Counseling Challenges: Working With Older Clients and Caregivers

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Appropriate and effective counseling is essential to a family’s successful adjustment when one of its members experiences a communication disorder. If the counseling process is ineffective, no one comes away satisfied and client progress is hindered. The following scenario, drawn from a real-life clinical setting, illustrates multiple breakdowns in the service delivery process that could have been avoided through appropriate counseling.

John was a 67-year-old retired minister married to Susan, age 49. The couple had no children or nearby relatives. John was hospitalized following a stroke that resulted in Wernicke’s aphasia, feeding apraxia, temporary delirium, and mild problems with balance and ambulation. Upon admission to the acute care hospital, Susan was asked to provide information regarding John’s medical history. John was subsequently admitted to an extended care unit, then to a rehabilitation hospital. Susan was never asked for additional information about her observations of her husband’s behaviors, her feelings about his condition, or her personal situation. In fact, so little information was obtained that the medical team continued to be unaware of the exact nature of the relationship between John and Susan, as illustrated by the director indicating that Susan needed to start considering local nursing homes because “her father” might never improve. This was an unwelcome suggestion, considering John had at one time expressed total opposition to nursing home placement. The team provided Susan with some information about her husband’s problems, without determining whether she understood the terminology or the implications of the information provided.

Effective communication was a major priority for this couple. When Susan met with the speech-language pathologist, she was presented with written treatment objectives. Susan was not asked for her input, despite the fact that both she and John felt that the therapy activities were not assisting in functional communication. In John’s chart, this meeting was reported as a “family conference” in which “consensus” regarding communication goals was reached. Prior to discharge from the rehabilitation hospital, John’s delirium and feeding problems were resolved, but he continued to experience confusion and frustration associated with his language deficit. Although nursing home placement was presented as the only option, Susan chose to bring her husband home. Her repeated attempts to obtain assistance in identifying home care options were not addressed by any of the professionals involved. This was particularly stressful for Susan because she was the sole source of income for the couple and home care was essential. Except for generic handouts on stroke, Susan and John were given no information on the specific communication difficulties they might encounter and no instruction on how they should respond. At the same time, Susan’s widowed father was experiencing health difficulties. Being an only child, Susan was required to fly to another state to care for her father following multiple hospitalizations. Both John and Susan experienced periods of depression. During the next 2 years, Susan suffered two heart attacks and required three surgeries.

The rather harsh ending to the above scenario is only too real. A team of professionals was involved, John did receive speech therapy, Susan was informed about therapy goals, and a discharge recommendation was made. Too often, this series of activities passes for counseling. Unfortunately, these activities focus only on John’s communication disorder.

ABSTRACT: Counseling older clients and their caregivers poses some unique challenges for speech-language pathologists and audiologists. This article provides basic guidelines for improving counseling exchanges with older adults. Clinicians are asked to consider the effects of physical and cognitive aging, social and economic influences, and clinician behaviors, experiences, and biases.

KEY WORDS: counseling, older adults, communication disorders, clinical interaction
Clearly, there are many factors that influence counseling interactions and outcomes. If the client and/or caregivers are elderly, the process is often more complex. The older person is likely to have multiple and/or chronic health problems, a reduced social network, financial restrictions, and sensory deficits. The process of coping with changes due to normal aging may complicate adjustment to a communication disorder and reduce the ability to participate fully in counseling interactions.

Counseling has been described as part of the scope of practice of speech-language pathologists and audiologists for more than a decade. Yet we continue to have problems identifying how communication disorders professionals should engage in counseling activities, the goals of those activities, and the professional boundaries between our responsibilities and those of trained counseling professionals.

Shipley’s (1997) definitions of counseling, guidance, and psychotherapy may be helpful in this context. According to Shipley, counseling relates primarily to personal adjustment rather than to major personality changes. Guidance defines an educational process in which advice, suggestions, and information are used to influence another person’s thoughts and behaviors in a positive direction. In contrast, psychotherapy is seen as the province of specially trained professionals who deal with individuals with chronic life problems and serious emotional disorders. As defined here, both counseling and guidance fall within our scope of practice. Psychotherapy does not. Communication disorders professionals should not attempt to work with significant pre-morbid emotional and personality issues that impaired functioning prior to the communication disorder.

Webster and Newhoff (1981) suggested that helping families regain stability of functioning should be a primary goal of counseling interventions. They described four elements of counseling by speech-language pathologists and audiologists: receiving information that families wish to share; providing information to family members; helping individuals clarify ideas, attitudes, and emotions; and providing family members with options for changing their behaviors and/or the behaviors of the impaired person.

These four counseling elements are often cited in professional texts and might be considered a “traditional” approach to counseling in our discipline. As worded, this approach appears to consider the client as “separate” from the family. Information is obtained from and shared with the “family.” The “family” is given options for changing behaviors. In practice, this is often the approach taken when the client has a communication disorder. Professionals sometimes assume that the client cannot be an active participant in the counseling process. As a result, the emphasis is on helping family members learn about the disorder and manage the emotions they experience in dealing with the “impaired” family member. Adjustment is made “around” the person with the disorder.

