate is present. Siegel (1999) described emotional regulation as including "regulation of intensity, sensitivity, specificity, windows of tolerance, recovery, processes, access to consciousness and external expression" (p. 244). Some of these responses may be related to temperament and one's makeup based on genetics and physical/emotional experiences, and some to how the person assigns meaning to external and internal events. The assigning of meaning to events by the client refers to how one's world is framed. More information will be discussed about this under "New Perspectives."

Siegel (1999) stated that the time at which a person becomes most intense is the time of greatest need to be understood. Also, that is when the person feels most vulnerable and exposed. If there is a failure to be understood or connected at that point, there can be feelings of tremendous shame. The lack of emotional resonance can be profoundly painful. The power of resonance between client and clinician cannot be emphasized too much. Referring back to the story about the man who had a stroke, as he shared his story with its painful losses—loss of normal use of his limbs, loss of his feelings of accomplishment and self-esteem, loss of his familiar life, and so on—the importance of these feelings being resonated with someone is the beginning of the client being able to come to a balanced place, a place of self-regulation.

This is true with children also. Children are often seen but not heard:

Child:	Mommy, I'm tired.
Mother:	You couldn't be tired. You just napped.
Child (louder):	But I'm tired.
Mother:	You're not tired. You're just a little sleepy. Let's get dressed.
Child (wailing):	No, I'm tired! (Faber & Mazlish, 1980, p. 2)

The child in this case is being taught not to trust her feelings, as well as experiencing not being heard. What she is saying is denied. It is not surprising that she gets frustrated and angry. A better response might have been:

Child:	Mommy, I'm tired.
Mother:	Yes, I can hear that you are. That doesn't feel very good.

Child:	Sometimes I feel tired right after my nap.
Mother:	Well, you can rest while I go outside.
Child:	Wait for me. I'm not tired anymore.

It is sometimes surprising how effective it is to be heard, at any age. Another scenario from Faber and Mazlish (1980, p. 12) is as follows:

Child:	Somebody stole my new red pencil.
Mother:	Are you sure you didn't lose it?
Child:	I didn't. It was on my desk when I went to the bathroom.
Mother:	Well, what do you expect if you leave your things lying around? You've had things taken before, you know. This isn't the first time. I always tell you, "Keep your valuables in your desk." The trouble with you is you never listen!
Child:	Oh, leave me alone!
Mother:	Don't be fresh!

A simple, but effective response could be:

Child:	Somebody stole my new red pencil.
Mother:	Oh? (Mom is giving her full attention to her child)
Child:	I left it on my desk when I went to the bathroom and somebody took it.
Mother:	Mmmm.
Child:	That's the third time I've had my pencil ripped off.
Mother:	Uhhh!
Child:	I know. From now on when I leave the room, I'm going to hide my pencil in my desk.
Mother:	I see. (Faber & Mazlish, 1980, p. 12)

In this example, Faber and Mazlish (1980) demonstrate the child's ability to solve her own problem given an environment that is safe and gives her support in figuring it out. The child then walks away with feelings of accomplishment and self-sufficiency instead of anger and/or shame.

The clinician can guide the parent to hear the child better and to help the child find a solution to the problem. Farber and Mazlish (1980) identified responses that help parents to be more aware of the effect they are having on their child. First, they may be denying the child's feelings, "no, you don't really feel that way," philosophizing, "those things happen," advising, "here's what you should do," questioning, "what exactly happened?", defending the other person, "they probably had a good reason to do that," pitying, "oh, you poor thing," amateur psychoanalyzing, "you're probably mad because you didn't have your way earlier," or empathizing, "I know you're disappointed and sad." Active listening can provide an environment that allows adults or children to reorganize how they view themselves. They become freer to move toward a more positive view of who they are (Rogers, 1951, 1961).

New perspectives. The value of the work that has taken place between the client and clinician moves the process to the next phase. The accepting milieu that has been created by the clinician's empathy and availability to the client while observing the client, listening, and reflecting, frees the client to begin to see from a different perspective than before. The client has gained feelings of more self-acceptance and increased confidence. Some obstacles that seemed large have become smaller, and the client has a sense of more internal control. The client has better skills to solve problems. The client questions old assumptions and perspectives as a change in the cognitive structure is taking place (Beck, 1976; Ellis, 1984; Ellis & Harper, 1975; Meichenbaum, 1977). The client becomes aware of new options. Awareness of faulty assumptions may occur at different places along the counseling process. It is not necessarily linear, that is, sequential. It may occur at any point during the counseling. It can be as though someone turned on the light in a dark room, a view from a mountain top, or just a realization that there are other options. Cognitive restructuring provides a sense of choice to the client.

