# Counseling in Speech-Language Pathology and Audiology

## Reconstructing Personal Narratives

**Anthony DiLollo, PhD, CCC-SLP**
**Robert A. Neimeyer, PhD**

# CONTENTS

# FOREWORD

It is a pleasure to be asked to prepare a foreword for any good book. But it is a special pleasure to do so when you are familiar with the authors' work and look forward to reading chapters that you know will be thoughtfully and skillfully prepared. Students and professional clinicians in the professions of speech-language pathology and audiology will find this book an essential tool in their therapeutic practice. As I read through the concise and engaging chapters, I often found myself thinking of the many clinicians who—as the research indicates—are hesitant about counseling their clients. Although all readers and their clients will benefit from this book, it is the hesitant clinicians who will find this book especially useful. DiLollo and Neimeyer provide the clinician with a clear theoretical rationale and intuitively appealing processes for connecting with and assisting clients with communication problems. Readers will be moved by the case illustrations that document the heroic journeys that are possible as a result of effective counseling for communication problems.

The authors explain in the preface that their goal in writing this book is "to provide an empirically informed and practically oriented manual for counseling clients with a broad range of communication disorders" (p. X). Their many years of counseling experience are necessary for achieving this goal. But it's their thoughtful sequencing of the 26 chapters and their clear and engaging writing style that make it happen.

The early chapters provide a model that includes counseling as a natural and essential feature of the therapeutic experience for those with communication problems. The authors also document that counseling is clearly within the scope of practice for professionals in our discipline and that effective therapy and counseling are inseparable. They make the essential point that, in the vast

majority of cases, we are assisting essentially healthy people who must cope with specific communication problems rather than people who need help with more basic personality issues. Of the four levels of progressively more concentrated counseling outlined in Chapter 2, the first two levels of counseling, focusing on a greater understanding of the client's situation and the client's ability to experiment and adapt to more effective coping, are all that is necessary for most individuals.

In Chapter 3, the authors describe the unique stance of the clinician as one of "adaptive leadership" rather than providing a service intended to "fix" the client. Rather than considering the person through the lens of the medical model where a breakdown in the system needs to be repaired, a more holistic approach is offered that considers the person as a complex adaptive system where changes to one part of the system results in changes to other parts. The primary goal of the clinician is to mobilize the client to do the work that is necessary for change to occur. Adaptive leadership by the clinician leads to adaptive change by the clients, with clients experimenting, not only with new ways of behaving, but also with new ways of conceptualizing themselves and their situations. In this chapter and throughout the book, the authors provide vivid examples of clinical experiences that illustrate the concepts and techniques that are necessary for change.

Part II (Chapters 4–8) provides clear descriptions of the theoretical foundations of counseling (humanistic therapy, behavior therapy, and cognitive therapy) and introduces the reader to the primary focus of the book, the constructivist-narrative approach. Part III (Chapters 9–13) describes the processes that are part of the constructivist-narrative approach, with each process accompanied by a case description that is both vivid and moving.

The reader begins to appreciate that at the core of the constructivist-narrative approach is a focus on the "client as the expert" and each client's personal narrative. Rather than being in the role of the expert or the "fixer," the clinician has the opportunity to share an adventure with clients as they alter their relationship with their problems. The clinician's stance is that of a curious observer and listener of the client's current narrative. As the client's dominant narrative is deconstructed and externalized via activities that are a natural part of the therapeutic conversation,

the conceptualization of the situation moves from "the person as the problem" to "the problem as the problem." The therapeutic experience becomes more about the development of a dynamic therapeutic alliance and the meaning of the activities as much or more than it is about the behavioral techniques that are a necessary but not a sufficient aspect of successful therapeutic change. The goal is to help clients to experiment with their relationship with the problem and to develop an agentic life style. Along with providing supporting empirical evidence for the effectiveness of the constructivist-narrative approach, the case illustrations in Chapters 11 and 12 bring home informative and touching examples of the power of adaptive counseling centered on the client and client's resources and values.

Part IV (Chapters 14–25) describes the rationale and procedures associated with a variety of "tools" for working with clients from the constructivist-narrative perspective. These 12 chapters in Part IV are intended to be stand-alone chapters that can be read by the clinician as the need arises. The final section (Part V, Chapter 26) is a thoughtful addition intended to help instructors teach the constructivist counseling framework to students.

