Chapter 1

COUNSELING IN CLINICAL PRACTICE: OVERVIEW

Introduction

Speech-language pathologists and audiologists (SLP-As) bring expertise in specific clinical areas to the evaluation and management of communication disorders. Both students and practicing clinicians need to develop counseling skills if they are to serve clients and their families effectively. Counseling is necessary to support decisions and behaviors that optimize quality of life. Knowledge of effective counseling techniques supplements the professional's knowledge about communication disorders and his or her skills in managing these disorders. Finally, appropriate counseling greatly increases the opportunity for an optimal outcome for clients, whether this involves resolving a specific disorder or maximizing quality of life by means of coping and adjustment techniques.

The role of speech-language-hearing professionals is usually complex. Children with severe hearing losses or cerebral palsy, along with their families, face lifelong struggles. Complex problems

arise at the other end of the age spectrum as well: Adults who acquire aphasia or dementia, for example, must learn to deal with profoundly changed lives. Our treatment goals for individuals with communication disorders are certainly to minimize the disorder's effects, but counseling also can help involved persons to live productively and successfully with the communication problems, or despite them, or around them.

Effective counseling principles are both learnable and fairly general: The techniques and skills are similar for helping a family with a new baby who has a cleft palate or a hearing deficit and for supporting an adult client with poststroke aphasia, and his family, who face the realities of living with impaired communication. The disorder-specific facts differ, of course, and require disorder-specific understanding of them as well. According to the American Speech-Language-Hearing Association's (ASHA) Scope of Practice statements for speech-language pathology (2007) and for audiology (2004), counseling is an integral part of clinical responsibility for both families and children with speech, language, and hearing disorders, and for adults who have acquired such disorders. Counseling is the basic tool we have to help our clients achieve their lifelong goals. SLP-As often feel uncomfortable about the counseling role, however, and consequently are reluctant to undertake it.

A number of reasons may underlie this reluctance. Perhaps a lack of explicit training in counseling explains it. During our professional education, we are given a wealth of information about the potential problems confronting individuals and families with communication disorders but are taught very little about how the counseling process can be used to help resolve them. Indeed, the ASHA provides no curriculum requirements for SLPs. In their case, it is likely to be tagged onto the end of disorder-specific courses, rather than presented in its own right as a skill to be learned through coursework and practice. The curriculum for AuDs is more enlightened: a counseling course is required.

Counseling for individuals with communication problems has been strongly influenced in the past by traditional concepts derived for counseling individuals with psychological problems. Basic information concerning Freudian defense mechanisms, and the client-centered approaches pioneered by Carl Rogers (1995), have

been particularly influential in our field. We suspect that another factor contributing to the reluctance of SLPs to assume a counseling role is that we recognize the implicit mismatch between the forms of counseling originally developed for individuals with disorders such as anxiety or depression and problems faced by individuals who stutter, or for a family with financial problems stemming from the breadwinner's Parkinson disease or incapacitation following a motor vehicle accident.

People who are in need of communication counseling are likely to have been coping with their lives fairly normally before the onset of the communication disorder. This is not to say that individuals with psychological or behavioral problems are immune to communication problems, but a majority of the people for whom SLP-As provide counseling or coaching probably react to the world in ways that are not pathologic. The abnormal models of counseling do not fit very well; they are difficult to apply in clinical practice, even after we have taken a course or two in abnormal psychology. Most communication problems have unique, significant, and reverberating effects on families, who are likely to be as unprepared for them as those who actually incur the problems. Our discipline's reliance on abnormal psychology has seldom been questioned or examined, although it may explain at least partially why many practitioners feel uneasy with their counseling roles.

In this book, counseling for communication disorders has a different theoretical perspective. This approach requires essentially abandoning a treatment model based on what is *wrong* with people who have such disorders. Instead, the emphasis is on what is *right* with them, and how they can mobilize their strengths to deal with the adversities that have befallen them as the result of an unexpected event that threatens one of the most basic human characteristics—the ability to communicate. Thus, the counseling process starts with the assumption that the cup is half full, not half empty. Before onset or recognition of a communication disorder, the affected person and his or her family—whether an adult client who has experienced a stroke with resultant aphasia or the parent of a newborn infant who has been found to be at risk for such a disorder, for example—probably already have been coping reasonably well with life stresses. How do we as counselors capitalize on, and build on, the positive?

