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A Counseling Training Module for Students in Speech-Language Pathology Training Programs

Joan N. Kaderavek
John M. Laux
Norbert H. Mills
University of Toledo, OH

Speech-language pathologists (SLPs) receive very little training in counseling during their graduate education. It has been reported that 82% of speech-language pathology graduate students indicated a need for more training in counseling methodology and more counseling practicum experiences during their training programs (Luterman, 2001; Rosenberg, 1998). It is also significant that there are very few studies that report research related to counseling issues. This lack of research is significant given the profound impact of the clinical counseling relationship for positive client outcomes.

This article describes a brief training program that was undertaken to develop counseling skills in speech-language pathology graduate students and a project during which students' counseling skills were evaluated before and after training to determine the effectiveness of this teaching approach. This article is organized in the following manner. First, an overview of issues relevant to training counseling skills in speech-language pathology students is provided. Second, a three-part training module is described along with case scenarios. Third, data are reported demonstrating the effectiveness of this teaching approach.

ABSTRACT: This article provides (a) a discussion of issues related to training speech-language pathology students in counseling skills, (b) a three-session counseling training module that was used to improve the counseling skills of speech-language pathology graduate students and, (c) data demonstrating the effectiveness of this training module. The training module emphasized specific counseling behaviors to facilitate a client-centered focus and enhance the emotional–affective clinical environment. Data demonstrated a significant improvement in counseling behaviors in 10 graduate students following implementation of the counseling training module.

KEY WORDS: counseling, professional training, speech-language pathology

TRAINING COUNSELING SKILLS

It is undisputed that SLPs should have excellent counseling skills. The difficulty is in deciding what should be included in counseling training and how these skills are to be taught. Clearly, SLPs are not qualified to provide in-depth counseling services for individuals with ongoing and systemic mental health issues. On the other hand, many, if not most, of the clients or family members who are seen in the speech-language-hearing clinic will have emotional and psychological overlay resulting from the ramifications of their communication disorder. Consequently, SLPs should be prepared to develop excellent counseling skills and to support their client's emotional and psychological concerns as they relate to the communication disorder (American Speech-Language-Hearing Association, 2001).

During graduate training, speech-language pathology students are often provided basic information outlining the type of counseling services provided within assessment and

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remediation processes. Training usually includes explanations of the information-getting, information-giving, and counseling interviews (Shipley, 1997). The information-getting interview is typically completed during the assessment process; here, the client is asked to provide a description of the communication disorder, developmental history, educational history, and so forth. The information-giving interview is frequently conducted following completion of the initial assessment. At this time, the SLP explains the results of the assessment, makes recommendations, answers questions, and describes the recommended remediation plan.

The counseling interview has a different purpose than the information-getting or information-giving interview. Counseling interviews are initiated by the SLP to influence behaviors or support and encourage the client's acceptance of the communication disorder (Shipley, 1997). As part of their training in counseling skills, speech-language pathology students are sometimes provided with a series of descriptive lists outlining behaviors that are most closely associated with effective counseling skills. These skills include (a) putting the client at ease by using appropriate nonverbals, (b) limiting social conversation, and (c) making concise and reflective comments to the client (Shipley, 1997).

Some counseling skills are easier to learn than others. Information-getting and giving interviews generally focus on *facts*. In contrast, counseling sessions frequently concern clients' *feelings*. In order to help clients work through attitudes and feelings, students must develop a client-centered focus in contrast to a clinician-directed focus (Shames, 2000). This process includes learning to tolerate silence during the client–clinician interaction, to reflect client emotions, and to clarify clients' self-perceptions.

Learning to deal with clients' affective responses can be challenging. Students develop appropriate counseling responses with knowledge and experience gained through assigned readings, classroom lectures, group discussions, and supervised clinical training. However, because the vast majority of SLPs report that they did not receive enough counseling training to feel competent (Luterman, 2001; Rosenberg, 1998), additional opportunities for student instruction should be explored.

