Counseling in Communicative Disorders

Edited by

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Emotional and psychological insight — factors necessary for comprehensive treatment of any physical disorder — are not often examined in the therapist's formal training. Through the anecdotal material provided in this text, both the novice and experienced professional will benefit vicariously from the experiences of practicing counselors. Each chapter presents an overview of the communication problem, discusses counseling for the specific disorder, provides guidelines for techniques and procedures, and offers suggestions for evaluating effectiveness. Aphasia, cleft palate, cerebral palsy, laryngectomy, delayed language, stuttering, and deafness are among the disorders discussed in this sensitive book.

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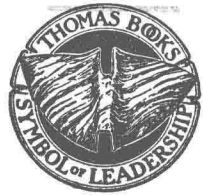

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INTRODUCTION

ONE OF THE CONCERNS expressed by many beginning therapists and by some experienced practitioners is that they feel ill prepared to counsel their clients. They know the textbooks and the techniques and procedures for dealing with the communicative disorders per se, but they do not know what to say regarding the emotional and psychological problems and adjustments that are related to the disorder. The beginning therapist, for all practical purposes, is thrust out from the security of the training institution into the real world of facing both routine and emergency situations on his own. He would usually like to have some source of help. The speech pathologist/audiologist needs to know something of the various ways people react psychologically and emotionally to communicative disorders.

Some few fortunate therapists have had some classwork and a bit of supervised practicum in psychological counseling and guidance. They are fortunate in that they have been exposed to the principles and theories, yet they still want and need direction in relating these principles and theories to the unique problems that are parts of the lives of patients with communicative disorders. They also want specifics of what has worked for other counselors. They want to know what has *not* worked and why it did not work.

There is a desire by the professional to know how to relate, react, and respond to the psychological-emotional aspects of their contacts with patients. They want to know what to say and how to say it. They want to know when to say nothing. They want to know who is to receive guidance and who should give it.

With these points in mind, and in response to requests for it, this book is offered by persons who are active daily in counseling in their subspecialties and/or who have "lived and died" with the speech or hearing problem. The text is written to be very

readable and personal. There has been considerable use of anecdotes to make the reading a vicarious experience shared with each contributor.

We work with people. This book, hopefully, will help you take your eyes off the speech or hearing problem to look at the entire child, man, or woman, his associates, and the world in which each one lives.

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Counseling in Communicative Disorders

Chapter 1

THE FIRST SESSION—WITH WHOM

R. E. HARTBAUER

COUNSELING BEGINS with the initial contact between therapist and patient. Interpersonal relations have their foundations set when the supposedly unrelated automatic greetings are exchanged. Both the therapist and patient establish the initial "ground rules," and each is attempting to ascertain degrees of rigidity or plasticity which may be appropriate for the next several sessions.

It is true that in many cases there is a tentative relationship established before the first face-to-face meeting on the basis of the therapists' reputation, training, and experience, as perceived by the patient, and on the basis of the advanced case history information on the patient as reviewed and interpreted by the therapists. In due time these tentative relationships may prove basically correct and functional or basically and patently erroneous. They may be erroneous and a hindrance, or they may be erroneous but yet a stepping stone toward successful therapy.

There should be no hesitancy to establish tentative relationships; they are starting points, introductions, and the framework for exchange of information. Experienced therapists do not rush this phase nor do they consider it a waste of time.

During the initial interview, the therapist is the person who is in charge of the developing relationship. He either assumes command or loses it and becomes a pawn in the hands of an able manipulator. In the latter incident, therapy is destined to go nowhere. Without being cognizant of it, in many cases the patient, just as a student with a new teacher, is trying to see just how far he can go. He attempts to establish what he feels will be his latitude.

Patients will react differently during this initial interview, which will be quite a different process for a parent, spouse, or

attendant than it is for the patient. The reader will note some similarities between the two, as discussed in this chapter, but will find that the redundancy adds strength to the total discussion.

Patients come or are brought to the therapist's office for a variety of reasons. The "perfect" patient is the one who comes (or is brought) willingly. He has insight into his problem because of excellent and accurate information from a referring practitioner or agency. He has an accurate case history at his command and has no desire to hide anything. His sole purpose is to get treatment, and he has no desire to have a pathological boost to his ego or to try to "con" the therapist.

The "perfect" companion (parent, spouse) representing a patient has the same characteristics. In the case of the companion, these ideal facets may be more difficult to find because a third personality is being injected, a third ego, and another interpersonal relationship. The companion is an intermediator, interpreter, and in some cases, a buffer for the patient. Depending on the unique situation of each case, the companion may be either quite objective or subjective. Therapists may debate the relative value of objectivity and subjectivity, but they all agree that the more accurately the intermediator can transmit the thoughts, feelings, and concepts of both the patient and the therapist, the more fortunate will be all concerned.

Several questions which may arise include the following: (1) Should the companion or intermediator have an emotional involvement with the patient? (2) To what extent should the goals, aspirations, and objectives of the intermediator direct the course of the initial interview? Note that particularly in the case of parents, this juncture *is* a vital involvement. There are no stock answers for such questions as, "Has the intermediator an accurate history and understanding of the problem and the therapy to be designed?"