Themes of Interest

Five themes that focus on how to help individuals with communication disorders to develop optimism and resilience constitute a framework for this book. These themes are described next, in no implied hierarchy; all are equally important.

Theme 1: Wellness and Positive Psychology

Much of the content of this book is based on a conviction that appropriate models and approaches for communication counseling should be grounded in what we know about normality and wellness rather than in what we know about illness and psychopathology. The recent explosion of information about and interest in positive psychology provides the best example, particularly as it is illuminated by the work of M. E. P. Seligman and his colleagues. Here is just a sampling of relevant books on positive psychology published since 2002, following the publication of Seligman's *Authentic Happiness*, which was published then. Some of these important books include: Ben-Shahar, 2010; Diener and Biswas-Diener, 2008; Fredrickson, 2009; Haidt, 2006; Peterson, 2006; Reivich and Shatté, 2002; and Seligman's most recent book (2011), which significantly increases the worldview of the movement. More detailed exploration is central to Chapter 2 of this book.

The first theme of this book is its reliance on the principles and tenets of *positive psychology*, focusing on mental health and well-being and how to achieve and maintain them. Positive psychology is oriented away from illness and toward wellness, both for understanding what it means to live positively and for providing ways to increase authentic happiness in one's own life and to promote a healthier society in general. This book links those principles to counseling individuals and families who experience and live with communication disorders.

One of the most appealing aspects of focusing on wellness and positive psychology as a counseling model in communication disorders is that it fits squarely with the facet of counseling with which SLP-As are most comfortable: providing information. We are skilled educators and good providers of information. Training in

speech-language pathology and audiology produces good teachers, whether we are teaching children to move a lateral lisp into a more acceptable /s/ production, or reestablishing semantic skills in aphasic adults, or teaching effective hearing aid use. Counseling is a change process, as are many of the other techniques used by SLP-As. To the extent that our counseling can capitalize on our teaching skills, we can become comfortable with a counseling role.

A core feature of positive psychology is its development of explicit ways to increase resilience and optimism. These two attributes are particularly critical for learning to cope with the many disasters or catastrophes that occur in the process of simply living life. Basic principles of positive psychology are covered in Chapter 2, and a number of its experimentally validated exercises are presented there. Other exercises that have been adapted specifically for communication counseling are scattered throughout the book.

Theme 2: Living the Catastrophe, Dealing with Crisis

In this book, the words "catastrophe" and "catastrophic" generally are used in the conventional sense of *disaster* and *disastrous*. They imply the kinds of wrenching problems that result from the spectrum of communication disorders ranging from developmental disorders discovered in infancy to the dementias that occur late in life. But *catastrophe* is also used in this book in the sense that Jon Kabat-Zinn used it in his book on stress reduction and meditation, *Full Catastrophe Living* (anniversary edition, 2005). Kabat-Zinn borrowed his title in part from Kazantzakis' *Zorba the Greek* (1996). In the film adaptation of Kazantzakis' book, Zorba responds to the question of whether he was ever married: "Of course I've been married. Wife, house, kids, everything . . . the full catastrophe!" Kabat-Zinn interpreted Zorba's remark as a basic appreciation of the roller-coaster nature of being alive. This usage of the word *catastrophe* embodies the spirit of accepting change and knowing that, in Kabat-Zinn's words:

> . . . it is not a disaster to be alive just because we feel fear and we suffer . . . [to understand] that there is joy as well as suffering, hope as well as despair, calm as well as agitation, love as well as hatred, health as well as illness . . . (p. 5)

The "full catastrophe" for most people involves good *and* bad, easy *and* hard, periods of happiness *and* periods of pain. In fact, someone who manages to avoid the negatives may be perceived in some way as diminished (and perhaps likely to be rather boring!). Although the issues we deal with in our communication counseling gravitate toward the negative pole, it is crucial to remember that the opposite, the positive, also is there. Good counselors respect and honor not only their clients and their problems but also the "full catastrophe" of the human condition.

Crisis models may be useful for clinicians who deal with the full catastrophe of parents experiencing that their child has Down syndrome, or that aphasia has resulted from the stroke one's husband has incurred. Before most people can accept the bad, they have to acknowledge it and come to peace with it. Crisis models, developed by Elisabeth Kübler-Ross for dealing with grief, death, and dying (1969), have been useful with many chronic health issues as well. Although her model has significant shortcomings, as adapted by Webster and Newhoff (1981) for our professions it can be useful for elucidating the process whereby individuals can learn to deal with catastrophic events.

