- On Teaching Counseling

Abstract: The purpose of this investigation was to examine the current state of counseling education . A 12-item survey was sent to all programs listed in the Council of Academic Programs in Communication Sciences and Disorders directory via the internet. Seventy-two responses were returned indicating little more than half of all programs offer a course in counseling and only a third require it. This result suggests there has been only a modest(5%) overall increase in course offering compared to survey data from the 1990's. All the increase in the present data can be attributed to the AuD programs. When the numbers from the AuD programs are subtracted from the data, only 28% of programs training SLPs offer a counseling course and of those only 25% require it. Which means that current speech pathology students have fewer counseling courses offered to them and fewer required than in the 1990's. It is concluded that present day audiologists within AuD programs are more apt to receive formal training in counseling while speech language pathologists are less likely to receive instruction. Examination of current studies indicates student and professional unhappiness with counseling instruction especially in the realm of personal adjustment counseling. Because of limited counseling training availability in the 1990's, current faculty are also likely to have minimal training in counseling creating a self-perpetuating model of inadequate instruction in counseling. This issue needs to be vigorously addressed by retraining current faculty with ongoing professional development opportunities within the department and on a state and national level as well. ASHA needs to be actively involved in promoting counseling instruction Suggestions for the in service and for teaching of counseling are proposed.

Key Words: Counseling, Instruction, Communication Disorders, professional development

There is probably universal agreement within academic and clinical training programs that counseling is a fundamental skill for students to acquire. ASHA (2016) delineates, education and thoughts, and emotions related to a communication disorder as within the scope of practice of SLPs and audiologists; indicating that counseling has both an information component and a personal adjustment component. Despite the acknowledged importance of counseling as a necessary skill, there is evidence that academic programs are not providing adequate training in counseling. McCarthy, Culpepper and Lucks (1986) surveyed academic training programs accredited by ASHA and found that only 40 % offered a course in counseling within their department. And only 12 % of the respondents felt that the program was effective in training for counseling. In a follow up survey, Culpepper, et., al., (1994), found little change ten years later. They also found that only 17% of the faculty, who responded to the survey, felt that students were adequately trained in counseling. Crandell (1997) surveyed audiology training programs and found that 48 % of the programs offered a course in counseling and only 13% required it, which he found alarming. The consequences of lack of training in counseling can be seen in the studies of Ekberg et.al. (2014) who examined the videotaped interviews of audiologists and 63 elderly hearing aid users. They found a mismatch in many cases between the psychosocial concerns expressed by the clients and the responses of the audiologists. Cienkowski and Saunders (2013) found that 66% of communications by audiologists during routine hearing aid fittings were information based and they concluded that clients would benefit greatly if audiologists became more comfortable with personal adjustment counseling. Simmons and Damico (2011) noted that clinicians working with aphasia patients were uncomfortable with emotional based material and one of their strategies was to deflect the client by resorting to information. Atkins (2007) surveyed current graduate students,90% in their first year, rating their counseling/interpersonal skills. She found that students rated their skills highly and still

wanted more emphasis placed on counseling in the curriculum. Phillips and Mendel (2008) surveyed recent graduates of communication disorders programs and found that 80 percent did not have a course in counseling and most did not feel prepared or comfortable to provide counseling They recommend that a 3-credit course in counseling be added to the curriculum and there should be more emphasis on counseling in practicum. Meibos et.al (2017) in comprehensive review of the literature of counseling by audiologists on client hearing aid use found that audiologists were much more comfortable with informational counseling than personal adjustment counseling and all felt a need for more counseling training. Whicker et.al.(2017) recently surveyed AuD programs and found that 76% of programs required a counseling course. Whicker et.al (2018) in a follow up surveyed 168 students in their final year of their AuD degree. They found that 90% of the students had a course in counseling, however they found wide variability in the support they received in their clinical interactions from their supervisors. The present study was undertaken to determine the current status of counseling education and to see if there has been any change in counseling instruction since the surveys of Culpepper et., al. (1994) and Crandell (1997) .

Method

A 12 item questionnaire (appendix A) was sent via email to the department chairs of 265 programs listed in the Council of Academic Programs in Communication Sciences and Disorders directory. The questionnaire was designed to yield both quantitative and qualitative data on counseling instruction within their departments. Respondents were encouraged to offer opinions on the inclusion of counseling within the curriculum regardless of whether their program offered a course in counseling.

Results

Seventy-two surveys were returned, 67 % were completed by the department chair,26 % by the graduate program director and 7 % by academic faculty.

Figure 1. shows the range of programs represented within the survey. (insert figure one here) It may be seen that 62 of the programs offered a master's degree,(12) AuD, one D. Ed and 14 PH.D. programs were included in the survey. There were 9 programs that offered only an undergraduate degree.

It may be seen in figure 2 (Insert figure 2 here) Of the 72 programs surveyed 38 (53 %) offered a separate course in counseling and 24 (33%) of the 72 programs required a counseling course. ; overall this means only a third of all students in current training programs are required to have a course in counseling and little more than half of programs are even offering a course in counseling.

Figure 3 presents the data on required counseling courses in program indicating that approximately two thirds of programs offering a course in counseling actually require it. On a total basis of all the programs surveyed, only one third of students are required to have a course in counseling. Tweaking the data a bit further, we found that of the ten programs having an AuD degree and having a counseling course 5 or 50% offered the degree to speech pathology majors and 5 or 50% required SLP students to take it; whereas 90% of Audiology majors were required to have the course. It appears then if a SLP student is enrolled in a program which also offers an AuD degree there is more likelihood that a counseling course is offered and required but not to the same degree as an AuD major. These numbers are small and require further study.