The clinician can facilitate the new perspective process by being aware when the client is approaching seeing something in a different light and verbalizing the possibilities. For example, a client may feel trapped in stuttering, believing that people are judging her and do not want to communicate with her. During the counseling, as the client begins to accept her self more and to feel accepted, she begins to wonder if people really do think less of her. This is an opening for the clinician to pose some possibilities. The clinician may ask about some scenarios, such as, "What would happen if the next time you're in a conversational setting, you focus on the content of what you would like to say instead of focusing on how you say it? I wonder how that would feel. I know it would be difficult, but it seems like it would be worth a try, maybe with someone you are comfortable with, first."

This is the beginning of an action that can have far-reaching consequences in bringing the client some freedom, empowerment, and an internal feeling of control. What was thought to be impossible has moved closer to being possible. There will be many steps in the process and it will go back and forth, but the change of perspective is on its way.

A key to this part of counseling is to recognize how the client appraises experiences. If the client labels and perceives the self as inadequate, the response to that perception will be that there are no other choices, that is, the client may generalize, "I always have bad luck. Nothing good ever happens to me." The job of the clinician is to help the client see things differently and cognitively reframe it when the client is ready. "When the client is ready" is a critical concept. If the client's pain, anger, and/or grief have not been heard and accepted, there will not be a readiness to hear the clinician. It will not work to try to cover over the distress by saying, "It's not as bad as you think," or "People like you for who you are." These words will be meaningless to the client unless the feelings have been dealt with.

Sometimes, it is difficult to be sure when a client is ready to shift perspectives. Therefore, clinicians may gently try to introduce some new possibilities when it is thought the client is ready. If there is a great deal of resistance, it

is important to respect that and to back away. When a different idea is suggested, it can be put into a framework of "I wonder how it would be if...," or "Have you ever thought of...." Trying the new concept on in this way allows the clinician to gauge where the client is by the response. The client may be frightened at the idea but willing to consider it, or frightened and absolutely not willing to consider it. If there is a willingness to hear a new approach, it can, at first, just be thought about, then perhaps role played, and then a onetime experience with a person the client is comfortable with.

The progression of new perspectives is accomplished with sensitivity on the clinician's part as well as support that allows the client to risk following new pathways. Along with displaying sensitivity to the client's readiness to change and supporting the change, the clinician encourages the client to move forward by giving realistic assignments. When the client reports back on the assignments, a great deal of information can be gained. Did the client fail to follow through? Then maybe the client is not ready. This needs to be explored so that the underlying reasons are brought out. In working with a child or an adult, perhaps it is too much to ask; smaller steps may be needed or the assignment needs to be structured better for the individual. A significant other could be brought in to help facilitate the task.

It is not helpful to "blame" the client either directly or indirectly. The clinician's job is to get to the underlying issues, not to force a change to take place. If the client has tried out the new way of looking at things and has been uneasy, it is necessary to explore these feelings and experiences. Work may need to focus on the client's feeling of internal control and empowerment, even when frightened. Sometimes, the client believes that courage means not feeling scared. It comes as a surprise that courage is something that is experienced when a person is scared. If the client has tried something and been rejected, it is very painful. It is as if the fears have come true. The client, however, can begin to take control even over these difficult feelings by assertively stating something such as, "I am feeling hurt about what you just said," without expecting a positive response. Although this is hard, there is a great deal of freedom when the client realizes that there is control over responses by learning to respond differently. Children can say, "I don't feel good when you say that," to a parent who has made a hurtful comment. Of course, it is much more difficult for a child to get a negative response, but often it will make the parent stop and think about the angry tone. Clients learn to take responsibility for their feelings by using "I" statements instead of accusatory "you" statements, such as, "I am feeling angry," rather than "You always make me angry" (Perls, 1973). Clients shift from giving the power to others to taking it themselves. They take responsibility for their feelings. Their part is letting the other person know what is being felt, then letting go of the other person's response. In the process, there is an increase in an internal sense of control.