Four stages are postulated to occur as individuals progress toward healthy resolution. These stages are called various names by various authors. In this book, Webster and Newhoff's terms are used. These are, in order, shock, realization, retreat, and acknowledgment. Certainly, not all individuals go through all stages in an orderly fashion, and not all individuals actually reach satisfactory acknowledgment. In fact, Goldberg (2006) commented that in his extensive experience as a hospice counselor, he has never observed an individual who followed precisely these stages of grief. Nevertheless, these stages should be kept in mind by SLP-As for their counseling work with parents, spouses, and persons who have experienced sudden catastrophic illnesses.

Immediately after a catastrophe, neither the family nor the person who has experienced it is in a particularly good position to take advantage of information concerning the problem offered then. Nevertheless, almost without exception, experienced clinicians routinely provide such information. Frequently, however, SLPs whose work focuses on chronic aphasia hear comments from clients and their families that "things were not explained" and that they had no idea what to expect. In such instances, the shock of the stroke may compromise the ability of the affected person and family mem-

bers to absorb new information in the earliest stages of recovery. This limitation does not mean that clinicians should stop providing information in the initial aftermath of a potentially disabling event. But we should not be surprised when affected individuals and families fail to comprehend all of the early information they receive, and we should be prepared to repeat it, perhaps frequently.

Of greater importance, this initial failure to comprehend or retain relevant information means that the first of Webster's (1977) counseling functions—listening—should be primary. Webster points out that listening to what people wish to share and to their fears about the future, and simply holding hands and being present, are what matters at this time. It also is valuable to provide information that is more permanent than the spoken word. Pamphlets, videotapes, and contact information sheets and the like will be useful later, when the realization stage is reached. Once the client and family members realize what this problem may actually entail, written information and relevant telephone numbers can be used productively.

Retreat is likely to be the least universal of these four crisis stages, at least for the types of problems encountered by SLP-As; however, retreat can manifest as denial that a problem actually exists or that the disorder will have a major impact in the long run. For example, Dora, the spouse of a man who has recently suffered a major stroke, comments, "Ralph may have global aphasia, but you don't know his will. He'll be back to work at his old job in 6 months, mark my words." As counselors, we must be aware of the delicate nature of such denial, as well as of the need to deal with denial when it occurs.

It is not uncommon for clinics to have spouses rate communication of their communication-impaired partner using the Communication Effectiveness Index (CETI) (Lomas, Pickard, Bester, Elbard, Findlayson, & Zoghabib, 1989). A frequent outcome is that early in the rehab process, spouses rate their partners as substantially higher than on CETIs taken later in the recovery process. After families have lived with a disorder for a longer period of time, problems often become more apparent. When Dora realizes Ralph is not back at work yet, and that their future may be very different from the one she has envisioned, counseling offers the mechanism for her reassessment.

Acknowledgment of the problem is not a synonym for giving up. Acknowledgment is recognizing the reality of the individual's

condition, making room for the changes, and moving on with life. Ram Dass (2000, p. 185), who completed his book *Still Here* after experiencing a stroke that resulted in aphasia and hemiplegia, eloquently described the good that resulted from acknowledging his deficit. He comments:

> The stroke was like a samurai sword, cutting apart the two halves of my life. It was a demarcation between the two stages. In a way, it's been like having two incarnations in one; this is me that was "him" . . . Seeing it that way saves me from the suffering of making comparisons, of thinking about the things I used to do but can't do anymore because of the paralysis in my hand. In the "past incarnation" I had an MG with a stick shift, I had golf clubs, I had a cello. Now I don't have any use for those things! New incarnation!

Theme 3: Change

Implicit in the above is that, as people live into their "full catastrophes" and move through their crises, differing counseling needs may appear, as well as different strategies for clinical management of problems that have evolved. Change is a reality of life, but this is a profession that counts on our knowing how to make it happen. Change is often assumed to be a matter of applying some behavioral techniques we learned in psychology class to the communication problems we learned about in excruciating detail in graduate school. But change is hard, and it demands some attention in its own right.