To enhance the above-mentioned learning opportunities, the first author developed a training approach consisting of a three-session instructional module. This three-session approach permitted the counseling module to be incorporated into a course not exclusively devoted to counseling theory (i.e., a course in diagnostic methods). The goal of the brief training module was to improve speech-language pathology graduate students' ability to use specific client-centered counseling techniques with limited instructional time and maximum student benefit.[1]

[1]The first author was fortunate to receive training in counseling theory and techniques as a beginning clinician from Dr. George Shames. The module presented in this article is based on lecture notes and activities completed at that time. More recently, Shames (2000) published his approach in a text. The module presented here, although adapted, is based on Dr. Shame's methodology and theory.

THE COUNSELING TRAINING MODULE

Before initiation of the counseling module, students were assigned a book chapter to read for theoretical background information regarding interviewing, counseling, and clinical communication (McNamara, 2002). The training module itself consisted of three sessions, with each session consisting of a lecture, a mock interview, and a self-evaluation.

During the first component, the lecture, the course instructor focused on the background information for the day's activities. The lecture lasted 40–50 min. During the mock interview, the second component, students divided into groups of three. The mock interview component lasted 40 min. The mock interviews were conducted in individual therapy rooms with videotaping capabilities. During the mock interviews, the students took turns in 10-min intervals taking the role of the (a) client, (b) SLP interviewer, or (c) observer. The observer evaluated the counseling skills of the SLP interviewer by completing the Counseling Skills Checklist (see Appendix A).

During the final self-evaluation component, the students returned to the classroom and discussed their reactions and self-discoveries for approximately 30–40 min. At this time, students wrote counseling goals to be targeted before their next counseling training session (e.g., "I will wait at least 5 seconds before responding during a 5-minute conversation with my client."). As a follow-up activity, students reviewed their tapes before the next session and located examples of specific interview techniques.

Session One: Therapeutic Relationship/Attending Behaviors

Lecture. An important aspect of counseling is the development of an effective therapeutic relationship. A client-centered therapeutic focus is facilitated when the SLP follows and reflects clients' emotional responses. It is tempting for both the SLP and/or the client to fall into the position of thinking of the SLP as an "expert" who is able to solve the client's emotional problems. SLPs, however, must resist this role—even though they want very much to help. Humanistic theory (Maslow, 1962; Rogers, 1951) suggests that clients' self-discovery and self-actualization is best accomplished by clinicians listening instead of "prescribing" (Luterman, 2001).

Listening instead of talking and focusing on feelings rather than facts can be very difficult for the beginning SLP clinician. In fact, many of the behaviors underlying client-centered counseling are contradictory to students' prior clinical experience. Instead of clearly directing client behavior, beginning clinicians are asked to be reflective. Students must also learn to subordinate their own personal reactions and opinions and to instead focus on facilitating the client's personal growth. As Shames (2000) stated, "it is a very one-sided, non-mutual relationship. One person expresses, reveals, and examines while the other facilitates the process" (p. 13).

In order to develop a client-centered counseling session, speech-language pathology students need to become

comfortable using a variety of nonverbal behaviors. These include, among other things, facial expression, head nodding, body posture, and eye contact (Shipley, 1997). Awareness and effective use of these variables has been associated with counseling effectiveness (Burgoon, 1994).

The first lecture of this module outlined specific strategies to improve nonverbal communication. Students viewed videotapes of effective and noneffective nonverbal interview behaviors. In terms of body position and leaning, students were encouraged to maintain a relaxed, but slightly forward body position and to avoid a tightly "closed" body position (i.e., tightly crossed arms and legs). It was emphasized that this body position, along with appropriate facial expressions and deliberate head nodding, is associated with interest and favorable affect and encourages client verbalization (Mehrabian, 1972; Shipley, 1997). Students learned that nonverbal behaviors usually occur in combination sequences and support the counselor's verbal behaviors.

The variation in eye contact that occurs in typical communication (i.e., shorter) versus the amount of eye contact that is appropriate for a counseling session (i.e., longer) also was discussed. However, students were cautioned that they should be sensitive to cultural variation in eye contact. For example, the European North American pattern is to use more direct eye contact when listening and less when talking. In contrast, some African Americans may have the opposite pattern, demonstrating more eye contact when talking and less when listening (Cormier & Nurius, 2003; Hackney & Cormier, 1996; Ivey, Ivey, & Simek-Morgan, 1993).