Table 1 shows a comparison of the results of the present survey with the Culpepper et.al. survey of 1994 of all ESB certified programs and the Crandell survey of 1997 which examined counseling course in audiology programs with the present study. In addition, the data from the 12 AuD programs in the current study are included to obtain comparable data to the Crandell study. The data in the present study, compared to the

Culpepper survey of 1994 suggests there has been an overall modest increase (5%) in course offering in the 24 years separating the surveys. While there is no appreciable change in the percentage of programs requiring a counseling course 33% to 35%. However, there is a very different result when we examine the data for audiologists. Crandell found in 1997 that only 48% of audiology programs offered a counseling course and 13% required it. In the current study there were 12 programs offering an AuD degree 83% (10) offer a counseling course and 75% (9) require it. This is consistent with the Whicker et.al.(2017) data which found that 76% of AuD programs required a course in counseling. This means that the overall modest increase in counseling requirements compared to the Culpepper study of 1994 can be attributed solely to the AuD programs .In fact, If we take out the AuD numbers from the current data then only 28% of programs solely training SLPs, offer a course in counseling and of these only 25% require it. This is markedly less than was available to students in 1994 when 43% offered a course and 35% required it. These numbers are inadequate for training in such a fundamental clinical skill and no wonder 80% of interns in speech pathology had no course in counseling and feel unprepared to work with clients as reported by Mendel and Phillips(2005).

Other data gathered by this study indicated that not all programs offer a three credit course; of those programs offering a course 45% are three credits 31% are two credit courses and 24% are one credit courses. This indicates that even when counseling is offered within a program in over fifty percent of the time it is for less credits than disorder courses.

Eighty nine percent of the courses are being taught by departmental faculty indicating that there is a cadre of faculty trained in communication disorders who feel qualified to teach counseling. One other question asked in the survey tried to examine the content of the counseling in terms of the recommended approach to counseling. This question was deemed invalid as the questionnaire was not necessarily filled out by the instructor.

The comments of the respondents can be found in appendix (B) This is data is hard to quantify but interesting none the less. The comments from respondents in programs offering a course in counseling were almost unanimous in their remarks on the importance of counseling in the curriculum . Threaded throughout the comments are words like" necessity" ,"critical"," must have" " important" ," believe strongly" and lastly "vital". indicting a strong commitment to teaching counseling.

Examination of the responses of those from the 31 programs that do not have a course in counseling indicated that two programs out sourced counseling to the psychology department and the 29 other programs respondents reported that counseling was infused throughout the curriculum or the practicum. Others indicated that counseling was taught as a subtopic of a disorder course. Only two respondents indicated unhappiness with how counseling was being taught within their program.

Discussion

There seems to be a marked disparity between the recognized importance of counseling as an essential clinical skill, within the scope of practice by ASHA and program availability and training for SLPs in particular. When barely 50% of programs offer a course and even less require it does not seem to match the needs of the students or of practicing clinicians. There is also a marked reduction in counseling course availability over a twenty-year span for SLPs. This may be due to trying to keep the required number of course constant within a master's degree while adding other courses. Swallowing disorders comes to mind as a course being offered now that was not offered in the 90s. Given the restraints of the overall course requirements for a master's

degree, it seems that counseling courses were crowded out or marginalized within the curriculum. This may be short sighted as counseling is a foundational skill that needs to be central to the clinical education.

The divergence in education between SLPs and Audiologists began with the dispensing of hearing aids which lead to the establishment of the AuD degree. In dispensing hearing aids there is a clear counseling mandate and with the expansion of the curriculum provided by the AuD degree, counseling courses can be offered and required. In current training programs it appears that audiologists are receiving much more counseling exposure than SLPs'. Of concern also is what is actually being taught in counseling courses. Whicker et.al. (2017) examined the syllabi of 53 counseling courses within AuD programs and found wide variability and concluded there was "a need for better counseling skills development" In a follow -up study Whicker et. al.(2018) surveyed students and found dissatisfaction with how counseling is taught and how supervisors support students in their clinical interactions. This is consistent with other data indicating student dissatisfaction with counseling instruction for audiologists especially in the area of personal adjustment. , Meibos et. al. (2016) Meibos et. al. (2017)

Another restraint on the growth of counseling availability may be due to the lack of counseling expertise in the faculty as a whole. Our current teaching faculty received their degrees in the 80 'and 90's when we know from the Crandell(1997) study and the Culpepper et al(1994). that there was a paucity of counseling courses required or taken and only 17% of faculty in the Culpepper study felt that students were adequately prepared in counseling. Many of the graduates of the last two decades of the 20th century, are the current teaching and supervising faculty. We can infer then, that most present-day faculty have had minimal exposure to counseling within speech pathology in their training programs and we seem to have a self-perpetuating system with large holes when it comes to teaching counseling. While faculty may have had exposure to counseling theory and practice in courses outside of speech pathology it does not seem to translate into effective instruction within the department. Infusion of counseling training within the curriculum, as many programs feel they are doing, makes no sense when we do not have adequately trained faculty. If we don't actively address this problem now, we will create another generation of instructors who are badly trained in counseling.

ASHA has delineated two aspects of counselling as within the scope of practice: Informational and personal adjustment counseling. The informational aspects are easy to teach and fit well within the expectations of clients and professionals, the personal adjustment aspects, which involve client feelings and vulnerabilities are much more challenging to students and most professionals in the field. The failure to prepare students in the personal adjustment realm may very well be caused by the faculty not being well prepared to teach this aspect of counseling. It should be noted that informational counseling and personal adjustment counseling are not mutually exclusive; Several studies, some going back many years, have demonstrated how little clients retain of content at the time of diagnosis. Williams and Derbyshire (1982), Martin,et.Al (1990) Margolis (2004). Kessels (2003) has noted that the client's ability to retain medical information is directly related to their anxiety level.; therefore, unless client anxiety is addressed, informational counseling without a personal adjustment component will not succeed. It seems counter intuitive and perhaps ironical; if you want greater retention of information in clients then focus needs to be placed on personal adjustment issues.I suspect because we have, in general poorly trained faculty in counseling ,the emotional components are not being taught well.