Consider 5-year-old Alan with a relatively clear-cut phonological problem involving his use of /s/. Alan began talking at around 2 years of age, and the /s/sound he started out with is the one he continues to use. None of us can dare to estimate how much practice he has had with it, but all of us can see the difficulty of expecting him to change it in a semester's worth of clinical time. *That* we would like to get him to change is one thing; *how* to accomplish it is another. The techniques for effecting this are within our counseling purview (and involve his parents and Alan, of course).

Change issues are not unique to children. The issues become accentuated with communication disorders in aging. Lifestyles, attitudes, behaviors that increase the probability of another stroke,

and role reversals all involve changes. Here is a pertinent clinical example: An aging investment banker who has recently suffered an aphasia-producing stroke must learn to trust the clinician sitting across from him as she instructs him on word finding, that is, following the advice of a clinician likely to be nearer his daughter's age than his own. The task, the situation and its history, and the age gap all potentially require some element of change if they are to be managed well. We consider change and how to effect it more directly in Chapter 3, but change is a pervasive theme throughout our clinical work and shows up in other chapters as well. Change, however, serves as a good introduction to our next theme.

Theme 4: Who Are the Experts?

The social model of disability has been growing in strength and influence over the past 30 years. It has significant implications for the practice of speech-language pathology and audiology. Perhaps its greatest significance relates to our profession's counseling functions. Briefly put, the social model makes it clear that disability itself is not a problem of disabled persons alone; it also is a substantial result of living in disabling societies. Furthermore, disability is perhaps not a tragedy but a fact of life (part of the whole catastrophe, as it were). Finally, the problems faced by people with disabilities are broad social ones, requiring similarly broad social solutions and sweeping attitudinal change on the part of the nondisabled, including the professionals who work with them.

The disability movement (Barnes, Mercer, & Shakespeare, 1999; Oliver, 1996) embodies those social concerns and has had a significant impact on the development of the International Classification of Functioning and Disability (ICF) (World Health Organization, 2001). Although full discussion of the ICF is beyond the scope of this book, it is a topic with which all SLP-As must become familiar. One important implication for counseling is that the social model of disability insists that societies rethink the question of expertise in relation to any disabling condition. It asks the question, "Who is the expert?" This question has powerful ramifications for counseling. People with disabilities have strongly challenged the traditional assumption that *professional* is synonymous with *expert*. In this book, we challenge that assumption as well.

The initial approach to counseling should recognize that as SLP-As, we have an undeniable expertise consisting of our technical knowledge and our ability to compile the resources that might be available to our clients. But does this expertise ensure that we are the experts? In fact, at least one and possibly two or three other experts are involved. One of these other experts is the person who lives *in* the disorder. (This is particularly relevant for adolescents and adults who have incurred their disorders after they have achieved some autonomy.) The final experts are those who live *with* the disorder. This means families and significant others. In much the same way in which meaning in conversation is co-constructed by a speaker and a listener, counseling is co-constructed by these experts—that is, the disabled person, those whose lives are connected to the disabled person, and the counselor.

This expanded concept of "expert" became apparent to Audrey even before the advent of the social model of disability. As a beginning clinician, I often found myself smugly amused when parents would comment about their child, "He never acts like this at home." "Hmm," I would think, "it's amazing what sort of blinders parents wear, particularly if experts aren't around." Then I had children. The first time I heard myself utter, "He isn't like this at home," I recognized my professional limitations as the expert. I learned that as clinicians, we could claim only one of the two or three places at the experts' table. Ryan's experiences in fatherhood led him to the same conclusion.

Theme 5: The Importance of Stories

The fifth theme of this book involves narrative as it relates to problem solving and counseling. Telling one's own story is part of the healing process that precedes the development of resilience and optimism. It is crucial. Illness narratives contain a lot of the narrator's power; see the writings of Coles (1989), Frank (1995), and Kleinman (1988) for excellent examples of the genre of illness narrative. Hinckley (2006) and Shadden, Hagstrom, and Koski (2008) have addressed this topic in relation to stories written by persons with aphasia and other neurogenic communication disorders and their families. In his novel *Still Life with Woodpecker* (1980), Tom Robbins notes that we "all star in our own movie."