The need to tolerate "clinical silence" was also emphasized in the first lecture. One of the most powerful techniques for maintaining a client-centered focus is for the SLP to permit and tolerate silence during the interview (Capuzzi & Gross, 2003; Corey, 1991; Cormier & Nurius, 2003; Seligman, 2004; Sue & Sue, 1990). Silence is more than just the absence of speech; silence can indicate respect, agreement, or empathic consideration of the speaker's communication (Battle, 1997). However, in general, North Americans feel very uncomfortable with silence during conversations. SLP students often interpret silence as negative or as indicating tension. In contrast, for individuals in other ethnic or cultural groups (e.g., Asian, Native American, Middle Eastern), silence is seen as appropriate and positive (Battle, 1997).

The North American cultural disinclination to tolerate silence leads many speech-language pathology students to dread the occurrence of silence during the counseling interview (Shames, 2000). Consequently, one of the main goals of the first mock interview was to highlight the importance of permitting silence to occur and to increase students' tolerance for conversational pauses. Students were told to mentally count to five before making a comment or reflecting feelings (skills that were the focus of later mock interviews).

The positive benefits of silence were discussed with the speech-language pathology students. Positive benefits of silence include allowing the client to process information, maintaining a client-centered versus clinician-directed focus, and providing an open invitation to the client to talk. Often—with 5 s of pause time—clients will elaborate or explore their feelings without additional clinician input (Shames, 2000).

Along with pause time, the use of minimal encouragers (e.g., use of "mmm-hmm," "yes," or "I see") was explored during the first lecture. Students viewed videotapes in which the interviewer used facilitative sequences of head nods, minimal encouragers, and conversational pausing. It was discussed that minimal encouragers act as verbal reinforcement demonstrating clinician attention and approval (Hackney & Cormier, 1994). Pause time and minimal encouragers used together establish the SLP as a listener instead of a "director" during the counseling interview (Luterman, 2001).

Mock interview. In the first mock interview, as in all of the mock interviews, the class was divided into groups of three and students rotated the roles of SLP interviewer, client, or impartial observer. During the first mock interview, the primary goal for the SLP interviewer was to tolerate silence during the clinical session, to maintain a facilitative body posture, and to use appropriate nonverbals and minimal verbal encouragers.

During the client role, students discussed an issue of personal importance (e.g., the stress associated with being a graduate student). During the observer role, students used Part I of the Counseling Skills Checklist (Appendix A) to provide feedback to the SLP interviewer. Each student was responsible for audio- or videotaping his or her interview.

Self-evaluation. Following the mock interviews, students returned to the classroom and discussed their impressions of the mock interview experience. Students were generally surprised at their low tolerance for conversational pausing. Before the next session, students were asked to listen to their interview tape and to compute the mean of their three longest pauses.

Session Two: Open Versus Closed Questions/Focusing on Feelings

Lecture. During the second week, the students were introduced to the issue of open versus closed questions and the importance of supporting a client's discussion of feelings. The students were reminded that because silence increases a client's responses, questions were to be considered a secondary rather than a primary interviewing behavior. Students were provided with definitions of open and closed questions—open questions allow the client or family member to respond in a number of different ways, whereas closed questions typically require a specific response (Cormier & Nurius, 2003; Seligman, 2004). Examples of open and closed questions were also provided.

Open questions:

SLP: Tell me why you came to the clinic today.

SLP: How are you feeling about how things are going at school?

Closed questions:

SLP: Has your son already been diagnosed with a language delay?

SLP: How old was your son when you first noticed the problem?

Students viewed videotaped examples of SLP interviewers using different kinds of questions. They were asked to identify the different question types and to discuss the relative merits of each kind of question. It was emphasized that whereas closed questions help the SLP secure information and are very time efficient, open questions encourage client talk; communicate SLP interest; and reveal the client's knowledge, feelings, and perspective (Shipley, 1997). When discussing the interviews, students suggested that clinicians might be tempted to use too many closed questions because of a low tolerance for silence or in an attempt to "look professional." Overall, the students reflected on the facilitative use of open-ended questions in creating a client-centered focus.