The fact that some programs training SLPs can find curricular space for a required counseling course while almost three quarters do not ,suggests that there needs to be a departmental commitment to counseling instruction It needs to be seen that counseling is a foundational skill, central to clinical education, and should not be acquired haphazardly, which seems to prevail in many programs. As a profession we need a paradigmatic shift on counseling instruction in which it is infused in the curriculum requiring a coordination between academic and clinical faculty.

I think counseling can be taught effectively , without a specific course if there is a faculty wide commitment and training; this needs to be ongoing in order to be effective When a program has adequately trained and integrated faculty then infusion makes sense and can succeed; just adding a counseling course, whether required or not, is not going to be sufficient. Emphasis needs to be placed on professional development of current faculty in the area of personal adjustment counseling. The faculty in- service training can take several different forms for example, but not limited to:

Selection of a counseling text and faculty meeting once a month to discuss a chapter.

Kaderavek et. al. (2004) Administered a three session counseling training module for graduate students that can be adapted for faculty use.

A faculty retreat on counseling facilitated by a mental health professional or a faculty member versed in counseling skills.

Lastly ASHA needs to be involved by promoting counseling instruction in national workshops and a reexamination of academic counseling requirements.

Conclusions and Recommendations

This study was undertaken to determine if there has been any appreciable growth in the teaching of counseling within the curricula of communication disorders programs. Results indicate there is only modest overall growth in counseling courses which can be attributed solely to the advent of the AuD programs. There is less counseling course availability and requirements for current SPL students than was available in the 1990s. Speech language pathologists are not getting adequate instruction in counseling, while it appears that audiologists may have sufficient course availability there are still indications that the instruction may not be adequate. The lack of growth in program availability for SLPs , may be a function of the restraints imposed by a master's degree and faculty commitment. It is strongly recommended that programs undertake an ongoing program of in-service to train current faculty on acquiring and teaching counseling skills; counseling instruction needs to be infused within the entire program to be effective. ASHA needs to prioritize increasing counseling education as a national goal.

Addendum

I have been teaching counseling for over thirty years and would like to offer the following thoughts**:**

Counseling is a necessary skill that cuts across all disorders and all clinical encounters. In fact, from my perspective, counseling skills are life enhancing and affect all relationships personal and perfessional in a positive way.

The universal to counseling skills is listening. Clients need to be heard and seen, students need to be taught to begin the therapeutic or diagnostic endeavor from a listening stance and if they learn nothing more in their course than listening deeply and selflessly to clients, without judgement this may be sufficient.

Multicultural awareness is not a separate issue in counseling. We are all multicultural and each client needs to be approached as a wonderful experiment of one

Counseling within the field of communication disorders is essentially grief work. We are encountering clients who have lost the life that they thought they would have, and this loss must be acknowledged. Grief is not pathological.

What are the boundaries of counseling and when to refer is always an important issue. Students need to be taught that referral is the clinician's problem in that the material being discussed has exceeded the clinician's scope of practice; and only that needs to be acknowledged with the client. Clinician- initiated referral can be potentially damaging to a client who is not ready for mental health counseling or is culturally appalled by it; clients need to actively participate in the referral in order for it to be successful.

There are several scales that can be adapted to assess counseling skills of clinicians, but as the supreme court judge said about pornography, "I know it when I see it." so too with counseling. When the clinician is in the moment and listening deeply, in the service of the client then counseling is taking place.

Counseling skills need to be taught as an experiential endeavor; with the instructor modeling counseling behavior. Distance learning course in counseling can only be successful if they include an intensive weekend on campus as part of the course requirements.

There are several articles on teaching counseling through learning specific behaviors by using role playing and standardized patients (actors role playing) and these can be successful in teaching specific skills. I have taught counseling from an experiential personal growth perspective that encourages student self-awareness and self -acceptance: when that happens technique ensues.

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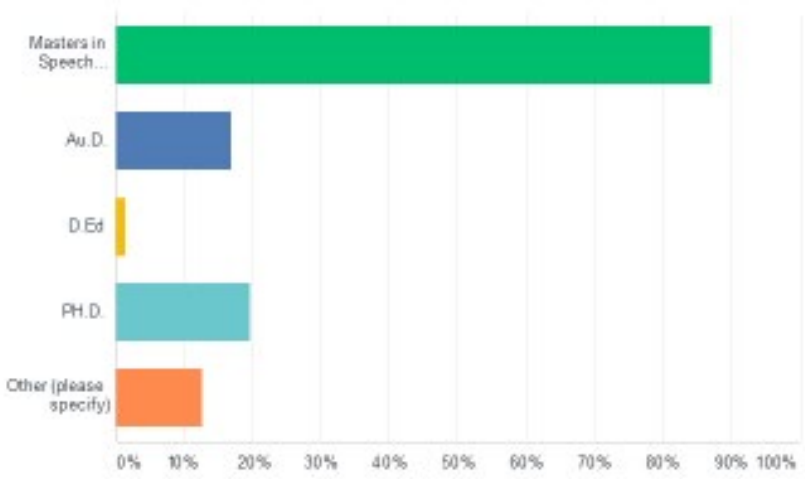
Q2 Degrees Offered

Answered: 71 Skipped: 1



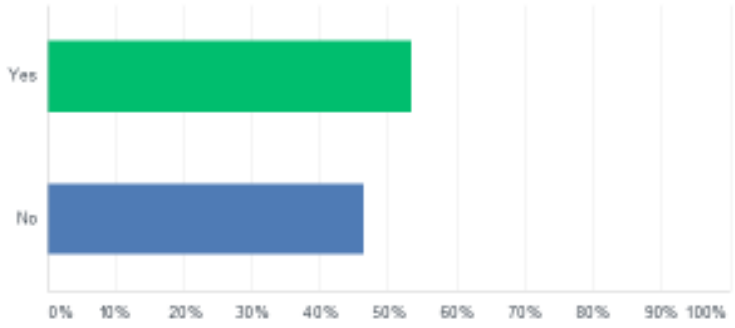
ANSWER CHOICES	RESPONSES	
Masters in Speech Pathology	87.32%	62
Au.D.	16.90%	12
D.Ed	1.41%	1
PH.D.	19.72%	14
Other (please specify)	12.68%	9
Total Respondents: 71		

#	OTHER (PLEASE SPECIFY)
1	Undergraduate
2	undergraduate CSD
3	BS Communication Disorders
4	BA in SLHS
5	undergrad degree, comm disorders
6	Application for Candidacy has been submitted to CAA
7	BS
8	undergrad only
9	BS and applied for accreditation for MS

Figure 1

Q3 Is there a separate course in counseling within the curriculum?