As a clinician and a person with a history of stuttering, I have often witnessed two essential changes that occur during a successful therapy experience—clients' abilities to reconstruct their cognitive view of themselves and to successfully manage their communication problem. This book provides a concise, engaging, and effective way for the client and the clinician to facilitate those changes and create an agentic and autonomous lifestyle. I recommend it to both students in the discipline and seasoned professionals who are looking for a theoretically elegant, empirically informed, and immensely practical way of helping clients revise constraining stories of their relationship to their communication problems in the course of responsive counseling.

—Walter H. Manning, PhD
Professor, School of Communication Sciences and Disorders
The University of Memphis
Author of: *Clinical Decision Making in Fluency Disorders*
Clifton Park, NY: Delmar|Cengage Learning
March 2014

# 1

# COUNSELING IN COMMUNICATION DISORDERS

What is the role of counseling when working with people who have communication disorders? The answer, it seems, depends on who you ask! On the one hand, the official position of the American Speech-Language-Hearing Association (ASHA) and the American Academy of Audiology (AAA) is to regard it as a mandatory dimension of clinical practice, as we will see below. On the other hand, more than a few students and practitioners are leery of stepping into a territory they associate more with psychology or psychiatry than with speech-language pathology or audiology. Our goal in this brief chapter is to provide a general introduction to the concept of counseling in our fields by exploring the "disconnect" between policy and practice, and to consider prevalent myths about clinical practice that act as barriers to counseling.

*A number of years ago, I was teaching a course on counseling to speech-language pathology and audiology graduate students. We had just finished a discussion of the importance of counseling and the need to get to know your client's story when, during a break, one of the students came up to talk with me. "I have an aphasia client," she said, "and, based on*

*what we have been learning in this class, I wanted to spend our first session together getting to know her and how she feels about her life now." "That sounds like a great idea," I said, feeling rather pleased with myself for making an impact—until she finished her story: "But my supervisor told me that I had to follow my lesson plan because the client came here for therapy, not counseling."*

## A Mandate for Counseling

As speech-language pathologists and audiologists, what we do is at least in part directed by a series of documents that have been carefully drafted by committees of our peers through our national accrediting agencies, ASHA and AAA. These documents provide detailed descriptions of the role of speech-language pathologists and audiologists, including the skills and practice patterns that are deemed appropriate given the goals of the professions.

### Scope of Practice and Preferred Practice Patterns

The term "counseling" is specifically and extensively referenced in key documents officially regulating practice for both speech-language pathology and audiology. For example, in the *ASHA Scope of Practice for Speech-Language Pathology* (ASHA, 2007), the wording related to counseling clearly states that clinicians should engage in "counseling individuals, families, coworkers, educators, and other persons in the community regarding acceptance, adaptation, and decision making about communication and swallowing." Furthermore, ASHA's document titled *Preferred Practice Patterns for the Profession of Speech-Language Pathology* (ASHA, 2004) notes that counseling should be "conducted by appropriately credentialed and trained speech-language pathologists" and that it should involve "providing timely information and guidance to patients/clients, families/caregivers, and other relevant persons about the nature of communication or swallowing disorders, the course of intervention, ways to enhance outcomes, coping with disorders, and prognosis."

Similarly, ASHA's *Scope of Practice for Audiology* (ASHA, 2003) specifically mentions counseling in its description of "what audiologists do," and *The Preferred Practice Patterns for the Profession of Audiology* (ASHA, 2006) lists counseling in Section IV, Item 23, and provides a detailed description of the process of counseling as "interactive and facilitative, wherein the communicative, psychosocial, and behavioral adjustment problems associated with auditory, vestibular, or other related disorders can be ameliorated." Furthermore, AAA's *Scope of Practice* (AAA, 2004) document describes the role of the audiologist as providing "counseling regarding the effects of hearing loss on communication and psychosocial status in personal, social, and vocational arenas." Likewise, AAA's *Standards of Practice for Audiology* (AAA, 2012) indicates that audiologists must provide counseling to "improve a person's use of residual auditory and/or vestibular function or cope with the consequences of a loss of function" and to "provide support to patients and their caregivers to address the potential psychosocial impact of auditory and vestibular deficits."