Another participant in the counseling process should also be considered, that is, the professional providing the counseling. Beyond basic competencies, the professional must have the skills and attitudes that allow successful counseling. According to Shipley (1997), the characteristics of good counselors include flexibility, openness, honesty, emotional stability, trustworthiness, self-awareness, belief in the client’s ability to change, and commitment to helping people change.

Exchange of information is fundamental to successful counseling. To be effective, there must be a balance of control between the client, the caregivers, and the professional. Throughout the therapeutic process, each of these participants must be given opportunities to provide and receive information. This information can then be used to set goals, identify resources, facilitate the therapeutic process, and promote successful communication.

Counseling is the key to treating the whole person (Luterman, 1996). Successful counseling with older adults depends, in part, on the clinician’s understanding of both aging and counseling dynamics. The remainder of this article provides a series of rules to guide this process. Although it is written primarily from the viewpoint of speech-language pathologists, most of the concepts apply equally to the practice of audiology. The case of John and Susan will be used to illustrate specific aspects of counseling failure and therapeutic breakdown.

**RULES OF THE COUNSELING EXCHANGE WITH OLDER ADULTS**

- Know what’s normal.
- Learn about the individuals involved.
- Provide sufficient time.
- Create a therapeutic partnership.
- Develop and maintain trust.
- Adjust your communication style as needed.
- Accommodate learning styles.
- Adapt to evolving needs and concerns.

**Know What’s Normal**

Clinicians who do not fully understand the effects of aging often confuse signs of normal aging with symptoms of disorders. Granieri (1990) suggested that factors affecting the elderly can be categorized into primary, secondary, and tertiary aging.

- **Primary factors** are the result of the normal aging process. In communication, this might include changes in vocal quality and respiratory reserves, slight increases in active word-finding problems, increased response time, and possible problems in understanding long, complex written or spoken passages.

- **Pathological factors** are secondary aging factors. Elderly people are more prone to conditions such as stroke, heart disease, arthritis, impaired vision, and hearing loss. Additionally, the elderly person is likely to suffer from more than one of these conditions.

- **Tertiary factors** are those that result from social, psychological, and environmental changes. The social and support network of the elderly client is often
reduced from retirement, death of peers, children moving away, and loss of mobility. The elderly couple may be on a fixed income, with illness further reducing their financial resources. When these factors combine, it is not unusual for the older person to experience depression. If both the client and the spouse are elderly, the aging factors affecting each must be considered.

In counseling the elderly client and his or her caregiver, the speech-language pathologist may need to help them make successful adjustments to the normal aging process. The clinician should be able to provide reassurance regarding primary aging processes while not discounting concerns regarding these changes and their effects. It is likely that the majority of speech-language pathologists will feel most comfortable in dealing with secondary aging effects, the nature of the pathology, its etiology, and the potential benefits of treatment. The basic issues addressed in counseling will vary depending on whether the condition developed suddenly or gradually and whether the disorder is static or progressive. The implications for treatment, caregiving, and adjustment are also different if the problem is primarily physical versus primarily cognitive.

To be effective, counseling must address the effects of the pathology on tertiary aging factors. Tertiary factors will often determine the degree to which the family is able to make successful adjustments. If significant emotional reactions are observed, the family should be referred to a mental health professional. Referrals should be considered carefully. Not every mental health professional feels comfortable or qualified to deal with a client who has a significant communication impairment. Clinicians must also monitor their own counseling exchange carefully for signs of loss of personal objectivity. At the very least, reduced objectivity and increased personal involvement should signal the need for an outside perspective.

To engage effectively in the counseling exchange, particularly when caregivers are involved, the speech-language pathologist must have a basic understanding of family systems, the dynamics of family equilibrium, and family roles (Norlin, 1986). The primary issues faced in counseling may be concerns about power, roles, intimacy, and conflict management. These same issues may be central to the adaptation of the older client and caregivers.

Presumably, in the case of John and Susan, normal primary aging processes were occurring, although the health care system did not address these issues. Certainly, there was no attempt to deal with the age difference between the couple and their potentially different stages in coping with primary aging. Apart from the stroke and other medical information, no information was gathered about secondary or tertiary aging factors. As a result, appropriate counseling interventions could not be designed. Only generic, disorder-oriented counseling was provided, and it was limited.

Learn About the Individuals Involved

To achieve a balanced exchange of information and develop management strategies, the client, primary caregiver(s), and speech-language pathologist must all be involved in the counseling process. Characteristics of each “player” will influence the outcome of counseling. Failure to understand these characteristics can result in a major therapeutic breakdown.

Clinician. The old adage—“Know thyself”—is particularly important in working with older adults. Many clinicians have biases about aging, age-related disorders, and what the elderly should or should not be doing. Some of these biases are negative, in terms of the limited value attributed to the older adult or certain stereotypes of limited capacity that are associated with aging. Negative biases may influence decisions about the length or nature of therapy and determinations of prognosis. Positive biases also exist. The “Isn’t she a sweet little old lady” perspective does not exactly further the therapeutic process, and denial of very real aspects of aging decline may prevent development of a reasonable and practical treatment program.