Answered: 71 Skipped: 1

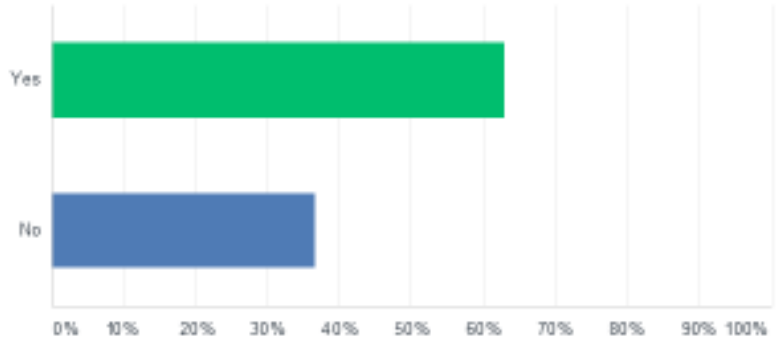


ANSWER CHOICES	RESPONSES	
Yes	53.52%	38
No	46.48%	33
TOTAL		71

Figure 2

Q5 Is this a required course?

Answered: 38 Skipped: 34



ANSWER CHOICES	RESPONSES	
Yes	63.16%	24
No	36.84%	14
TOTAL		38

Figure 3

Table 1 Comparison Of surveys regarding availability of counseling courses

	Luterman	**Culpepper**	**Crandell**	**AuD**
Year	2018	1994	1997	2018
# Programs	72	121	77	12
Course Offered	53%*	43%	48%	83%
Course Required	33%*	35%	13%	75%

Note* These numbers include the AuD programs when they are subtracted from the current data the percentage of SLPs having a course offered is 28% and 25 % of programs require it.

Appendix A The survey

1. What is your role within your program?

    - ○ Department Chair
    - ○ Graduate Program Director
    - ○ Academic Faculty
    - ○ Other (please specify) _____

2. Degrees offered

    - ○ Masters in Speech Pathology
    - ○ Au.D
    - ○ D.Ed
    - ○ PhD
    - ○ Other (please specify) _____

3. Is there a separate course in counseling within the curriculum?

    - ○ Yes (jump to Q4)
    - ○ No (jump to Q10)

4. If Yes, at what level is the course?

    - ○ Masters
    - ○ Au.D
    - ○ PhD
    - ○ Other (please specify) _____

5. Is this a required course?

    - ○ Yes

- ○ No

6. How many credits is the course?

   - ○ 1
   - ○ 2
   - ○ 3
   - ○ 4

7. Who teaches the course?

   - ○ Communications Disorders Faculty
   - ○ Mental Health Professional
   - ○ Other (please specify) _____

8. What approach is recommended and taught?

   - ○ Content Based
   - ○ Client Centered
   - ○ Cognitive/Behavioral
   - ○ Family Centered
   - ○ Behavioral
   - ○ Other (please specify) _____

9. What are your thoughts on counseling within the curriculum? _____

10. If no, could you indicate how counseling skills are acquired by the students?

    _____

11. What approach to counseling is recommended and taught?

    - ○ Content Based
    - ○ Client Centered

- ○ Cognitive/Behavioral
- ○ Family Centered
- ○ Behavioral
- ○ Other (please specify) _____

12. What are your thoughts on counseling within the curriculum? _____

Appendix B

Q9 What are your thoughts on counseling within the curriculum?

Answered: 34 Skipped: 38

#	RESPONSES
1	I think it needs to be included in the curriculum as a required course. It needs to be a experiential type of learning course.
2	Needed
3	We embed this content as part of our practicum course. There is a true need for understanding how counseling fits into our field and the responsibilities we have as clinicians in this domain.
4	It is important to have a course that focuses on counseling skills specifically, and it is also important for counseling to be addressed in other content courses within the curriculum. Counseling should be taught before students get to externship, preferably before or right when they start clinical practica so that they can experience real-life examples as they learn the skills.
5	I believe it to be a necessity.
6	needed
7	It should be a required course.
8	Absolutely critical content for students in our profession!
9	It is important and, while, content courses discuss counseling relative to working with a particular population, it is not well understood by both faculty and students,
10	I think it is an important part of the curriculum. SLPs-in-training need to know what and how to communicate with persons who have communication disorders and their significant others.
11	I think that it is an important component but with number of required classes that we need to teach, it is hard to justify requiring it of all students. We do just each every year so that students have 2 opportunities to take it as an elective.
12	I feel it is an essential component, and if not taught, it is unrealistic to think students will acquire the skills on their own. Counseling provides clinicians with the tools to be intentional in their communication and interactions to help individuals and families achieve their desired goals and improve their outcomes.
13	Students can receive relevant information about counseling in multiple courses in addition to having the option to take a specific course on counseling.
14	We are focusing on scope of practice restrictions and delivery. We use theater students to provide simulation opportunities to highlight different approaches to counseling.
15	Must have at least as an option
16	Absolutely necessary! But I don't think we have a unified approach across the academic and clinical experiences.
17	Our department values counseling content in our curriculum.
18	We have determined that counseling is a critical aspect of the speech-language pathology service delivery. In the era of inter-professional education, a taught perspective in counseling is essential.
19	I think it is a very important course that needs more prominence within what is already a packed curriculum
20	It is important to include counseling for specific disorders within the curriculum in addition to having a stand alone counseling course.
21	I would like to integrate into more of the curriculum so that students don't think that "counseling" is a separate service that should be provided. Rather it is how we communicate at the beginning, middle and end of the appointment.
22	We believe strongly that it should be included in the curriculum.