Following the discussion of question type, the difference between content-related responses and affect- or feeling-related SLP responses was introduced. When paraphrasing content, the SLP rephrases the words said by the client. Content responses are the more frequently used response by clinicians. Content responses have the positive benefit of encouraging clients to elaborate on specific informational aspects (Shames, 2000), but can make the session fairly predictable and may not encourage the client to elaborate on his or her emotional reaction to the event (Luterman, 2001). Examples of content paraphrasing were provided.

Client: He began to stutter when he was about 3.

SLP: (5 s pause) about 3 years old….

In contrast, affect- or feeling-related responses respond to the client's emotional expressions. Reflecting these emotions is important because often clients may minimize or hide their emotional reaction to their communication disorder. Clients may also feel that if they express feeling, they might be rejected by the SLP (Shames, 2000). Luterman (2001) stated that the beginning clinician may feel that feeling-related responses are risky. However, the use of SLP feeling-related comments is one of the most significant illustrations of empathic listening (Rogers, 1951) and is influential in building a supportive clinical environment (Luterman, 2001). Students were provided with examples of feeling-related paraphrasing.

Client: I thought that something was wrong, but everyone kept telling me he would grow out of it. I asked his doctor and preschool teachers—they are supposed to be the ones that know about these things, right? But no one told me that it could be something so serious.

SLP: You feel angry that you weren't given more help in figuring this all out at an earlier age.

Specific practice of content- versus feeling-related SLP paraphrasing was not targeted until the third mock interview. However, during Session Two, the students were encouraged to identify differences in the two types of paraphrasing and to recognize that paraphrasing can be used to reflect clients' expressions of both positive and negative (i.e., frustration, grief, anger, confusion) emotions.

Mock interview. Before the second mock interview, each student was provided with a simulated case report. The cases reflected a variety of disorder groups, ages, and family histories. During their client role play, the students were asked to imagine that they were the parent or adult client in the case example.

The SLP interviewers were expected to ask both open and closed questions while also demonstrating previously learned behaviors (e.g., correct body posture, tolerating silence). SLP interviewers were asked to focus primarily on the use of open questions because this is often more difficult for the beginning SLP clinician. Students were cautioned to avoid a common mistake of quickly following up an open question, such as "Tell me why you came here today?" with a closed question, such as "Are you worried about his speech?" A nervous clinician who fears a momentary silence while the client contemplates his or her response can demonstrate this response. The observer was asked to complete Parts I and II of the Counseling Skills Checklist.

Self-evaluation. During the self-evaluation session following the second mock interview, students shared their videotapes from the prior week. Students shared both positive and negative instances of their interviewing skills. Students also began to reflect on their interviewing behavior in the clinic with their clients. For example, one student recognized that a client shared an emotional response that previously might have been overlooked or minimized. In order to generalize new skills, students wrote counseling goals, such as "I will ask at least two open questions during my diagnostic interview."

Session Three: Paraphrasing and Summarizing Feelings and Content/ Handling Negative Emotions

Lecture. The discussion of content- versus feeling-related responses was elaborated by discussing the differences between paraphrasing (discussed in Session Two) and summarizing. When paraphrasing content or feelings, the SLP attempts to closely and immediately mirror the client's utterances (content) or immediately capture the underlying emotion (feelings) after it is expressed. When summarizing, however, the SLP condenses the content or feelings expressed over a longer period of time—perhaps even 10 to 12 min of conversation (Shames, 2000). Summaries are useful to conclude an interview and allow the SLP to confirm that he or she has "gotten the message right." Very often, the client will respond to a summary statement by confirming or denying aspects of the message or feelings expressed. Students typically need to practice effective summarization; the goal is to look for the "big picture" in as few words as possible (Shames, 2000).