Some speech-language pathologists may fear what is happening to the older person, perhaps due to personal experiences with older family members. Over-personalizing can be positive (“You remind me of my grandmother”), but still inappropriate. Professionals may feel that they have to control the client and caregiver, or they may have preconceived ideas about what the elderly client and caregiver should want, do, and feel. The clinician must be careful not to assume anything simply because a client or caregiver is old.

Stereotypes, biases, and fears are exacerbated when the practitioner has little or no understanding of normal aging and the complex variability associated with the aging process and with older adults. Speech-language pathologists should acknowledge their biases and stereotypes, as well as their strengths and weaknesses, concerning their knowledge of normal aging. They need to be aware of what factors in their personal background and training are influencing the way they participate in the counseling exchange.

Caregivers. For intervention to be successful, it is essential that clinicians understand the primary caregivers, the burdens placed on them by the client’s needs, and their response to the stress of their change in roles and added responsibilities. Most elderly persons are cared for in the home, with spouses or adult children providing much of the necessary care. Many elderly clients are cared for by adult children who are also senior citizens. It is not unusual for these older caregivers to assume responsibility for more than one aging family member (e.g., a parent and a spouse). The impact of caregiving on the physical and emotional health of any family member should not be underestimated, but it is especially risky for the elderly, who are likely to suffer from chronic health problems themselves.

In evaluating factors that might impact emotional adjustment, several variables have been identified that relate to increased caregiver stress (Cantor, 1983). Stress is increased by change in the caregiver’s life. Areas of change are multiple: role reversal, social network reduction, altered living environment, and strained financial status. Relationship to the client can also be a factor in stress. Spouses suffer the most stress, and “favored” children report more stress but less burden than “problem” children. Caregivers with limited family ties and those who are not “raised” to
be caregivers experience higher stress levels (Henderson, 1994). Female caregivers feel more emotional stress than male caregivers, which may be due in part to females being less likely to seek help from other family members and more likely to quit their jobs instead of hiring outside help.

Degree of caregiver stress has also been found to vary with the type of disorder demonstrated by the client. Although we often think of the greatest burden being experienced by those who provide physical care, the level of caregiver stress is actually greater when the disorder is characterized by cognitive changes and declines in communication ability. Caregivers of demented clients often feel that their social network is reduced and experience feelings of isolation.

The issues confronting the caregiver are obviously multiple and complex. Consequences of resulting stress can be devastating, with possible physical effects being numerous (Pruchno & Resch, 1989). The autoimmune system of the caregiver is often affected, making them more vulnerable to disease. Persistently high levels of stress create excessive allostatic load, a measure of the body's level of stress over time (Ryff & Singer, 1998). If stress is ongoing, the body will always be mobilized for crisis responses. As a result, stress may contribute to chronic fatigue, heart attacks, headaches, ulcers, obesity, and high blood pressure.

Psychologically, spouses are often plagued by concerns about their future financial condition and their ability to continue to care for the client. Cost of institutional placement is often prohibitive and may exhaust a couple's savings in only a few months. If placement in a nursing home is required, spouses may be required to divest themselves of most of their assets to qualify for Medicaid funding. Elderly caregivers may not be receiving available financial help because they do not know it is available, do not know how to apply for it, or feel that it carries a social stigma.

Adjustment of the caregiver has a direct impact on the well-being and progress of the client. Reported stress is reduced when the caregiver "knows what to expect"—an outcome of adequate counseling. Caregivers can learn to adapt to their new roles, adjust to the requirements of their new lifestyle, and accept the changes in their plans for the future. Families may be helped to establish closer ties, develop new respect for each other, and realize greater self-worth.

Caregiver stress and burden should be evaluated systematically with instruments such as the Caregiver Burden Inventory (Caserta, Lund, & Wright, 1995) and the Caregiver Burden Interview (Zarit, Reever, & Bach-Peterson, 1980). With a thorough understanding of the problems confronting the caregiver, the speech-language pathologist is better able to identify needs and available resources, develop communication strategies, and provide appropriate support, thus reducing the negative impact of caregiving and preventing a crisis in care.

**Client.** To understand a client's communication problems, speech-language pathologists commonly use a variety of strategies, including case history questionnaires, medical records, interviews, standardized tests, and behavioral checklists. Current communication partners, settings, and environments are evaluated. Although these tools provide some information regarding the client's premorbid characteristics, the scope is often limited to variables that can be related directly to current communication functioning.

Before making recommendations or engaging in goal setting, speech-language pathologists should try to determine if the client ever expressed any strong negative feelings toward communication disorders, specific intervention strategies, or residential placements. By considering these "taboos," the clinician can avoid a negative reaction and possible rejection of all recommendations. Acceptable recommendations can be made and active client participation encouraged if the speech-language pathologist gains an understanding of the client's premorbid communication style, social roles, conversational preferences, and adjustment patterns. Valuable information may be obtained by learning about the client's occupation, hobbies, interests, and educational level. Communication questionnaires are helpful for identifying topics of interest and obtaining information about the client's personal communication style. Instruments such as the Self-Assessment of Communication (Schow & Nerbonne, 1982) and the Subjective Communication Report (Felix, 1977) provide information regarding willingness to modify behavior, attitude toward environmental changes, and feelings about intervention strategies. If possible, these scales should be completed by both the client and his or her significant other.