23	It is very important for SLPs. We want to make it a required 3 credit course
24	In addition to having this in a single course, it should be distributed throughout the curriculum. I teach a lot of counseling in my childhood speech sound disorders course, for example
25	It is a crucial class to prepare our graduate students for their externships.
26	In addition to a 1 cr introduction to counseling this is woven throughout the curriculum & emphasized in seminars in diversity and those that support practicum as well as academic coursework.
27	Unfortunately, I do not believe students are appropriately trained to work with families, clients or other professionals. I believe there is a lot of overlap between the concepts/techniques discussed and utilized when counseling, supervising and collaborating, all of which are topics which may be lacking in graduate programs.
28	This is a critical need for SLP's. Unfortunately we currently have it late in the curriculum, but ideally it would occur sooner.
29	It should be required in all Master's programs
30	It is very important to have the course in the curriculum.
31	It is an area that few are well equipped to contend with early on in their careers. Before the elective course, we included a unit on counseling in the clinical methods course.
32	Necessary for preparation of professional SLPs. Would appreciate more guidance from ASHA on this topic
33	I believe it is an important, intrinsic piece in the curriculum and it is infused with everything we do. We are investigating increasing the credit hours and working on it in an intra-professional context.
34	Vital!!

Q10 If no, could you indicate how counseling skills are acquired by students?

Answered: 31 Skipped: 41

#	RESPONSES	DATE
1	Psychology courses	
2	18 hours of psychology (including 6 upper level counseling classes)	
3	Not well enough! We incorporate counseling into every unit of study, and have a one-day workshop by a counseling psychologist in the spring. Our challenge has been finding experts to teach our students.	
4	Lectures within classes	
5	Incooperated in different courses. However, our faculty recognizes we need coursework in counseling.	
6	infused in class and clinic contexts	
7	Included as 2 1/2 hour class during the first semester and again in the second semester (to build on what students' learned). We work with our Counseling program to provide this information and collaborate.	
8	We incorporate studies of how our clients are suffering, how people with disabilities are to be valued, and how we are to care for clients and their families beyond just the therapy session.	
9	Included in academic coursework that accompanies clinical practica; opportunities for practice during clinical experiences	
10	Included in several other courses, including fluency and hearing management. Also addressed in clinical practica.	
11	Within the dysfluency and dysphagia courses	
12	We include a unit in our clinical methods class, required of all senior students.	
13	During practicum experiences	
14	Within specific courses	
15	Knowledge is threaded through coursework and skills are developed in clinic.	
16	In all disorder based coursework there is a module on counseling as applicable to those populations	
17	In each disorders/processing course as a subtopic area	
18	Counseling is currently infused across the curriculum. We are considering adding a separate course on counseling.	
19	Counseling is taught within disorders courses. We offer an elective on counseling as well.	
20	Counseling topics are addressed within other coursework and skills are refined in clinic practica.	
21	We use Luterman's book in our Methods of Treatment course. At times we have offered a Special Topics course on counseling. One faculty member is also a licensed psychologist so she brings in the counseling element to various courses.	
22	Lectures in individual disorders classes or pro seminars	
23	through the clinic and individual course discussions; an elective is offered	
24	It is infused throughout the curriculum and also taught in clinical practicum	
25	We have a professional issues course that covers some skills.	
26	It is inbedded in all courses, most especially the Stuttering course and the Medical Issues course.	

27	Counseling skills are taught in each graduate level course and through clinical discussion groups
28	We teach counseling across three semesters. The topic is covered as half of the clinical intervention curriculum.
29	Through a variety of courses
30	We have a shared course in diagnostics and counseling called Clinical Assessment and Counseling
31	In our professional issues course and threaded throughout curriculum.

Ruminations of an Old Man—A Fifty Year Perspective on Clinical Practice

David Luterman, D.Ed.

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I have been blessed with 50 years of active clinical involvement. I began my professional life as a diagnostic audiologist and morphed into a rehabilitation audiologist, specializing in helping families of newly diagnosed children with hearing impairments make the transition to their new reality. I feel incredibly fortunate to have stumbled into my life work and have found a niche that nourishes me and at the same time benefits others. Immersed in my life journey it seemed disjointed; from this vantage point it seems inevitable. At this stage in my life, I find myself more reflective with a strong desire to look back, distill my clinical experience and pass it on to current and future generations of clinicians. Here then is the Luterman 10:

1) Grief is not pathology

At heart we are grief workers. We are dealing with people undergoing transitions in their lives because they have lost the life they thought they were going to have; whether this is the parent of an autistic child or the spouse of an aphasic patient or the adult child of a nursing home patient. Grief is not culture bound or disability specific: it is endemic to disability. While many things have changed in our profession, the human equation is unchanging; we are dealing with clients who are emotionally *upset not emotionally disturbed.*

Grieving and the concomitant feelings are a normal response when a person is suddenly confronted with a life challenge in which there was no preparation; as a profession we need to give ourselves permission to do the necessary grief work. While technology may have altered the therapeutic landscape it doesn't bypass the need to interact with our clients on an emotional plane.

2) Ignoring the emotional component can be perilous

When people are emotionally upset they cannot process information well. I had to learn this the hard way as a practicing diagnostic audiologist. After making the diagnosis of hearing loss in a child my notion of counseling at that time was to give information. I rapidly developed set speeches about the audiogram, hearing aid maintenance and educational options. I gave these mini lectures without recourse to the parent's emotional state. What I learned on subsequent evaluations, much to my dismay, was that they retained almost nothing of what I had said. They were much too upset to retain much content and in fact I had overwhelmed them with information and contributed to their fear and anxiety. Especially in the early stages of diagnosis people are helped best by being allowed to grieve.