In Session Three, the instructor elaborated on the therapeutic client-centered relationship by discussing the importance of paraphrasing, accepting, and responding appropriately to clients' negative emotions such as anger, fear, or sadness. Many individuals have difficulty listening to someone express negative emotions; instinctively, one wants to offer reassurance that "things aren't so bad" or

"you shouldn't worry." However, students were encouraged to consider that effective intervention should include opportunities for clients and families to discuss negative emotions associated with their communication disorder. If the SLP is able to hear these feelings, accept them, and reflect them back to the client—the client has the opportunity to work through his or her negative feelings.

To elaborate this discussion, students were asked to verbalize statements that they might say if they, their child, parent, or spouse had a severe communication disorder. What feelings and frustrations might they express? Students took turns reflecting and paraphrasing the feelings of these messages. It was discussed that often, the SLP can follow paraphrasing with an interpretation or clarification to help clients better understand their feelings. Examples were provided.

SLP Responses to Client's Negative Emotions

Example 1:

Client: I think sometimes that I am the one that has caused this problem; I could have done something to prevent it.

SLP: As a parent, you feel guilty (reflection of feeling). That's a very natural reaction (interpretation).

Example 2:

Client: I just can't deal with him anymore. I'm at the end of my rope.

SLP: You are very frustrated (reflection of feeling). It's good that you are recognizing your limits (interpretation).

Students discussed the advantages of creating a therapeutic environment that permits clients to share both positive and negative emotions. In the examples above, the client's emotional expressions could lead to a discussion of causation (Example 1) or result in a much-needed client referral (e.g., potential referral for respite care in Example 2).

Mock interview. For the client role, students were given a case scenario in which there was an underlying negative emotional reaction to be revealed at some point during the interview (see Appendix B for examples). The SLP interviewer was to respond appropriately to the client's negative emotion by paraphrasing feeling and providing interpretation when appropriate while continuing to demonstrate previously learned behaviors. At the conclusion of the interview, the SLP interviewer was asked to summarize the client's content and feelings. The observer completed all parts of the Counseling Skills Checklist in the evaluation process.

Self-evaluation. During the final self-evaluation, students indicated how real the interview felt and expressed their anxiety about responding appropriately to the feelings expressed. The observer reactions were used to judge the adequacy and helpfulness of the SLP interviewer responses. Students found that there were often a variety of correct responses (Luterman, 2001).

In summary, the three lectures, mock interviews, and self-evaluation components were designed to improve the counseling skills of graduate students in speech-language pathology. This module was integrated into a semester course. The authors were uncertain, however, if such a brief experience could positively impact graduate students' counseling behaviors. The following case study was designed to explore this question.

CASE STUDY

This case study was implemented with a pre–post treatment design; the treatment consisted of the counseling training module described above.

Subjects

Ten female first-semester speech-language pathology graduate students participated in the project. The students indicated that they had discussed aspects of counseling in their undergraduate studies but had received no prior specific training in counseling techniques. Six of the graduate students had some prior clinical experience as undergraduate students (< 50 clock hr); four of the students had no previous clinical experience. Before their participation in the module, students read a chapter describing counseling theory and application for SLPs.

Methods

The training sessions took place over three sessions (approximately 8 hr of training). The pre- and posttraining interviews were conducted the week before and 2 weeks following the counseling module. The training consisted of three 40–50-min lectures (Lecture One: Therapeutic Relationship/Attending Behaviors, Lecture Two: Open Versus Closed Questions/Focusing on Feelings, Lecture Three: Paraphrasing and Summarizing Feelings). Each lecture was followed by a mock interview in which the students were placed into triads and during which they alternately took on the role of (a) SLP interviewer, (b) client, and (c) observer during a 40-min session. Following each mock interview, the students participated in a 30–40 min self-evaluation activity.

The pre- and posttraining interviews were conducted with paid actors with previous experience in medical role playing (i.e., playing the role of a patient in a medical school training program). The actors (one male, one female) played the role of a family member of an individual with a communication disorder. Scripts were provided to the actors; each script contained emotionally laden material or statements. To the extent possible, the actors maintained similarity in their content, amount of talk, and so forth across the pre- and posttraining sessions and across students. Students were assigned in a random manner to one or the other actor. Five students participated with the female actor during their pretraining interview, five with the male actor; assignments were alternated during the posttraining interview. Students were told that they would be interacting with actors (as contrasted with real clients) but were unfamiliar with the presented cases.