When communication impairment is severe, the client may be unable to complete attitude scales or provide information about interests, attitudes, motivations, and preferences. Some of these clients may respond to simple yes/no questions, but response validity and reliability are often questionable. Although we may be forced to rely primarily on family input in these cases, we should remember that family members are not always an unbiased source, and different members may present opposing opinions of the client's characteristics. For example, a spouse may inform us, "I don't understand why he wants to talk now, he never wanted to talk before," or a child may describe lengthy story-telling episodes. One family member may describe the client's reaction to problems as calm and thoughtful, whereas another reports it as demanding and impatient. Even in the most severe cases, we can obtain some idea of the client's expectations, desires, and frustrations by careful observation of behaviors—how the client interacts with various communication partners, how he or she responds to assessment or therapy stimuli, and how he or she performs in different settings.

**Ongoing assessment of participants.** As suggested above, assessment must address more than linguistic and communicative performance. For example, scales such as the Code-Muller Protocols (Code & Mueller, 1992; Code, Mueller, & Herrmann, 1999) allow the speech-language pathologist to explore client, family, and professional perceptions of psychosocial adjustment at different times. This scale is also used to identify any significant discrepancies in the perception of participants in the counseling process.

No single test or test battery is appropriate for all older clients and caregivers. Many relatively brief and focused assessment instruments are available to probe depression,
mood, affect, quality of life, life satisfaction, psychosocial well-being, psychosocial adjustment, coping and stress (including measures of control), interaction; independence/dependence, activities, aspects of disability (extent and adaptation), and caregiver strain, stress, and burden. Some of these assessment options are listed in the Appendix. Once behaviors and needs have been identified formally, appropriate counseling and other management strategies with practical outcomes can be designed.

John and Susan were at obvious risk for frustration, conflict, and stress. John’s inability to communicate effectively forced him to be more dependent on his spouse, which is a frequent source of fear and resentment. Their lack of a family support network and John’s adamant rejection of nursing home placement forced Susan to shoulder most of the responsibility for caregiving. Obviously, the couple’s long-term plans for the future were altered and Susan was placed in conflicting roles of spouse, only child, and breadwinner. At no point in this lengthy rehabilitation process did any professional truly “take the temperature” of these individuals. With the combination of these factors, the depression experienced by John and Susan, and the deterioration in her health, are not surprising.

Provide Sufficient Time

One of the greatest challenges in health care today is finding sufficient time to spend with the client to conduct a comprehensive assessment, obtain a complete history, and gain a thorough understanding of present status, including physical condition, psychosocial issues, environment, family, needs, concerns, and fears (Butler, 1999). Speech-language pathologists are allowed only brief units of time to complete their assessment and provide appropriate remediation. In some settings, the entire counseling process is limited to an initial session that describes the assessment results and a discharge session that reviews outcomes and recommendations.

Ideally, counseling should be an ongoing process. The information-sharing process may begin before the participants ever meet and continue long after the client has been dismissed from therapy. A “good start” requires that the older person be allowed to provide information in his or her preferred style. For example, many older people are most comfortable relating information in stories. Although this method of information gathering is time consuming, it may be essential to gaining important facts and perceptions. Stories provide a wealth of personal life detail that can be helpful in designing interventions and suggesting strategies for communication work outside of the clinical setting.

If long-term consequences are considered, it may actually be more productive to spend time counseling, listening, and understanding “up front.” Interfering factors can be identified early and their potential effects on therapy reduced. One model that demonstrates the advantages to the client and caregiver when adequate time is allotted early in the intervention process is the Geriatric Evaluation and Management (GEM) program. GEM programs provide an opportunity to provide assessment and continuing care by a team of health professionals. In our area, the GEM team schedules 2 hours for the initial information gathering and assessment with a new older client. Subsequent visits are scheduled for 1 hour. Preliminary evidence from GEM models of service delivery suggest that there is, indeed, an investment effect (Toseland et al., 1997). In other words, higher health care cost and frequency of usage at the front end results in reduced cost and health care usage after approximately 2 years.

Create a Therapeutic Partnership

One of the secrets of success in working with older clients and caregivers involves creating a genuine sense of partnership in planning goals, strategies, and communication activities. The speech-language pathologist should facilitate, not control. Sometimes, our best advice is inappropriate for a particular client, given his or her history, lifestyle, financial resources, value system, or stage of emotional adjustment. At any particular stage, a client or caregiver may not be ready to accept certain recommendations. A common example is seen in the rejection of augmentative communication technology in the early stages of a progressive neurological disease. What may be an obvious need from the professional’s perspective may be a genuine “non-issue” from the client’s or caregiver’s point of view.

A key element in creating and maintaining a therapeutic partnership is the way in which information is solicited, the types of information requested, and the manner in which information is used. Clinicians can make the client and caregiver feel valued early on by actively seeking input. It may be helpful to begin the process by encouraging the caregiver and/or client to prepare lists of background information, issues and concerns, questions, and any other information they believe the clinician should be provided. Conversations should begin in a less formal manner, with casual or familiar topics that set up an environment of shared control and balanced exchange. The clinician can move on to critical information after the interaction has been comfortably established. Once information has been obtained, it is crucial to demonstrate that the information has been used effectively to modify treatment or make recommendations.