I have found that people are seldom allowed to grieve as most people conspire to make them feel better. They do this by instilling hope ("they will find a cure") or by positive comparisons (" It could be worse he could have …."). All this serves to do is to emotionally isolate the person and deny them the right to grieve. What people in emotional pain often need the most is to be listened to and have their feelings validated. This is counterintuitive for most people as the tendency is to want to take the pain away by solving the problem or distracting them. I have learned that I cannot take the pain away; these disabilities represent a loss and that loss will always be there despite anything I might say or do. What I can take away is "feeling bad about feeling bad."

Once as I was beginning to facilitate a support group for parents of newly diagnosed deaf children one mother looked at me and said "you are going to make me cry' and I said to her "No. I am going to give you permission to cry," whereupon she started to cry. In the past I would have felt guilty that I caused

that parent to cry; what I have come to understand is that I am not putting the feelings in but creating the conditions that enable the feelings to emerge. What I have also come to understand is that feelings just *are;* you do not have to be responsible for how you feel but always for how you behave. This notion has enabled me to enter the realm of feelings with clients to their benefit because embracing painful feelings is the first step in healing. The current emphasis on evidence based practice I find worrisome because emotional growth does not readily lend itself to measurement, yet it is in the emotional realm where a great deal of the action takes place. Communications is best achieved when there is both content and affect components present. I hope we can learn, as a profession to balance our content counseling with our affect counseling and value both equally.

3) Counseling is not about making clients feel good

The purpose of counseling is to not necessarily to make people feel better, the entertainment industry does that. The goal of counseling should be to empower clients so that they can make self enhancing decisions for themselves and their family members. In the course of the counseling experience painful feelings will emerge including anger. I have always seen the emergence of the painful feelings as a positive sign because these clients are not in denial and if I am mindful of my role they will take ownership of the communication disorder; there can be no meaningful change without ownership of the problem by the client. This ceding responsibility to the client is often in itself painful for clients as frequently they prefer a passive role in the habilitation process hoping and expecting the professional to "fix" it.

4) Listening is our most important clinical tool

As a beginning clinician I assumed my professional role was to give information and direction to the client; that I needed to be a very active participant in the therapeutic process. I had a "lesson plan' mentality with specific goals in mind and my scripted mini- lectures were designed to ensure that clients left our encounter with the information that I thought they needed. In retrospect I can see that the set speeches and advice giving were a reflection of my own insecurities and need to limit the clinical interaction in predictable, content based

ways that I could manage. By listening to the client without a pre conceived "lesson plan" enables the client to participate more fully in the therapeutic endeavor; it forces client to be active in the relationship. Listening for client affect and reflecting it back enables the client to identify their feelings and express them in a safe relationship; this attenuates client isolation and validates their feelings. Listening deeply to our clients is a great gift we can give them.

As I have become more self confident in my clinical skills I have been able to cede more and more control of the therapeutic process to the client. Learning proceeds best when the learner is an active participant in the process. Listening enables the clients to reveal themselves allowing me to find ways to be most helpful; the client will teach us if we listen. I had to learn to cultivate the art of not doing and at the same time being present for the client. The irony here is that often the less I do the more the client learns.

5) **Over helping teaches helplessness**

In the early stages of diagnosis clients are usually overwhelmed and feeling very inadequate to cope with the disability. This is a critical juncture for the clinician because the tendency is to want to rescue the client from their actual and felt inadequacy. If we rescue by advice giving and taking responsibility from the client we can contribute to their fear and sense of inadequacy. It is very easy to teach helplessness and create the dependant client who then accepts a passive role expecting the clinician to fix it. I have had to learn how to be responsible *to* my clients rather than being responsible *for* them. Finding the therapeutic equator of helping is not easy because it is constantly shifting with each client and at different times with a client. I have had to learn to trust clients to eventually make the best decision for them, and that wisdom, which is the best use of information, resides within the client and not in me. My role is to judiciously share my information as client needs it and asks for it. I avoid giving advice and assuming responsibility for the client at all costs. Enhancing client's self esteem is the premier goal of the therapeutic encounter thereby creating the independent client who no longer needs us.

6) **The support group is a invaluable clinical vehicle**

It is hard for me to conceive of a program that does not include a support group. Having a catastrophic event in your life becomes emotionally isolating

because almost everyone in the client's everyday life is invalidating their painful feelings while seldom understanding what the client is experiencing. The support group is usually the one place that individuals are understood; feelings can be validated and help can be given and received. Professionals, by non judgmental listening, can validate feelings but lack the instant credibility that the members of a support group have. Support groups are not disability specific; I think they are especially helpful for the families of clients who are often on the periphery of clinical services. Mixed support groups, where there are clients and family members are very challenging to facilitate but usually helpful in promoting family unity. My major clinical role, the past 45 years has been as a group facilitator for parents of young children with hearing impairments. I have found this to be an immensely rewarding activity; every group has presented unique challenges and invariably taught me something valuable

7) A collaborative family centered model is the most efficient one

It is unfortunate that students in our training programs are seldom exposed to a family centered model of service delivery; the individual pull -out model seems to be one of choice. I think this is an easier model to select for the beginning therapist as he or she need only focus on the identified patient. Unfortunately this is the least efficient way of working with clients. By working with the family unit we can extend the goals of therapy to the home and create a milieu that is supportive of change. This model requires a greater skill set of a therapist because it mandates working with family members who do not have an overt communication disorder. Families also need to be broadly defined to include the milieu of the client whether this is a hospital setting or a classroom. Training programs need to see that the pull-out model is a way to start the training but students need to be quickly exposed to and trained in the broader model of a family centered approach to service delivery; family centered therapy needs to be the gold standard.