This is a profound notion.[1] We learn from ourselves as we hear ourselves tell our own stories. We also learn when we listen to each other's stories (in effect, when we "go to" each other's movies) and derive important lessons and role models from them. When interviewer Charlie Rose recently asked U2's Bono to tell his story, the truly remarkable musician and humanitarian commented that "Everybody's story is valuable . . . mine is not more important than everyone else's."

A sage aphasic client pointed out that one of the most healing aspects of his aphasia group was the frequent ritual of each group member telling the story of his or her stroke and the progress that person has made since its onset. These stories never lost their centrality, and each new member was always welcomed into the group with telling and sharing the stories of the veteran group members, as well as the story of the new member. When Holland, Cherney, and Halper (2010) asked a fairly large sample of aphasic individuals to develop monologues that they subsequently learned to produce, the clear topic of choice was the story of their aphasia. In most cases their narratives included comments reminding their listeners that they were the same person they were before the stroke, and that they continued to get better, however long ago their stroke occurred.

Accordingly, stories about real people with real communication problems appear frequently throughout this book. These stories are positive but usually not heroic. They are simply everyday instances of getting along with life, of moving on. They reflect the importance of positive attitudes and behaviors, and they serve to remind us of the importance of finding and using such stories and role models in counseling.

Summary of Themes

Wellness and positive psychology, the full catastrophe and crisis, change, shared expertise, and narrative, are essential elements of the counseling approach developed in this book. These elements

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[1]But as Chodron (2001) points out, "It is possible to move through the drama of our lives without believing so earnestly in the character we play." This serves as a reminder of our role in the big scheme of things, and of our need for perspective. This is important, too.

form the basis for the concepts, techniques, skills, and exercises presented throughout the text as tools to increase the effectiveness of SLP-As in counseling clients and families across the spectrum of communication disorders. First, however, a number of definitions need to be clarified to permit their use as a kind of shorthand in the rest of this book. Finally, a few other topics, such as the role of group and individual counseling, are dealt with briefly in this overview.

Definitions

What Is Counseling in Communication Disorders?

Counseling is, above all, a listening process. The first task of this process involves *trying to understand how the world looks to clients*. This requires careful self-examination of the SLP-A's personal, subjective worldview, and then systematically taking the steps necessary to remove personal biases that would compromise the listening process. Once unbiased listening has been learned and practiced, we can apply it in our counseling for clients whose worldview, cultural beliefs, and personal principles may differ significantly from our own. The ability to see how the world looks to our clients provides the context for understanding and acceptance that makes clients comfortable enough to express their feelings, concerns, anxieties, and so forth. The second task of counseling is to *encourage their expression*. The clinical atmosphere for counseling must ensure that a client feels safe, as well as cherished and respected. The third task in the counseling process is *advising*, that is, providing the information that people need to help them understand what is happening to them, as well as showing them how to get on with their lives and live in a realistic fashion, with both optimism and resilience. Then comes the last task of counseling and the most difficult step: *helping individuals to translate information into satisfying and successful actions*. (Note that in this paragraph, the themes of wellness, narrative, and change have already come up.)

The goal of the counseling process is to help individuals and families to live as successfully as they possibly can, despite the intrusion of events such as a motor vehicle accident that results in a child's traumatic brain injury, a stroke that occurs just as retirement

is nearing, a dawning awareness of an infant's developmental disability, or any of a score of other catastrophic events that result in communication disorders. (Now note that the theme of catastrophe and crisis has joined in.)

The major aspects of communication counseling were identified many years ago by Webster (1977), as follows:

■ To receive information that the individual and his or her family wish to share with you
■ To give information
■ To help individuals clarify their ideas, attitudes, emotions, and beliefs
■ To provide options for changing behaviors.

Note that this last point does *not* mean prescribing therapy or even necessarily advocating for a particular form of intervention. It merely means providing all of the information necessary for clients to make their own informed decisions from among the range of alternatives. (Here is the theme of recognizing the client as an expert.)

The intent of counseling with communicatively impaired persons and their families is to help them achieve the following:

■ To grieve what has been lost
■ To understand what has happened as fully as possible
■ To develop coping strategies and to increase resilience
■ To make peace with the disorder
■ To make sensible adaptations to the disorder
■ To capitalize on strengths in order to minimize weaknesses
■ To live as fully as possible, despite impairment.

(All the themes are now mentioned.)