The work that has been done to get to this point of new perspectives is worth all the effort. The connection of the relationship that has taken place between two people is healing and freeing for the client. The clinician also grows along with the client. The freedom the client experiences can be applied in many circumstances throughout the client's life. Irrational beliefs can now be recognized better and challenged. The client is more aware of the kind of self-talk experienced. It is not just automatic and unobserved anymore (Ellis, 1984; Ellis & Harper, 1975). The counseling is like a pebble in the pond that continues to have positive ripples long after it has ended.

SPECIAL CONSIDERATIONS FOR CHILDREN AND PARENTS

Development

Knowledge concerning the developmental ages/stages of children is basic in understanding what to expect and how to respond to children's behaviors. Children go through very distinct stages on their road to maturing. To have information about what to expect at a given age/stage provides a backdrop for understanding and connecting with the child. Also, it is helpful information for the parents when interacting with their child.

In order for the clinician to be most effective in child counseling, there must be a working knowledge of what is expected, in general, at different stages. The clinician must also be aware, however, that the stages defined in various resources often refer to an average time of development and behavioral dynamics, not a specific time. Children, in general, move from dependent stages to more independent ones, but timing varies. Some children are precocious in some areas and yet very immature in others. For example, a child's language may be quite advanced, yet his or her social skills may be those of a much younger child. If this is not clear to the parents, they may feel frustrated with the child's shy and withdrawn behavior because the child is using language and understands concepts of a much older child. Information about the variability in each child and encouragement for the parent to accept both aspects of their child can provide realistic expectations. Therefore, knowledge about the child's age/stage is necessary and helpful; however, it should not become a rigid mold into which the child is pushed into conforming.

For example, the famous behavior of the 2-year-old (the "NO" stage) may be well-known and recognized. However, the 4-year-old behavior may be less known. When the 4-year-old in his exuberance and excitement tries to take control, it may seem that he is reverting back to some 2-year-old behavior. Parents and the clinician may view his extreme emotions as regressive. If that is how it is labeled, then the reaction may be non-accepting and there may be disappointment on the part of the parents. Often, parents are afraid that the undesirable behavior exhibited by their child is a statement about how he will grow up to be. If the child is seen from this perspective, parental fear becomes the driving force behind their attitudes and actions. They want to change him, now, to head off future disaster. The attitude from the adult that emerges from these reactions would most likely not be understanding and

acceptance related to guidance. The "message" is communicated to the child that something is wrong with him. This is a message that can have a far-reaching impact.

It is common for parents to want their child to be behaving 6 months or more older than he is. They are not necessarily aware that their expectations are unrealistic, so they might keep pushing their child to be "older." It is clear that if this is the case, both the parents and the child will be miscommunicating and feel frustrated. Under this kind of expectation, the child consistently may not be heard.

Temperament. Temperament is defined as the "stylistic part of personality; it is the distinguishing flavor, style, or characteristic that makes one's personality unique" (Carey, 1997, p. xix). "About half of a child's temperament is inherited. The other half comes from a variety of physical and psychological factors in the child and in the environment" (Carey, 1997, p. xx). In terms of the physical and psychological dynamics of temperament, Siegel (1999) addressed the behavioral and neuronal paths of individuals and how they are established. During infancy, attaching and bonding begin a basic mode that will continue throughout the child's life, with modification in various ways.

Attachment is a necessary requirement for the infant's health, physically and emotionally (Bowlby, 1969, 1988). The lack of early attachment can affect a child throughout his or her life. In conjunction with the need for attachment is the child's inherent response or the inherited part of temperament. The child comes into the world with a genetic tendency to have a certain disposition. The disposition is modified by physical and environmental experiences.

Ainsworth, Blear, Waters, and Wall (1978) conducted landmark research in observing the interaction between infant and mother in order to understand the dynamics and ramification of attachment better. The children were observed during the first year of life. The object was to create a way of quantifying and classifying the internalized model of attachment. Ainsworth et al. found that if an infant had a secure attachment to the mother, the infant would be able to soothe him- or herself quickly by her presence and go back to playing. If there was not a secure attachment, the child would not be soothed by her presence and would not return to play. As these children were followed into adolescence, the patterns most often persisted. A lack or presence of an ability to self-soothe was evident. That is not to say that they could not be changed. Bowlby (1988) described the malleable nature of the attachment system as the internal working model of attachment.