8) Affirmations are words for every occasion

Words spoken mechanically without feeling and/or out of context will never be helpful "This too shall pass" were the words the wise men came up with for the king who wanted something to say for all occasions. There are counseling words that are equally useful that I call affirmations. "It must be so hard" is an empathetic remark that validates the client's experience while "that's O.k." gives sanction to the client's feelings. Probably the most useful words are 'uh huh' which says to the client "I hear you. Tell me more." In a long counseling career probably the most useful words to the clients are the ones I haven't said.

9) Mistakes are nuggets of gold

I have come to see that clinical mistakes are inevitable. Even after fifty years I still have my occasional gaffes. I have had to learn to be gentle with myself and accept the fact that errors are an inevitable consequence of clinical growth. I think any learning and growing clinician needs to be pushing at the boundaries of their comfort zone however, in that boundary region reside errors. I have learned that the "mistake" is a useful marker for what I need to learn. I learn best from my blunders and it is only a mistake if I do it twice. Fortunately we are not brain surgeons, clients usually recover from the gaffes and there is often an opportunity to apologize and correct the error and move on; if the fundamental relationship is strong it can withstand errors.

10) **Self Care is a critical component of clinical work**

On the surface a counseling relationship looks conventional in that two people are dialoging. The reality is that one person, the counselor, is helping the other by practicing selfless, deep listening. The mantra for the counselor needs to be "It's not about me." Deep listening requires that the counselor put aside all personal agendas and be there in the service of the other; this is not an easy thing to do and rarely experienced outside of a counseling relationship. Being in service to the other is very demanding and while in many cases, technology has altered the clinical landscape, the most important clinical "tool' is still the clinician. Clinical tools need periodic care and much like the audiologist sending the audiometer out to be recalibrated clinicians must take periodic timeouts to recalibrate themselves. To be a selfless listener requires a personal centering that mandates clinicians have a fulfilling personal life; we need to be able to give to our clients

from our abundance. Too often one sees in the helping profession clinicians with strong needs to be needed that they try to fulfill by creating dependant relationships. Clinical burnout is a consequence of clinicians who do not practice good self care and have many dependant relationships.

Fifty years seems like a long time yet it has gone by bewilderingly fast; it has been a marvelous ride much better than I ever expected. I am often asked how I have been able to remain clinically active for so long amidst so much pain and suffering without burning out. For me it's a matter of practicing good self care, avoiding developing dependent relationships with clients, and above all understanding that personal growth is often forged in the crucible of the pain of these disabilities. I do not see these disabilities as tragedies but rather as powerful teachers that promote transcendence. We give to life what life demands and the disabilities often force clients to develop capacities that would otherwise lie latent. I love being able to participate in promoting growth and when you love what you do it is not work; I have often been amazed that they actually pay me to do it. To participate and facilitate the personal growth of clients provides moments of grace that makes our profession so worthwhile. I would love to be around for another 50 years but the actuarial tables are against me.

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Helping the Helper

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The counseling relationship is one in which the counselor practices deep, selfless listening in order to help the client. The act of deep listening requires a great deal of energy and the capacity to focus attention for a long period of time. In order to be selfless in the listening the counselor needs to be psychologically centered. This is known as congruence. When the counselor's needs are met outside of the counseling relationship then the counselor is able to be present for the client. If the counselor is in an emotionally needy state then listening selflessly becomes very difficult if not impossible as the counselor seeks to find congruence through the client relationship. In order to be a successful helper the counselor needs to practice and model self-care. In my experience of 40 years of teaching, I have found very few speech and hearing personnel who practice good self-care. Consequently, I have found many clinicians who are "burnt out" relatively early in their career; burdened by a great many dependent client relationships. It is my belief that good counseling skills and effective helping is best achieved through a focus on helper congruence and helper self-care rather then on counseling technique. Following are some suggestions for helping the helper.

Many people who are attracted to the helping professions have a strong need to be needed. Consequently there is a tendency to be over involved with the client and with work; leading to professional burnout. (Meadow, 1981)I have called this process the Annie Sullivan syndrome.(Luterman,2008) Annie Sullivan seems to me, to epitomize the over helping and over involved professional. While she turned out an amazing pupil in Helen Keller she did this at a great expense to her own personal life. She was entirely devoted to Helen and. despite Helen's remarkable skills; she never learned to live independently. Annie, who had a very deprived childhood, needed someone to love and someone to love and need her. Consequently, she was unwilling to let go of Helen and teach her independent living skills. She actually needed Helen more than Helen needed her although to a casual observer it might not look that way. This is an extreme example of the dysfunctional helping relationship; nonetheless, elements of the Annie Sullivan model permeate many of the helping relationships in our field. Helpers who have an unsatisfactory personal life with many unmet needs frequently try to fulfill themselves within the helping relationship. This is seldom beneficial, in the long term, to the client. The net result of this dynamic is many dependent relationships for the professional leading to the burnout.

The lynchpin of dependent relationships can often be seen as a failure of the professional to set boundaries There are boundaries that are set on the relationship as well as the emotional boundaries separating the helper and the heplee In The *Family Crucible*,

a text I use in my counseling course, therapists describe their work with a dysfunctional family. At the first meeting, the therapists refuse to initiate therapy because the son did not attend. They sent the family home. The fact that the therapists took control of the meeting and did not accommodate the family members that were present always amazes the students. The students, and I suspect many professionals in our field, have embedded in their psyches the notion that it is their responsibility to accommodate to the clients needs and to not impose their limits on the client. As a result, clients often run therapy and the therapist is assigned the responsibility to "fix" the problem then the disorder subtly becomes the therapist's

On the emotional level many professionals seem to "own" the client's problems and respond as though they had the disorder. What needs to be recognized by helpers is that they need to relate to the client's problems with compassion and with an understanding that it is their obligation to assist, listen and inform when necessary, but not to assume the burden. When we over help; clients learn helplessness. It is often very difficult to find the therapeutic equator of supportive helping without inducing dependency. It is a matter of being responsible *to* the client rather then being responsible *for* the client Helpers always need to keep in mind that it is the client's problem. While that may seem hardhearted it is in the long run in the best interests of both the helper and the helpee Client growth is always facilitated when they learn how to be independent of help and to take responsibility for themselves. One of the hardest things professionals have to learn is to allow clients the dignity of making mistakes; although very often what I thought of as a "mistake" has turned out the very best solution for the client. Letting go of taking full responsibility often teaches humility. Reading the following piece, author unknown, has been very helpful to me:

To Let Go

To Let Go is not to stop caring,

Its recognizing I can't do it for someone else.