What Is *Not* Counseling in Communication Disorders?

Although frequently taught together, counseling and interviewing have different goals and therefore are merely related processes. For example, a veritable chasm separates taking a case history from listening to a story and reacting appropriately to that story. *Interviewing* is the skill of finding out about another (in this case, someone with a communication disorder or a family member) through perceptive questioning and observation. In contrast to

the counseling goals described earlier, the goal of interviewing is to provide the clinician with valid and pertinent information that informs the entire clinical process, including appropriate methods of intervention. This book is not about interviewing—it is about communication counseling.

Because the primary training of SLP-As is in communication sciences and disorders, not in clinical psychology or psychiatry, our clinical skills have implicit limitations and boundaries. Practically every specialized counseling textbook stresses the importance of placing some limits on counseling performed by the respective specialists. Counseling in our disciplines is no exception. The ASHA Scope of Practice statements for both audiology and speech-language pathology (ASHA, 2007, 2004) limit our counseling responsibilities to those that relate to communication disorders.

As counselors to clients with communication disorders, we are not clinical psychologists, and as is reiterated throughout this book, one of our primary sensitivities must be to know when our skills are not enough, and when referrals to other professionals such as psychiatrists, psychologists, genetic counselors, or social workers are appropriate. Box 1–1 lists some activities that can be considered outside the scope of practice for communication counselors.

In the remainder of this book, the term *communication counseling* replaces the rather burdensome phrase "counseling individuals and their families who have communication disorders." Use of this term should provide a continual reminder of the boundaries of our counseling work.

Coaching

Coaching is a fast-growing new entry in the broad field of the helping professions and is relevant to communication counseling; thus, a brief note on coaching is in order here. Audrey has been trained as a life coach, but both of us practice many of its principles and tactics primarily in helping people (with and without language disorders) to age and to do it successfully, and in helping adult children to plan with and support their aging parents. The principles and skills of life coaching provide at least as pertinent a model for SLP-As as that on which more conventionally defined counseling is based. Coaching is a process that is grounded in wellness. Its emphasis is on normalcy and health, on correctly identifying sources of

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**Box 1–1. Outside the Scope of Practice of
Speech-Language Pathologists and Audiologists:
Selected Activities**

As SLP-As, we do not have the background that would permit us to predict:

- The outcome and course of recovery for Mr. A's aphasia
  We are not fortune-tellers.
- Whether Ms. G's next child also will have a hearing loss
  Not only are we not fortune-tellers, but also we are not genetic counselors.
- If Mark and Arlene's marriage will survive their child's traumatic brain injury
  We are not fortune-tellers, genetic counselors, or marriage counselors.
- What the course of Mrs. Z's Alzheimer disease will be
  We are not fortune-tellers, genetic counselors, marriage counselors, or neuropsychologists. Furthermore, no true professional would attempt to make such predictions.

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problems and teaching problem-solving skills to apply to them, and developing and implementing pertinent action plans. Coaching also focuses on differentiating those problems that are within a person's ability to control from those that are beyond such control.

Process-Specific Definitions

Who Practices Communication Counseling?

Who are the health-related professionals who practice communication counseling? The answer, of course, is SLP-As.

With Whom Is Communication Counseling Practiced?

In identifying those persons with whom communication counseling is practiced, no term is entirely suitable. The word "patient" implies

sickness. The phrase "individuals with speech, language, or hearing disorders" (much less "and their families") seems just too big a mouthful. So for simplicity, currency, and clarity, the term "client" is used throughout this book; thus, SLP-As practice communication counseling with their clients.[2]

When Does an SLP-A Provide Counseling?

Communication counselors at times may set aside sessions for counseling their clients. An example of such sessions is the resilience and optimism-building workshop models described in Chapter 8. The counseling provided by SLP-As, however, is more likely to be accomplished "on the fly" or around the edges of more traditional therapy, during more communication-focused intervention sessions with adult clients, for example, when an aphasic man with inconsistent family support may express doubts about the value of this therapy for him, or when a dysarthric woman whose progress has failed to meet her expectations voices her disappointment.