This process of writing down observations and questions is maintained throughout the treatment process. The clinician should schedule consistent opportunities for review of the information. This “journal” format can be useful for long-term counseling and monitoring of behaviors. Some older clients or caregivers may need little or no direction in maintaining such a journal, once they realize that the information is valued and is used productively. Others may require some guidance in focusing their written observations; for example, the clinician may need to ask the person to record specific observations about a single behavior, such as ordering in a restaurant.

One risk in information exchange is that, if the clinician controls information content and flow excessively, there may be a breakdown in the counseling and therapeutic process. To avoid this dilemma, throughout intervention and continuing into long-term follow-up, it is crucial for the clinician to provide open-ended opportunities for the sharing of issues and raising of questions. Similarly, rather than assume that the participants require information about,
for example, the characteristics of aphasia, it might be better to begin by asking, “What are some of your questions about what’s happened?” or “What do you need to know?”

Speech-language pathologists are often most comfortable eliciting and providing information about the communication disorder. However, if we hope to treat the whole person, we must collaborate with others to piece together a broader picture of the life circumstances of the client and caregivers. We must also be willing to listen to shared information and feelings that go beyond the speech consequences of Parkinson’s disease or the word-retrieval problems of the aphasic client.

As speech-language pathologists, we may be essential to the client’s ability to participate in the partnership. The client may want to convey a great deal of information but may be unable to do so verbally. Because all behavior should be considered a form of communication, the speech-language pathologist should be attentive to the broad spectrum of nonverbal cues that may signal a desire to initiate information exchange. The clinician must also facilitate the client’s attempts to communicate his or her needs, wants, questions, and goals. Communication notebooks such as those created by the North York Aphasia Centre (Kagan, 1998) can be particularly helpful in these activities. Asking questions with restricted response choices, or even using a 20-question format, are appropriate. Encouraging drawing, gesturing, and other communication modalities is important. Visual Analogue Scales (Stern, 1997, 1999) can be used to allow the client to express mood state.

The speech-language pathologist must often negotiate between caregiver and client in setting goals. The client may want something the family cannot afford, or demand more than the caregiver can supply. Occasionally, the caregiver shows greater reluctance than the client to accept communication limitations by setting unrealistic goals and challenges. It is important that the speech-language pathologist present options, citing the pros and cons of particular alternatives. Avoid becoming attached to your recommendations, or having your sense of professional self-worth become wrapped up in the successful adoption of recommended behaviors. Explain a recommendation; do not argue with the client or family member. Demonstrate why you are making a recommendation by showing its application to the lives of the participants in this counseling process. Ultimately, decisions about actions are in the hands of the client and caregivers.

It is also important to avoid taking sides. Clients often recognize that the speech-language pathologist understands their problems best, and so they often want support for their efforts and issues. Spouses frequently try to enlist the speech-language pathologist to tell the client to do, or stop doing, something. It is sometimes difficult not to be caught up in what Norlin (1986) called the “triangle effect,” where the assigned roles are those of victim, rescuer, and persecutor. Needless to say, speech-language pathologists tend to gravitate toward the rescuer role. When we find ourselves beginning to favor the perspective of one participant, covertly if not overtly, we need to reevaluate our role and actions.

In recent years, the concept of health contracts has been introduced (Haber & Looney, 2000). A health contract is a written document outlining the organization and implementation of a series of cognitive, social, and behavioral skills needed to meet a specific health goal. A health contract results from the collaborative efforts of a health care professional, an older adult, and, potentially, caregivers. The contract can be set up as a calendar to delineate time requirements and to meet realistic goals. The health contract concept is one that could be helpful to speech-language pathologists working with older adults and their caregivers.

In essence, the health care contract symbolizes the therapeutic partnership. Development of the contract would be the result of one or more counseling interactions in which consensus was reached on specific goals. All participants engage in this process and in monitoring progress. The health contract defines what constitutes success, thus providing intrinsic reinforcement.

Develop and Maintain Trust

Effective counseling requires that a relationship of trust develop. To establish this relationship, all participants, including the speech-language pathologist, need to be valued and to feel that they are making a contribution to the process. Unfortunately, it is not uncommon for professionals to devalue input from the elderly, and for the elderly to devalue the opinions of the professional. This “devaluation” can be conveyed by nonverbals, tone of voice, or seemingly harmless, well-intended remarks, such as, “I hope I’m doing as well when I’m your age.” Devaluing the opinions of the professional is particularly problematic if the clinician is young. A relatively young clinician may have to “demonstrate” professional competency more than an older, more experienced clinician.

A professional is not automatically a trusted source of information for all elders. Elders from higher socioeconomic classes typically value “expert” opinions and trust professionals; however, elders from lower socioeconomic classes often place more trust in information obtained from friends and acquaintances. Some attributes appear to qualify one as a “trusted source” for all people, regardless of age or social class. For example, we tend to trust someone who has been through the same life experience, such as, “I know how you feel, I forget things all the time.” Professionals who have really “been there” often find that clients accept their advice more readily when they are aware of the common experience. There is greater confidence that the professional has a clear understanding of the issues involved, an awareness of solutions and resources, and investment in resolving the problem. Obviously, trust is earned when professional recommendations consider the needs of the client and caregiver, support their current beliefs, and result in improved communication.