In addition to scope of practice and preferred practice patterns, both AAA and ASHA provide a code of ethics that also guide clinicians in what they do. Both of these Code of Ethics documents (AAA, 2011; ASHA, 2010) mandate that clinicians should engage in all aspects of the professions within the scope of practice and provide all services competently, using all available resources to provide high-quality service.

What emerges from study of these guiding documents is that we as clinicians have a mandate to provide clinical services beyond the simple teaching of behavioral techniques or use of technology. Moreover, it is our ethical responsibility to seek further education to ensure that we are providing services commensurate with our scope of practice and preferred practice patterns.

## A Disconnect Between Principles and Clinical Practice

As might be gleaned from the vignette at the start of this chapter, despite the clear mandate to engage in counseling embodied in the scope of practice and preferred practice patterns for both

audiology and speech-language pathology, many clinicians histori-
cally have been reluctant to provide such services (Citron, 2000;
Clark, 1994; Crowe, 1997; Erdman, 2000; Garstecki & Erler, 1997;
Kendall, 2000; Luterman, 2001; Rollin, 2000; Stone & Olswang,
1989; Sweetow, 1999). More recently, Holland (2007) and Simmons-
Mackie and Damico (2011) reaffirm this reluctance, reporting that
speech-language pathologists continue to resist engaging clients in
a counseling relationship. Silverman (2011) further suggests that
many speech-language pathologists in the United States believe
that counseling is simply not a part their job description. With a
certain degree of cynicism, Silverman states that these clinicians
prefer to think of themselves more akin to physicians, even adopt-
ing the medical title of "pathologist." She warns, however, that, "it
is well to remember that physicians who practice pathology study
the causes, nature, and effects of diseases by examining organs, tis-
sues, fluids, and dead bodies. They do not relate to living patients.
Assuming the mantle of speech-language pathologist has led many
of us to practice similarly" (p. 190). Why, then, does this discon-
nect between our guiding principles and clinical practice exist? To
consider this question, in the next section we will address some
of the myths about clinical practice that seem to act as barriers to
clinicians engaging in counseling.

## Myths About Clinical Practice

Through both anecdotal evidence from clinicians and a more formal
review of the literature, several possible explanations emerge for
why clinicians in our field fail to engage in counseling in their clini-
cal practice. In this section, we look at a few of the common "myths"
that militate against audiologists and speech-language pathologists
engaging in counseling, and how the current text might provide
clinicians with the necessary tools to overcome these barriers.

*Myth #1: Behavioral principles are sufficient.* Behavioral
treatment methods are typically very good at addressing surface be-
haviors and symptoms but are less well suited to addressing deeper
issues that relate to the emotional and psychosocial consequences

of communication disorders. Of particular difficulty for behavioral methods is promoting long-term, meaningful change, as is evident from the high rates of relapse for strictly behavioral treatments of addictive disorders (Craig, 1998) and stuttering (Craig & Hancock, 1995).

The framework for counseling described in this book is designed to complement rather than replace traditional behavioral approaches to treatment in speech-language pathology to allow clinicians to impact both psychosocial/emotional and behavioral aspects of communication disorders.

***Myth #2: Counseling is the province of psychologists and counselors, not speech-language pathologists or audiologists***. The World Health Organization's (WHO) health classification system, known as the International Classification of Functioning, Disability, and Health (ICF; WHO, 2001), forms the framework for ASHA's preferred practice patterns and scope of practice for both audiology and speech-language pathology. This classification system proposes that disorders—including speech, language, swallowing, and hearing disorders—consist of more than the simple observable behavioral and structural disruptions, giving equal status to more intrinsic aspects related to attitudes, psychosocial, and emotional factors. Given this approach to classifying disorders, speech-language pathologists and audiologists are reminded that their treatment of speech, language, swallowing, or hearing disorders must address these less concrete factors; and the only effective method for doing so is through engaging clients in counseling.

The framework for counseling described in this book has been designed specifically with audiologists and speech-language pathologists in mind. It is based in established psychotherapeutic theory and practice but tailored to fit the unique demands that speech-language pathologists and audiologists face in their clinical practices and to seamlessly merge with many of the behavioral activities that clinicians are already using.

***Myth #3: Contemporary clinical practice has advanced to the point where addressing the human side of the problem is no longer necessary***. Just as with other areas of knowledge, clinical practice in our field has improved over the past