The second author, a clinical counselor, independently selected the rating scale and carried out the rating evaluations from the videotaped counseling interviews. The Counselor Rating Form (CRF), a 36-item bipolar rating scale, was used to rate the speech-language pathology students on three clinical dimensions labeled attractiveness, expertness, and trustworthiness (Barak & LaCrosse, 1975). Recent research findings suggest that a summed total score (collapsed from the three separate dimensional ratings) results in more reliable evaluations; this procedure was used in the current study (Guinee & Tracey, 1997; Heppner, Humphrey, Hillenbrand-Gunn, & DeBord, 1995; Hoffman, Hill, & Taffe, 1996). The range of total scores for the CRF is 36–252, with lower scores representing limited presence of the attribute. The CRF is a widely accepted tool that has been used in counseling research and is reported to be a structured and efficient method of evaluating counselor behaviors (Corrigan & Schmidt, 1983).

The CRF was used to rate the videotapes of the SLP interviewers during their pre- and posttraining interviews by two raters who were enrolled in a counselor education and supervision doctoral training program. After being trained to reliably score the CRF by the second author, the raters viewed and independently scored each of the pre- and posttraining interviews in random order. The raters were unaware as to whether the session reflected a pre- or posttreatment session. The calculated interrater reliability estimate for the CRF ratings between the raters was .84. Given this high correlation, the scores from the two raters were averaged. This combined mean was used as the dependent variable in the data analysis below.