Trust is enhanced when the speech-language pathologist demonstrates empathy, not sympathy. This may be an attitude that is difficult to “fake.” Sympathy is often
revealed in casual comments or by subtle nonverbal reactions. Empathy may be expressed through earnest attempts to understand the problem, genuine expressions of concern, and a sincere desire to assist the client/caregiver. Trust is also encouraged by participants feeling that the professional is a long-term partner. If intermittent follow-up is promised and provided after the client is discharged, the family feels that they have a continuing source of support and advice.

Any trust that is built can be rapidly destroyed if the clinician is not careful to maintain confidences. Clients may share information that they do not want the spouse to know; conversely, the spouse may request that the clinician not share concerns with the client. Occasionally, this lack of sharing may seem to inhibit progress and openness of the counseling process, but violating confidences can cause irreparable damage to the established relationships.

Development of an atmosphere of trust and mutual respect often begins in the first encounter through observance of appropriate conversational conventions. The speech-language pathologist should remember that many of today’s older adults come from a generation that emphasizes formality and convention. Clinicians don’t need to be stiff, but they do need to convey an understanding of these conventions. First names or nicknames should not be used unless a relationship has already been established and permission has been given to do so. In fact, some older individuals would prefer to address the clinician in a more formal manner. The speech-language pathologist should be sensitive to the fact that older clients and caregivers may have difficulty responding to questions about feelings or psychological state. They come from a generation in which talking about feelings was uncommon. Again, establishing trust is a critical element here.

Adjust Communication Style as Needed

If counseling is viewed as an exchange, then communication—both verbal and nonverbal—is the essential tool of the exchange. How we talk to older adults can be the biggest single barrier to effective communication. In recent years, research has established that those who talk with older persons often modify the way they communicate in an unproductive and almost insulting fashion (Harwood & Giles, 1996; Hummert, Shaner, Garstka, & Henry, 1998). Commonly used terms for talk adjusted to the elderly include elderspeak, baby talk, and patronizing speech. These modifications, called speech style accommodation, occur partly because we are unconsciously changing our communication style based on stereotypes about older persons, as opposed to the real characteristics of a client or caregiver. Common changes seen in elderspeak include exaggerated intonation patterns, higher pitch, simpler vocabulary and grammar, frequent repetitions or redundancy, slower speaking rate, and use of additional controlling devices such as pet names (i.e., we, “Are we having a good day today?”) and use of tag questions (“We’re going to take our bath now, aren’t we?”).

More recently, we have recognized that there is more than one way that people talk down to older adults (Ryan, Hummert, & Boisch, 1995). The types of “talking down” vary in terms of how caring and controlling they are. Because both caring and controlling are issues in the counseling exchange, each of these communication styles is described briefly below:

- **Baby talk** is both caring and controlling. It involves many of the basic elderspeak characteristics and includes generic terms of endearment (e.g., Sweetie, Honey) and “cutesy” phrases such as one might use with a small child.

- **Overly personal** is high in caring but low in controlling. Older adults are spoken to as though they are a treasured toy (e.g., “I just love how cute you look today”). This type of overly personal speech is often accompanied by touch or other positive nonverbal behaviors.

- **Directive talk** is primarily controlling with little or no caring, a kind of institutional speech register. The goal appears to be getting through the communication exchange with as little effort as possible. Directive talk involves telling elders what they should or should not do, typically with a cold or angry tone and an implied message that the person is noncompliant.

- **Superficial talk** is neither caring nor controlling. The best example is when a speaker discusses an older person as though he or she was not present, or when the health professional abruptly changes topics when the elder is expressing strong feelings or needs.

Clearly, clinicians must examine their own communication patterns and tendencies in talking with older adults. There are some basic guidelines for verbal and nonverbal communication in the health care interaction that are particularly relevant to older individuals. Adhering to these guidelines will facilitate the establishment of trust, exchange of information, and promotion of a sense of self-worth for clients and caregivers, thereby creating the basic therapeutic partnership.

- **Provide an environment that is as communication friendly and age sensitive as possible.** Consider the arrangement of furniture to ensure safety, comfort, and ease of access. Ensure adequate lighting and eliminate glare, fluorescent lighting, and backlight if possible. Use contrasting colors to highlight room features. Reduce background noises that may be distracting (e.g., radio, television, hallway or external noises).

- **Be an active listener.** Don’t just pretend to be listening. Listen to the words and the underlying thoughts, connections, and concerns. Clarify or ask questions if you are not sure you understand what is being said. Be attentive. Demonstrate your attention by facing the person, using an open posture, leaning toward the person, maintaining eye contact, and avoiding distractions. Part of being attentive is appearing to be relaxed and giving your focus to the individual. (Remember how rotten it feels to have the doctor glance at his watch, then seemingly stop listening?)
• “Listen” to more than the words—all behavior is communication. Pay particular attention to nonverbal clues, including tone of voice, eye contact, body language, dress, and personal care. Observe nonverbal exchanges between the client and the caregiver for suggestions of concerns or problem areas.