The level of attachment of the child to the parent is often a reflection of the parent's attachment to his or her parents. Parents who are unavailable to their child tend to build an avoidant dynamic, that is, the child avoids the parent when he or she comes into the room. The inconsistently avoidant or intrusive parent contributes to the child having a resistant and ambivalent attachment.

A child's temperament can influence his or her response to attachment, which in turn can affect temperament. A hesitant, shy child may react to attachment problems by withdrawal and depression; an active child with aggressive responses may react with anger and acting out behaviors. The importance of being aware of these dynamics is to make clear that attachment and temperament are complex issues that are intertwined.

Temperament may be observed in a newborn baby. Some infants are "fussy" whereas others are "easy and happy." However, temperament is not always detected accurately in newborns because they often are still reacting to in utero and birthing experiences as well as environmental experiences (Carey, 1997). Young children can be "strong willed," "sensitive," "happy-go-lucky," "perfectionistic," and so on. They are individualistic. Some of the expressions of temperament are an intensity of emotional response, sensitivity to the environment, activity level, regularity of physical habits, approach to novel situations, adaptability, mood, persistence, and distractibility (Carey, 1996). A child's temperament may be labeled "good" or "bad." For example, a high-energy child may be labeled "bad" and a quiet child labeled "good." Self-esteem can be affected by these determinations and a self-fulfilling prophecy may begin. For example, a timid child who needs time to "warm up" to new situations may be described as "too quiet," "scared," and "very shy." The child may begin to withdraw even more as she views herself as having problems, not being as good as others, even perhaps not "normal." If a parent views the child with shame and disappointment, the child can develop a poor self-concept. The result could be even greater withdrawal or the child can attempt to appear to be different than she is. A negative "snowball" effect may be put in place.

Understanding and acceptance of a child's temperament is a part of counseling (Kagan, 1991, 1994). The counselor works *with* the child's temperament instead of attempting to change it. A counselor can help parents to understand and work with their child. As Carey (1997) stated, a child's temperament can have a strong impact on how parents react. Observation of the child is a beginning. Terms used in the observing process are more helpful if they describe the behavior rather than make a judgment, such as, the child may be described as loud and excitable instead of obnoxious and irritating.

There are nine behavioral descriptors of temperament identified by Carey (1996) (Table 1). Even though the temperament characteristics are described individually, they will appear in clusters.

A*ctivity* refers to physical motion, such as body movements during daily circumstances. Along with body movements, activity refers to the child's type of response. For example, does he run ahead when walking with a parent, does he enjoy playing quietly, and would he rather run than walk? The range is between very inactive to very active.

Rhythmicity is a way of looking at a child's daily regularity of eating, sleeping, and toilet habits. Does the child adhere to a similar daily schedule? Later, in older children, it is viewed by their organizational skills and predictability. The range is from very regular to very irregular.

Approach refers to the child's initial response to new situations. Is she cautious and withdrawn or eager to get into a new situation? Does she avoid new people or is she outgoing? If the child has had a negative experience concerning a specific situation, of course, she may be

Table 1. Categories rated by the Carey Temperament Scales: Middle Childhood Form.

Category	*"Low" indicates*	*"High" indicates*
Activity	Inactive	Very active
Rhythmicity	Very regular	Very irregular
Approach	Approaches	Withdraws
Adaptability	Adaptable	Non-adaptable
Intensity	Mild	Intense
Mood	Positive	Negative
Persistence	Persistent	Nonpersistent
Distractibility	Non-distractible	Distractible
Threshold	High threshold	Low threshold

Note. For further discussion of these categories, see Carey (1996).

reticent to participate. Therefore, it is important to observe many daily experiences that may present a new situation. The range is between not hesitant to very hesitant.

Adaptability is an important part of temperament. It differs from approach in that it refers to adapting over time. That is, can the child adapt to an initial response that may be negative by coming to a socially acceptable, problem-solving resolution? The range is between very quick to adapt to very slow to adapt.