These instances may reveal important relevant information, for example, that sleeping problems are interfering with concentration. Counseling also often gets tucked into brief parent or family encounters at the beginning of a session, before more structured treatment begins, or at its end, when we may be summarizing what happened during the session itself. A useful term for such mini-encounters is "counseling moments" (examples are provided throughout this book). As effective communication counselors, we must be alert for these moments and be prepared to practice our counseling skills in ongoing, small, and even casual interactions throughout more focused clinical interventions.

A Note on Depression and Communication Disorders

It is necessary to be emphatic about the association between communication disorders and depression and learned helplessness (Seligman, 1975). Without exception, communication disorders

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[2]In this context, it is striking how overwrought the language of this discipline is. This is rather ironic, because a basic belief of the profession concerns clear, concise, intelligible, and, for some people, even "functional" language.

potentially can result in reactive depression for both the affected person and family members. With disorders that involve brain damage, concomitant depression may be brought about by faulty or disturbed patterns of normal neural transmission. Finally, some clients may have come to their present disorder already depressed. Nevertheless, it is essential to recognize that counselors in communication disorders lack the technical skills and the credentials to treat depression, either behaviorally or pharmacologically. But because depression is so likely to co-occur with the catastrophic problems we deal with, it is extremely important for us to be highly sensitive to problems that forecast it. Although the newly released *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-V, American Psychiatric Association, 2013) has modified its classification of depressive disorders to some extent, the following still serve us well as characteristics of depression: mood disorders, lack of zest, unexplained weight loss, sleeping problems, psychomotor problems, excessive fatigue, feelings of worthlessness, and statements of futility. When these indicators are present, the ethical responsibility of the SLP-A is to state relevant concerns directly, make appropriate referrals, and provide adequate follow-up regarding implementation of recommendations.[3]

Organization of the Rest of the Book

As noted earlier, Chapter 2 provides an introduction to positive psychology, which is the theoretical heart of this book's approach to communication counseling. Chapter 3 concerns clinical skills and specific techniques. The next four chapters focus specifically on counseling in communication disorders. They are developed according to a lifespan perspective. Thus, counseling in the context and perspective of parents of children at risk for or with communication problems in childhood is the first of these chapters (Chapter 4).

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[3]Note that both authors accept mutual responsibility for all of the opinions in this book; however because we both often prefer to use personal pronouns, the "I" in the adult chapters is more likely to be ALH and the "I" in the child chapters is more likely to be RLN. But mostly we use Audrey or Ryan to disambiguate ourselves. The "I" that occurs in Chapter 9, refers to Stan Goldberg, who contributed that chapter.

Its focus is on working with parents and primary caregivers, in keeping with the principle that counseling without family "buy-in" will have only limited effectiveness. Counseling issues concerning children and adolescents with communication disorders are addressed in Chapter 5. Although many of the issues parents consider are similar, there are unique opportunities for productive counseling in our working with children as we assist them in meeting the aims of counseling described in Chapter 3.

Chapters 6 and 7 focus on adults. Chapter 6 concerns disorders whose natural progression is toward improvement (e.g., stroke, traumatic brain injury in adults, hearing disorders). Individual and group work is discussed for both individuals who have such disorders and their significant others. Chapter 7 concerns disorders whose natural progression is toward deterioration (e.g., Alzheimer disease, Parkinson disease). Chapter 8 presents some templates for workshops in resilience and optimism that can be adapted for use with families across the age span and for how to counsel individuals with communication disorders when time is the issue. Chapter 9, a gift from the pen of noted authority Stan Goldberg, provides insights into counseling for dying patients—an area that is virtually unmentioned in our field, yet one in which practitioners increasingly find themselves.

The "clinical" chapters (Chapters 4–7) are somewhat similarly ordered. Each chapter is organized to address issues that are unique in terms of the relevant information and counseling needs. We attend to both individual and group work. As noted previously, valuing stories and illness narratives is a critical part of the counseling process, so each chapter includes real stories about real problems providing everyday examples of a successful, positive, resilient outcome. Finally, each clinical chapter includes relevant learning exercises and formats for clinicians to use as practice. These exercises come mostly from our experiences in teaching communication counseling to graduate students.

There were significant, untouched topics in the first edition of this book. We wanted to more directly address issues associated with helping parents and families navigate the bureaucracy of systems and other areas of potential frustration. We also felt a need to more explicitly address communication counseling with children. Furthermore, the first edition did not cover issues such as counseling adult children of aging parents, attending to the specific needs

of adults with hearing impairments, the issue of worries about mild cognitive impairment, or the specific problems of aging parents who have raised to adulthood their children with chronic disabilities and communication disorders. To the extent possible, we have tried to accommodate these issues here. Of note, the principles embodied in the "wellness" approach to counseling are relevant to all of these issues and can be straightforwardly applied in appropriate instances.