• Be aware of your own nonverbal messages. Touch has been described as particularly important in communicative interactions, although not all older adults appreciate physical contact from a relative stranger. Gestures and facial expressions may be particularly important in communicating with an older adult with a hearing impairment.

• Allow time for conversation as well as other information gathering. Try to avoid the question/answer interaction that suggests that all the power is in the hands of the questioner. Provide opportunities for the older person to initiate topics or questions. Do not do all the talking.

• Allow the older person extra time to respond. Do not leap in if there is a pause.

• Stick to a topic for a while, rather than constantly shifting. If there are several people involved in the interaction, try to restate the topic periodically to help maintain continuity.

Clinicians need to understand these distinctions and monitor their own communications and stereotypical responses when counseling older individuals. Successful counseling exchanges can only occur when the clinician adjusts his or her communication style based on the individual attributes and situation of the older person.

Accommodate Learning Styles

The processes of therapy and counseling are learning experiences. Thus, the learning style(s) of older adults should be considered in any intervention. Obviously, given the heterogeneity of the older population, there will be considerable differences in optimal learning strategies. For example, persons with more years of education may respond better to structured, formal instruction accompanied by informative material to be reviewed outside of the therapy session. In general, people with more education are more inclined to trust authorities.

Typically, older learners respond better if they are presented with information that relates directly to their situation and is application oriented. Learning is also enhanced if information is presented visually and/or modified appropriately to compensate for sensory deficits. Active learning strategies and self-paced learning are most successful. For some older adults, it is helpful to use frequent redirection of their attention to tasks or topics and reinforcement of performance or information. Repetition of instructions and rehearsal and practice of tasks are important learning strategies. Information/training is provided best in the context of short, frequent sessions, with reduced requirements for the amount of information to be processed at one time.

Adapt to Evolving Needs and Concerns

The timing and content of counseling interventions is probably the most critical factor in the success or failure of such efforts. For an effective information exchange, the speech-language pathologist should be aware of the participant’s current adjustment and its relationship to his or her available coping strategies. To facilitate successful coping, the clinician is required to consider the unique way in which the communication disorder is experienced by each individual, the self-concept (identity) of the client and caregivers prior to the onset of the communication disorder, client and caregivers’ knowledge of the disorder and what to expect, and personal and family attitudes and beliefs.

Many elderly individuals are already dealing with feelings of loss due to normal aging processes when a communication disorder develops. Each may be in a different state of coping. The communication disorder itself, and the associated disruptions in interpersonal processes, become yet another loss to be managed.

There are many models for defining timelines and cycles in coping with communication disorders. One of the most frequently cited models of loss and grief associated with communication disorders is that of Tanner and Gerstenberger (1988). According to this model, the “grief response” can occur in response to perceived or real loss of person, self, and object (skill).

The first stage is usually denial, which may be either partially or completely activated. During denial, the individual may adopt one of the following four stances with respect to the speech-language disorder:

• I don’t have a problem but the listener does.

• I have a problem but it’s minor.

• I have a significant but temporary problem because God will fix it (external locus of control, passive stance).

• I have a significant problem but I can overcome it (internal locus of control).

Denial serves primarily as a buffer, buying time to confront the speech-language disorder at a different level. At this early stage of dealing with communicative loss, it may be difficult, if not impossible, for clients and caregivers to process detailed information. In fact, some information (e.g., prognosis) may be unwelcome. Information provided at this time may be ignored, or may simply confuse the individual. Counseling during this stage should focus on immediate issues and concerns identified by the client or caregiver. Additional brief written information about the disorder should be provided, but extensive educational efforts and complicated recommendations are not appropriate.

Frustration is described by Tanner and Gerstenberger (1988) as the next stage in the grief response. Frustration is used loosely as a term encompassing other emotions such as a sense of powerlessness, anger, and even bargaining. During this stage, the speech-language pathologist may find that suggestions are rejected or received negatively. The target for client and/or caregiver frustration may vary from
moment to moment. It is important for the clinician to avoid taking these reactions personally because inappropriate reactions on the part of the clinician can have long-term negative effects on the therapeutic partnership.

Depression is reportedly the third stage in coping with loss and grief. Reactive depression, in particular, emerges when earlier defense mechanisms have failed and the individual has finally recognized his or her loss. It is not appropriate to attempt to “cheer up” the client or caregiver at this stage, or to suggest that he or she should feel better because “things could be worse.” Depression at any age can leave the client or caregiver unresponsive and unmotivated. Progress may be limited during such time intervals.

The last stage of the grief response is acceptance, often used synonymously with terms such as adaptation, adjustment, and accommodation. At the point of acceptance, the client or caregiver acknowledges the full extent of the communication disorder and is willing to move forward with identifying what to do to make life better. Unfortunately, this important stage frequently occurs after the client has left a rehabilitation setting and has left the immediate care of the speech-language pathologist. Acceptance should not be confused with “resignation.” Resignation suggests passive toleration of fate; clinicians will find resigned clients or caregivers unmotivated. They have given up and truly believe that nothing more can be done.