Intensity refers to how much energy the child puts into responding. Is the child loud or quiet, vigorous or placid? Does fatigue or hunger significantly affect the level of intensity? Many situations should be considered for reactions ranging from very mild to very intense.

Mood may be quite variable. However, looking for a predominant pattern is the key. In general, is the child's mood pleasant or irritable, negative or positive, sunny or sad? Is it somewhere in between the extremes? How is the mood in the morning, at night time, when she is sick? The range is from very pleasant to very unpleasant.

Persistence and *attention* are combined. Persistence refers to the child's ability to stick to a task or return to a task when distracted or interrupted. Attention is how long a child can focus on an activity. These characteristics are seen in the child's ability to learn and complete tasks. The range is between very persistent to very nonpersistent.

Distractibility differs from persistence and attention in that the child who is easily distracted may or may not be persistent in finishing the task. Distractibility in an infant may improve his ability to be soothed. If he is irritable, distracting him may be beneficial. However, being easily distractible may be a detriment to a child in school. The range is from rarely distracted to very often distracted.

Threshold refers to the child's threshold, sensory, and affect of external stimuli—reactions to the feel of various materials, foods, loud noises, odors, light, and so forth. The child may be hypersensitive to the parents' moods, facial expressions, and discipline. Some children may be very perfectionistic and exhibit unrealistic demands and expectations of themselves. The range is from very nonreactive to very sensitive.

The tools of being aware, observing, and listening can be used in getting to know the child's temperament. The objectivity learned in observing serves to reduce the effect of being biased concerning the child's behaviors and responses. Gaining as much objectivity as possible by the clinician and parents significantly aids in getting to know the child's temperament. It reduces prejudice and fear on the part of parents. It allows the observer to see predominant patterns instead of rushing to conclusions based on a few examples.

A useful way of recording observations concerning the behaviors just described is to use a 1 to 6 scale according to the ranges mentioned and the ones found on the Carey Temperament Scale (Carey, 1996). Soon, the clinician and/or parent will have a feel for what each number represents.

When the clinician and parents have determined the child's cluster of temperament characteristics, the clinician and parents can begin to work within the framework. Basically, the direction of response is understanding and acceptance in conjunction with guiding a child toward a more balanced place. For example, give a child who has difficulty with new situations more time and tell him or her that you understand his or her feelings. At the same time, gently guide the child toward realistic risks, such as meeting new friends, trying a new taste in foods, or learning a new motor skill. With a high-activity child, it may be more productive to provide plenty of exercise and running space before settling down to do homework.

It is not always easy to guide children in a direction that they do not want to go. At times, behavioral problems and adjustment difficulties may develop. A helpful book addressing these problems is *Coping With Children's Temperament* (Carey & McDevitt, 1995). Seeking out a professional who works with children and has an understanding of temperament dynamics may be necessary. Clinicians and parents need to be open to learning to be more effective. One of the ways this can be accomplished is to understand temperament better and work with it instead of trying to make the child into a different person.

Termination of Counseling

The client makes the decision to end counseling. The client was given the choice to begin and commit to the counseling process; now the client again decides on an ending time. It is helpful for the clinician to use awareness, observation, and active listening skills to read the signs being communicated by the client. The client may be demonstrating self-sufficiency and independence in handling problems related to the communication disorder. The client may now have a perspective that is more congruent with reality and responds to difficult challenges with more balance and self-regulation. The client may be ready to leave the counseling experience while continuing to be a "counselor" to him- or herself. This is the goal that both client and clinician have been working toward. However, they both may feel a sadness about ending this part of the process. The client has indicated a readiness to move on and the clinician facilitates it. If the clinician does not facilitate it at the appropriate time, it may become more difficult for the client to leave.

Outcomes Expected

- The client will be more self-aware and be able to observe him- or herself with some objectivity.
- The client will exhibit reduced limitations that inhibit choices.
- The client will experience increased internal (vs. external) control.
- The client will be able to accept responsibility for his or her feelings, using more "I" statements and less "you" statements.
- The client will be able to deal with uncertainty with less anxiety.
- The client will have a more positive view of self and others.

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REFERENCES

Ainsworth, S., Blear, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Ames, L. B., & Ilg, F. (1976a). *Your three year old: Friend or enemy?* New York: Delacorte.