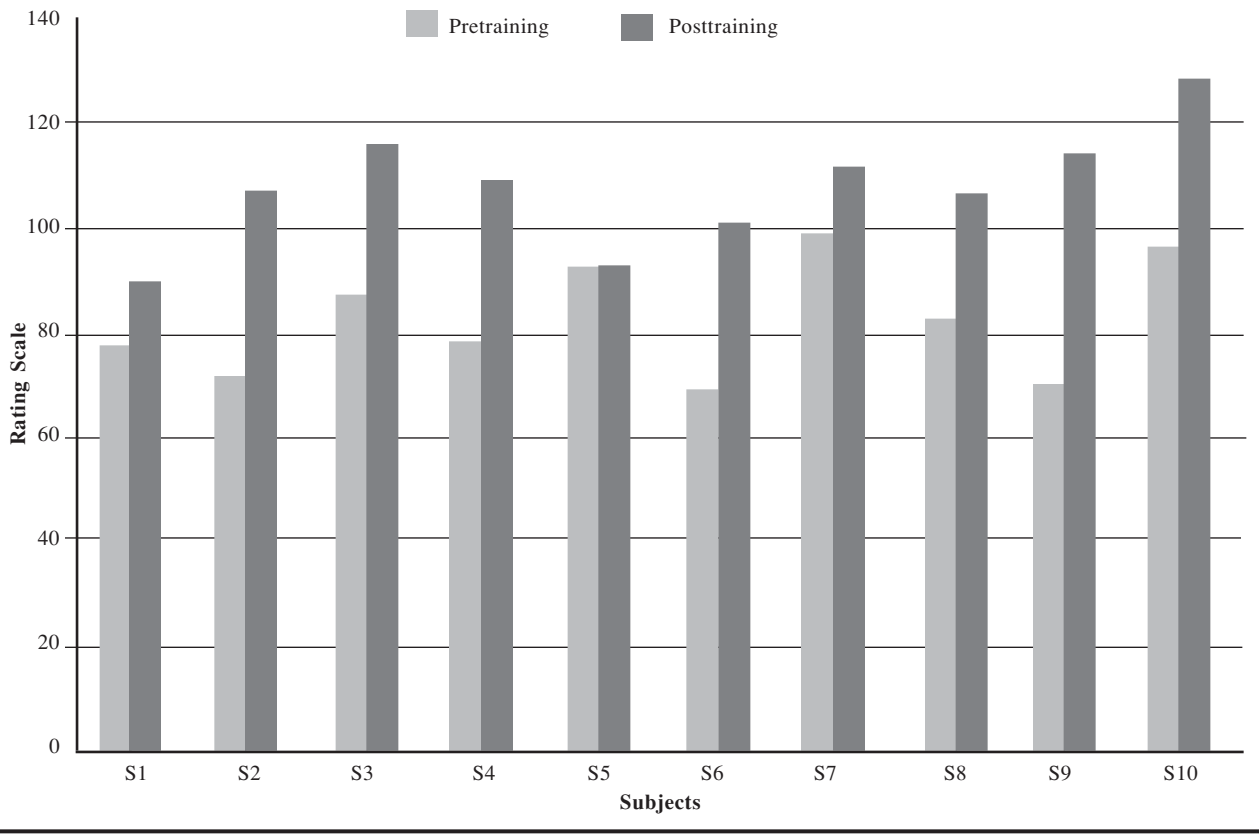
Results

This project was undertaken to determine the potential effectiveness of a brief training module for improving the counseling behaviors of graduate students in speech-language pathology. The nonparametric Wilcoxon Signed Rank Test was used to determine differences in the dependent variable (counseling rating scale) for the two related samples. A significant difference was demonstrated between the pre- and posttest counseling behavior of the student clinicians, $T = -2.8$, $p = .005$ (pretest $M = 82.5$, $SD = 11.09$; posttest $M = 108.1$, $SD = 10.75$). Figure 1 visually demonstrates the mean rating scores before and after treatment for the 10 graduate students.

DISCUSSION AND CONCLUSIONS

This study was designed to explore the benefit of a brief counseling module on the counseling behaviors of speech-language pathology graduate students. The goal of the

Figure 1. Counseling rating for speech-language pathology graduate students before and after training.



module was to highlight a client-centered counseling focus with an emphasis on increasing students' abilities to tolerate pause time, effectively use nonverbal behaviors and minimal verbal encouragers, become proficient in asking open as well as closed questions, and be able to paraphrase and summarize clients' expressions of content and positive and negative feelings. This study demonstrated a significant increase in speech-language pathology student counseling skill as measured by a counseling rating scale.

There are several issues warranting discussion. First, a three-session training module cannot replace the ideal situation of having an entire course devoted to counseling theory and application. Unfortunately, however, sometimes student exposure to important concepts has to be included within existing courses. The module presented here was developed under such constraints to make the best use of available time. The goal was to bring about a high level of student learning within a limited time frame. It is encouraging that this goal was met within these constraints.

Additionally, there are considerations for the case study data interpretation. Because the case study was implemented as part of a course, the students were not randomly selected. Further, the students were able to learn and benefit from their pretreatment interview; undoubtedly this experience improved their final performance along with the instruction they received during the actual training module. Interpretation of the findings is strengthened, however, by the fact that doctoral student raters were unfamiliar as to the timing of the session (pre or post) and used a rating scale that was unfamiliar to the first author, an SLP (the module instructor). Thus, the significant level of improvement that was noted in counseling skills was generally an independent and unbiased measure of the students' change in counseling skill.

Overall, the outcome was encouraging and positive. These data suggest that speech-language pathology students can improve a discrete set of counseling skills even within a limited time frame. A targeted learning module that combines a variety of instructional methods can help students develop important counseling skills.

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Contact author: Joan N. Kaderavek, Speech and Hearing Clinic, Gillham Hall, University of Toledo, Toledo, OH 43606. E-mail: Joan.Kaderavek@utoledo.edu

APPENDIX A. COUNSELING SKILLS CHECKLIST

Interviewer's Name: _____

Other Participants in Mock Interview: _____

Observer's Name(s): _____

Situation: _____

Part I. Attending behaviors

1. What did the counselor do particularly well to indicate that he/she was actively listening? Be specific.

2. Below indicate how well each of the attending behaviors was used.

	Well	Adequately	Inadequately	Not Used
Physical relaxation/posture				
Tolerance for pauses/silence				
Nonverbal reinforcers (eye contact, gestures, head nods)				
Minimal encouragers to talk ("mm-hm," "oh,", "and..."				