An understanding of long-term adaptation and coping requires consideration of strain, stress, distress, burden, depression, mastery or control, and premorbid personality and personal style. Coping responses are dynamic, not static. For that reason, speech-language pathologists must constantly monitor the emotional state of the client and caregiver, focusing on their reactions to the communication disorder and its impact on life events. It is important to avoid a simplistic view of these cycles of emotional adaptation (e.g., thinking “It’s nothing I did. Mrs. Jones is just in the anger stage right now”). It is also important to acknowledge the feelings being experienced and to accept them.

Two years after discharge from services, John and Susan found a stroke support group to attend. Prior to one of the meetings, John had been taken off most of his medications and was experiencing high levels of anger and frustration. He looked forward to the meeting so he could “vent” some of these intense reactions. Unfortunately, the speech-language pathologist facilitating the meeting chose to tell him that he “shouldn’t” be angry because he was so much better off than other stroke survivors. Needless to say, the anger lasted longer than was necessary, and Susan ended up being the recipient of the anger. Once again, the clinician had focused inappropriately on specific deficits, ignoring the whole person who was trying to move beyond his frustration and anger.

THE BOTTOM LINE

Counseling should be an ongoing process—the need for information exchange and guidance does not stop with discharge from therapy or medical care. Unfortunately, current health care guidelines and funding are drastically altering practice patterns. The name of the game today appears to be limited therapy using shortcuts for assessment and treatment with little or no follow-up. We are providing very limited counseling early on, and almost none over time.

In the case of John and Susan, there was no support for either of them—in dealing with the emotional, physical, social, and potential financial impact of the stroke and subsequent communication deficits. The lack of adequate information exchange and any counseling intervention left them literally at a loss in dealing with their altered circumstances. They did discover a stroke support group on their own, and used this group to move forward as they attempted to cope with life changes.

Ideally, by addressing the whole person, counseling promotes a sense of participant value, contribution, and self-worth. For the elderly client and caregiver, this may be the difference between passive resignation and successful aging.

REFERENCES


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**APPENDIX. OPTIONS FOR ASSESSING CLIENT AND FAMILY FUNCTIONING BEYOND IMMEDIATE LINGUISTIC AND COMMUNICATIVE PERFORMANCE**

### Specific Depression Inventories
- Center for Epidemiologic Studies-Depression Scale (Radloff & Teri, 1986)
- Geriatric Depression Scale (Yesavage et al., 1982)
- Zung Self-Rating Depression Scale (Zung, 1965)
- Beck’s Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbath, 1961)
- Cornell Scale for Depression in Dementia (Alexopoulos, Abrams, Young, & Shamoian, 1988)

### Other Mood/Affect/Emotion Scales
- Visual Analog Mood Scales (Stern, 1997, 1999)
- Affect Balance Scale (Bradburn, 1969)
- Profile of Mood States (McNair, Lorr, & Dropleman, 1981)

### Quality of Life, Life Satisfaction, Well-Being, Psychosocial Adjustment
- Code-Muller Protocols (Code & Muller, 1992)
- Psychosocial Well-Being Index (Lyon et al., 1997)
- Selection Optimization Compensation Questionnaire (Freund & Baltes, 1998)
- Geriatric Evaluation of Relatives Rating Instrument (Schwartz, 1983)

### Coping, Resources, and Stress
- Revised Ways of Coping Checklist (Vitaliano, 1993)
- Dimensions of Stress Scales (Vitaliano, 1993)
- Rotter Locus of Control Scale (Lachman, 1986; Lachman & Weaver, 1998)

### Interactional Scales (including self and other perceptions)
- Personal Relations Index (Mulhall, 1978)
- Family Interaction Analysis (Florance, 1981)
- Personal and Communicative Style (Swindell, Pashek, & Holland, 1982)
- LaTrobe Communication Scales (O’Flaherty & Douglas, 1997)
- How I See Myself and How I See My Aphasic Spouse/Family Member questionnaires (Thelander, Hoen, & Worsley, 1994)
- Interactive Communication Scales (Marshall, Freed, & Phillips, 1997)

### Independence/Dependence and Activities
- Structured Assessment of Independent Living Skills (Mahurin, DeBettinges, & Pirozzolo, 1991)
- Functional Life Scale (Sarno, Sarno, & Levita, 1973)
- Patient–Caregiver Functional Unit Scale (Daly & Fredman, 1998)

### Caregiver Measures
- Geriatric Evaluation of Relatives Rating Instrument (Schwartz, 1983)
- Patient–Caregiver Functional Unit Scale (Daly & Fredman, 1998)
- Caregiver Burden Inventory (Novak & Guest, 1989; Caserta, Lund, & Wright, 1995)
- Caregiver Burden Interview (Zarit, Reever, & Bach-Peterson, 1980)

### Disability Measures
- Disability Rating Scale (Rappaport, Hall, Hopkins, Belleza, & Cope, 1982)
- Acceptance of Loss Scale (Osuji, 1975)
- Reactions to Impairment and Disability Inventory (Livneh & Antonak, 1990)

### Measures of Adaptation to Illness
- Millon Behavioral Health Inventory (Millon, Green, & Meagher, 1979)
- Psychosocial Adjustment to Illness Scale (Derogatis, 1977)
- Sickness Impact Scale (Bergner, Bobbitt, Carter, & Gilson, 1981)

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