To Let Go is not to cut myself off,

Its realizing I can't control another.

To Let Go is not to enable,

But to allow learning from natural consequences,

.To Let Go is not to fight powerlessness,

But to accept that the outcome is not in my hands

To Let Go is not to change or blame others,

It is to make the most of myself

To Let Go is not to care for, it's to care about

To Let Go is not to fix it's to be supportive.

To let Go is not to judge,

It's to allow another to be a human being,

To Let Go is not to try to arrange outcomes,

But to allow others to affect their own destinies.

To Let Go is not to be protective,

It is to permit another to face their own reality,

To Let Go is not to regulate anyone,

But to strive to become what I can be.

To Let Go is not to fear less it is to love more.

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A key component of self-care is ability to reframe events. Because the cognitive processes determines the emotional intensity of an event stress can be reduced by changing the way an event is viewed. Thus, for me I can reframe the difficult client into a teacher and in the same vein I can see deafness not as a tragedy but also as a teacher. From both the difficult client and the disorder there exists a maximum opportunity to learn and grow. This is equally true for the client as well as for the clinician.

In the course of our clinical interactions, many clients are encountered who are emotionally needy and the professional is cast in the role of giver. If giving is seen and experienced as depleting then helpers quickly burn out. There is a child's story called *The Giving Tree* by Silverstein that defines giving as depletion. In the story, a little boy continually comes to the tree and asks for help, which the tree readily gives. By the time the boy is fully-grown the tree is reduced to a few wood chips The notion of giving can also be reframed. I think depletion is the wrong attitude towards giving. For me, in the course of my clinical interactions, I come away fulfilled and often thank clients for allowing me to help them. Assisting people in the process of growing ennobles me; it is the moment of grace that justifies my entering a helping profession. In order to give I have to be also sure that I have taken care of my own needs first. I need to give from my abundance not from my own neediness. In flying, we are often reminded by the stewardess that if we are traveling with a child and the oxygen mask deploys we are to put the mask on our face first. How could we help our child if we are unconscious? This makes good sense but is not always understood by parents; it is a powerful metaphor for the helping professional. Self-care comes first and helping is secondary to that. Leadership is what you have left over after you have taken care of yourself.

Self-care also should involve a commitment to personal growth. The best clinical "tool" is myself and much as the audiologist sends his audiometer out to be recalibrated, I need to find experiences that help me personally "recalibrate". During the course of my 40-year clinical experience, I have taken sensitivity groups promoting personal growth. I have also taken an Outward Bound experience, explored Yoga, massage and recently a workshop in abandonment. I have gone on several Buddhist retreats, which have

given me an opportunity to reflect on my life and to incorporate an authentic living style. We need periodic timeouts. I am reminded of the story I read in a running magazine. The author was in the lead truck watching Bill Rogers run the Boston Marathon in then record time. To his amazement, Rogers stopped occasionally at a water stop and calmly looked around. The author thought at first that if he hadn't stopped he might have broken the record by an even greater amount. But after he reflected a while he realized that Rogers had set the record precisely because he had stopped. Running on empty is just not going to do it.

I must also find in my daily living those activities that help me center myself .For me repetitive activities such as gardening, making bread and exercise seem to work. I am an inept meditator although I keep trying and meditate with my students in the counseling class. Meditation is very appealing as a centering activity because it is so portable. I need only to shut the door to my office and sit quietly focused on my breathing to center myself; my treadmill just doesn't travel well. I have found the book *Wherever You go There You Are* by Jon Kabat-Zinn to be very helpful in both delineating Buddhist thought and as a guide to meditation. In fact, I read excerpts from it before I meditate with the counseling students.

The key to counseling is the congruence of the counselor: as congruence increases technique slips away or more accurately becomes infused into personality. It is not necessary to be an entirely congruent person to be an effective helper; this is a goal one should be constantly seeking. To be effective the helper needs to have a deep interest in people and sensitivity to others. One needs to be a caring individual who does not impose beliefs on others, who maintains a constant awareness of self and strives always for mindfulness in every day living. Professional growth and our ability to be truly helpful will be measured by how we grow as individuals. We owe our clients and our profession no less.

***David Luterman is Professor Emeritus Emerson Co*LISTEN**

When I ask you to listen to me and you start giving advice you have not done what I asked.

When I ask you to listen to me and you begin to tell me why I shouldn't feel that way you are trampling on my feelings.

When I ask you to listen to me and you feel you have to do something to solve my problem, you have failed me, strange as that might seem.

Listen! All I asked was that you listen. Not talk or do-just hear me.

Advice is cheap:10 cents will get you both Dear Abby and Billy Graham in the same newspaper.

And I can do for myself: I am not helpless. Maybe discouraged and faltering, but not helpless.

When you do something for me that I can and need to do for myself you contribute to my fear and weakness.

But, when you accept as a simple fact that I do feel what I feel, no matter how irrational, then I can quit trying to convince you and can get about the business of understanding what's behind this irrational feeling..

And when that's clear ,the answers are obvious and I don't need advice.

Irrational feelings make sense when we understand what is behind them.

Perhaps that is why prayer works, sometimes for some people because God is mute, and He doesn't try to fix things." They" just listen and let you work it out for yourself.

So, please listen and just hear me. And ,if you want to talk,. wait a minute for your turn and; I will listen to you.

Annonymous

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