Part II. Open/closed questions

1. List some effective questions used by the interviewer.

2. Below indicate how well the interviewer used each type of questioning behavior.

	Well	Adequately	Inadequately	Not Used
Closed questions				
Open questions				

Part III. Focus on feeling/summarization of content

1. List some examples of paraphrasing of feelings.

2. Describe an example of summarization of feeling and an example of summarization of content that occurred during the interview.

3. Evaluate the adequacy of each of these aspects that demonstrate that the interviewer can focus on feelings and summarize feelings and content of the client.

	Well	Adequately	Inadequately	Not Used
Reflection of feeling (can restate feelings that are underlying client's talk but perhaps not stated)				
Paraphrasing (feeds back what the client said)				
Summarization of feeling (recapitulates feelings; usually occurs at end of interview)				
Summarization of content (recapitulates content; usually occurs at end of interview)				
Interviewer uses appropriate timing of comments				

Part IV. Summary

1. List two behaviors that the interviewer could use to improve his/her counseling skills.

APPENDIX B. CASE SCENARIOS

1. You are a 23-year-old individual who stutters. Your speech-language pathologist (SLP) has just informed you that he/she is dismissing you from therapy because of your "resistance" to therapy. For example, you have been asked as part of your therapy to complete some desensitization exercises that involve "stuttering on purpose." Although you and your therapist have thoroughly explored the rationale for this assignment, you have been unable/unwilling to complete these assignments. Conversely, you have found it difficult to discipline yourself to use your fluency-enhancing strategies (slower rate, continuous phonation). Your SLP has regretfully informed you that he/she thinks you are showing signs of resisting treatment, and he/she feels it would be best to discontinue treatment at this time. You feel angry and hurt that your therapist is "giving up on you." You recognize the problems, but feel you should be "able to get therapy anyway." Begin this session as if your therapist has just completed informing you of the situation.

2. You are a college-age client who has been diagnosed with vocal nodules. You are a music major with aspirations to teach singing and perform professionally. You decided to pledge a sorority/fraternity. Recently, your course work has been demanding, requiring several vocal performances and long hours of rehearsal. Pledging also turned out to be vocally demanding; you have been talking excessively all day long and well into the night, often shouting loudly at sorority/fraternity events. You have seen an ear-nose-and-throat specialist (ENT) and the doctor prescribed a period of vocal rest. You are feeling overwhelmed and frustrated by your problems with your voice and are afraid that you are physically not going to be able to have the vocal mechanism that can "hold up" to a professional career. You are disappointed that your social life is in conflict with your professional aspirations. Your family has not supported your desire to be a voice major—they want you to do something more practical. This diagnosis makes you begin to doubt your major and be fearful for the future.

3. You are the mother/father of a 6-year-old child who is not doing well at school. The SLP (who is interviewing you) has informed you that your child is showing symptoms of language-learning disability (e.g., reduced scores on phonological awareness assessment, difficulty with more complex sentence structure). You feel threatened by this diagnosis and are angry with the SLP for suggesting that your child has a problem. You attribute your child's problems to a recent move, his teacher, and "that he misunderstands his assignments." You don't want your child identified as having a learning disorder. You have just been informed that your child has done poorly on his testing.

Erratum

In the spring 2004 issue of *CICSD*, in the article by Ludo Max, Frank H. Guenther, Vincent L. Gracco, Satrajit S. Ghosh, & Marie E. Wallace, "Unstable or Insufficiently Activated Internal Models and Feedback-Biased Motor Control as Sources of Dysfluency: A Theoretical Model of Stuttering" (pp. 105–122), the equation printed on page 114 was printed incorrectly. The correct version appears below.

In the DIVA model, cells in the motor cortex generate the overall motor command M(t), which is a combination of feedforward and feedback commands:

$$M(t) = M(0) + \alpha_{ff} \int_0^t \dot{M}_{feedforward}(t)g(t)dt + \alpha_{fb} \int_0^t \dot{M}_{feedback}(t)g(t)dt$$

with α_{ff} and α_{fb} representing the amount of weighting toward feedforward and feedback control, respectively, and $g(t)$ representing a speech rate signal that is 0 when not speaking and 1 when speaking at the maximum rate.