Ames, L. B., & Ilg, F. (1976b). *Your two year old: Terrible or tender?* New York: Delacorte.

Ames, L. B., & Ilg, F. (1976c). *Your four year old: Wild and wonderful*. New York: Delacorte.

Ames, L. B., & Ilg, F. (1979a). *Your five year old: Sunny and serene*. New York: Delacorte.

Ames, L. B., & Ilg, F. (1979b). *Your six year old: Loving and defiant*. New York: Delacorte.

Battle, D. E. (1993). Introduction. In D. E. Battle (Ed.), *Communication disorders in multicultural populations* (pp. xv–xxiv). Stoneham, MA: Andover Medical/Butterworth-Heinemann.

Beck, A. T. (1976). *Cognitive therapy and emotional disorders.* New York: International Universities Press.

Bowlby, J. (1969). *Attachment and loss*: *Vol. 1. Attachment.* New York: Basic Books.

Bowlby, J. (1988). *A secure base: Parent–child attachment and healthy human development*. New York: Basic Books.

Carey, W. B. (1996). *The Carey Temperament Scales*. Scottsdale, AZ: Behavioral-Developmental Initiatives.

Carey, W. B. (1997). *Understanding your child's temperament*. New York: Macmillan.

Carey, W. B., & McDevitt, S. C. (1995). *Coping with children's temperament*. New York: Basic Books.

Cole, L. (1989). E. pluribus: Multicultural imperatives for the 1990s and beyond. *Journal of the American Speech-Language Hearing Association, 31,* 65–71.

Cooper, E. B., & Cooper, C. S. (1993). Fluency disorders. In D. E. Battle (Ed.), *Communication disorders in multicultural populations* (pp. 189–211). Stoneham, MA: Andover Medical Publishers/Butterworth-Heinemann.

Crowe, T. A. (1997). Counseling: Definition, history, rationale. In T. A. Crowe (Ed.), *Applications of counseling in speech-language pathology and audiology* (pp. 3–29). Baltimore, MD: Williams & Wilkins.

Egan, G. (1998). *The skilled helper: A problem-management approach to helping* (6th ed.). Pacific Grove, CA: Brooks/Cole.

Ekman, P., Sorrenson, E. R., & Friesen, W. V. (1969). Elements in facial displays of emotion. *Science*, *164,* 3875.

Ellis, A. (1984). The essence of RET. *Journal of Rational–Emotive Therapy, 2,* 19–25.

Ellis, A., & Harper, R. (1975). *A new guide to rational living* (rev. ed.). Hollywood, CA: Wilshire Books.

Faber, A., & Mazlish, E. (1980). *How to talk so kids will listen & listen so kids will talk*. New York: Avon.

Ilg, F. L., Ames, L. B., & Baker, S. M. (1981). *Child behavior.* New York: Harper Perennial.

Kabat-Zinn, J. (1990). *Full catastrophe living: Using the wisdom of your body and mind to face stress, pain, and illness*. New York: Dell.

Kagan, J. (1991). Temperamental factors in human development. *American Psychologist, 46*, 856–862.

Kagan, J. (1994). Inhibited and uninhibited temperaments. In W. B. Carey & S. C. McDevitt (Eds.). *Prevention and early intervention: Individual differences as risk factors for the mental health of children* (pp. 35–41). New York: Brunner/Mazel.

Luterman, D. M. (1991). *Counseling the communicatively disordered and their families* (2nd ed.). Austin, TX: Pro-Ed.

Manning, W. H. (2000). *Clinical decision-making in fluency disorders* (2nd ed.). Vancouver, Canada: Singular.

Meichenbaum, D. (1977). *Cognitive-behavior modification: An integrative approach*. New York: Plenum.

Patterson, C. H. (1985). *The therapeutic relationship: Foundation for an eclectic psychotherapy.* Pacific Grove, CA: Brooks/Cole.

Perls, F. S. (1973). *The Gestalt approach.* Palo Alto, CA: Science and Behavior Books.

Rogers, C. (1951). *Client-centered therapy: Its current practice, implications, and theory*. Boston, MA: Houghton Mifflin.

Rogers, C. (1961). *On becoming a person*. Boston, MA: Houghton Mifflin.

Siegel, D. (1999). *The developing mind*. New York: Guilford Press.

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