Counseling skills cannot be learned effectively by reading about them; rather, they are best learned through practice in constrained and nurturing environments, and through growing self-knowledge and introspection on the part of the learner. It is particularly critical for the SLP-A to think through personally experienced counseling moments and to evaluate them in ways suggested in this text.

The book's organization is based on the following assumptions. First, although a set of overarching principles is outlined for communication counseling, certain principles have more importance at some stages of the lifespan than at others. Such age specificity is a good reason for taking a lifespan approach. Furthermore, it seems unnecessary to differentiate a set of counseling principles aimed at specific problems. Principles that apply to counseling the parents of an at-risk infant (for example, helping them to become maximally resilient) apply across a wide range of disorders. Thus, each chapter presents a few disorders as illustrations or focal points, but the relevant techniques and skills have implications for the management of many other related disorders. These "focus disorders" are highly representative of the broader class of disorders that share their basic characteristics. Skilled clinicians rely on information concerning the facts of a given disorder, on community resources, and on the Internet. Such information itself is not inherent in the counseling process, but counseling certainly depends on it.

The Formalities

Finally, it is necessary to discuss the formalities of counseling for our profession. The most important ones are differences between group and individual counseling, the timing of counseling, and its intensity; these are discussed briefly next.

Group and Individual Counseling

A natural inclination is to relegate group counseling and individual counseling to two separate, mutually exclusive categories, each of which is restricted to use in specific circumstances or for specific clients. This view is difficult to justify, however. Both modes are effective, and they can even be undertaken simultaneously.

Our own clinical experience bears this out. Along with our commitment to shared expertise, we are inclined to favor group counseling. We like the notion of even more than two or three experts in a room. Short-term discussion groups and workshops for families concerning specific disorders provide an opportunity to promote and foster shared stories and problem solving. Skill-focused workshops on topics such as developing resilience or learning effective parenting techniques, or learning to change listening patterns and to tolerate hearing aids for older individuals, are excellent venues for sharing informational aspects of the counseling process.

Alternatively, there is undeniable value in one-on-one interactions as well, but much of this work, as mentioned earlier, occurs at the outset or conclusion of more direct intervention, or is nestled into such sessions.

Timing and Intensity of Counseling

Whether it is with individuals or groups, counseling should begin in the earliest phases of treatment, when it is most needed. This is true across the age spectrum, from parents' initial recognition that their child is at risk, to the early days following a stroke or a diagnosis of Alzheimer disease or hearing loss. As mentioned earlier, providing information is just one of the functions of counseling, particularly early on. It also is important to remember that support and reassurance, as well as information, will continue to be needed as life with a problem is lived, but that the intensity of those needs should diminish; thus, counseling often occurs in those counseling moments described earlier. Finally, a point worth repeating is that counseling is more than just a set of skills to be practiced with clients; it also incorporates perceptiveness and an attitude of respect and sensitivity that permeates every aspect of every clinical interaction.

Conclusion

This chapter provides an overview of a principled approach to communication counseling with a focus somewhat different from our profession's more traditional approaches. Although the SLP-A may view a leap into this relative unknown as a risky undertaking, the novel principles and techniques presented here are neither untested nor without application in other fields.

In the following poem, the rewards of maintaining an openness to change, despite its risks, are well illustrated:

<div align="center">

"The Guest House"

</div>

This being human is a guest house.
Every morning a new arrival.

A joy, a depression, a meanness,
some momentary awareness comes
as an unexpected visitor.

Welcome and entertain them all!
Even if they're a crowd of sorrows,
Who violently sweep your house
empty of its furniture.

Still, treat each guest honorably.
He may be cleaning you out
for some new delight.

The dark moment, the shame, the malice,
Meet them at the door laughing,
and invite them in.

Be grateful for whoever comes,
Because each has been sent
as a guide from beyond.

—Jalal al-Din Rumi
The Essential Rumi, translations by
Coleman Barks with John Moyne,
1995. Reprinted with permission
from HarperCollins.

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