Some types of clients who visit the therapist are the (1) "con" artist, (2) frightened, (3) know-it-all, (4) escapist, (5) misinformed, (6) uninformed, (7) overly enthusiastic, (8) masochist, (9) overly affectionate, (10) bewildered, (11) highly motivated, (12) educated with excellent understanding, and (13) emotion-

ally stable. Also, there are those who are facing such things as impending death within the foreseeable future. From the earliest possible moment, the therapist should find out which of these is appropriate for the identification of the patient.

HANDLING ANXIETY

One of the most important things in talking with the patient is to keep in mind that all patients, as well as staff, are anxious. Experienced therapists know that excessive anxiety is a danger signal which activates in the presence of trouble. When the warning is heeded, we ideally can pursue courses of action to resolve the situation or provide self-protection. In some cases, people with varying degrees of success disassociate the anxiety from its related problem and place it onto an alternate problem which they can resolve. When the anxiety is related to properly, the therapist will find he gets an accurate perspective of the problems.

The therapist should also be aware that the anxieties of the patient include questions such as (1) Will I be *cured?* (2) Is the therapist any good? (3) Will I like the therapist and his methods? (4) Will the therapist like me? (5) Will the therapist take care of all my problems or only this one? With the perplexed client, anxieties are both additive and cumulative. Some patients are very demonstrative with their anxieties while others may be secretive or nonarticulate.

What then should be the approach with an anxious patient? Let us start to answer that question by posing another—What is so wrong with letting him say he is anxious? It may be the best thing for him at that time. Why not start easing tension by telling an anxious person that he looks anxious? Recognizing this factor and revealing it to the patient negates the need for an attempt to have a facade of tranquility. Verbalization and an expression of anxiety reduce its cognate, harmful power. It cannot be objectified and continues its threatening existence if left to float at will without boundaries or limits. Many strange stories and fantasies will be revealed which may be a result of the problem. Along with verbalizing these anxious feelings, the therapist should find out how they are manifested. The patient may

feel jittery, worried, tense, uptight, faint, and/or frightened; he may be unable to eat or sleep or, conversely, may sleep or eat in excess. Biological processes of breathing, digestion, and elimination may be disrupted. The author has found that by listening to the patient's reports of these physical reactions he is also expressing concern over them.

In numerous cases, the anxieties of patients are hidden by other emotional problems. Some will strike out without accountable cause, and some will be nasty, aggressive, or seeking to provoke anxiety in others. Some of these characteristics are not demonstrated in the counselor's office, but the counselors are aware of a frightening short temper and/or sarcastic nature and will reveal awareness of them during the case interview.

There is little doubt that, over the course of any extended practice, any given therapist will have had an anxious person attack as a means of revealing or resolving anxiety. In most instances, such outbursts are not intended as personal attacks, and by doing this he frequently reveals something more vivid about himself than anything he would say.

So far we have discussed letting the patient face the reality of his anxiety; however, one must be warned about it becoming excessive. Occasionally, the individual who talks incessantly uses that specific anxiety to hide a greater concern. Exaggeration of anxiety can be a useful tool in avoiding a more critical reality. In each case, the counselor receives subtle cues which should warn him of this circumnavigation. The therapist, in cases of logorrhea, should pay more attention to the patient's anxiety than to his words. One method of bringing about a desired result is to determine how and when the therapist should intervene; however, it should not be allowed to deteriorate into a cycle of interrupting one another. Most of all, the therapist should not react by letting anxiety develop within himself; nothing can be gained by it, with the very worst being that the patient knows he, indeed, destroyed the counselor as well as having done further damage to himself.

In conclusion of the discussion, perhaps the wisest advice for this type of patient or intermediator is to know when to refer

the patient to more highly trained and skilled professional psychiatric help. The therapist becomes a greater person by recognition of his limitations, and this recognition and attitude can be the best possible care available for an anxious patient.

HANDLING GUILT

In all these cases, we are discussing both the patient and the parent, spouse, guardian, companion, etc. It is logical to discuss the guilty individual next because it is frequently found that anxiety is allied with guilt.

Frequently, a therapist will reassure a guilty person by saying that there is nothing to feel guilty about or that he has done nothing wrong. He might also go to the other extreme and tell the patient that the vengeance of God must be poured out in full measure. As a rule, the therapist does not have enough facts to make any judgment, particularly during the initial interview; nor does he have the right to judge guilt other than that there may be a cause-effect relationship between some previous or present activity and the problem to be treated.

It is always fitting to set the patient right on facts and give some reassurance to a person feeling mild guilt. However, if the client continues to belabor his concern over guilt, it is time for the therapist to take a reading on his bearings.

Parents frequently have feelings that if they had not *sinned,* their children would not be handicapped, and they may want to tell the entire story of their immorality or unhealthy activities. Spouses often reveal histories of their unfaithfulness. Patients frequently declare that they are convinced that their *afflictions* are due to their improper living habits.

Another type of guilt is not so much related to morality as to the guilt of failing to do what should have been done or having done what was felt to be correct at the time, only to find out later that it appeared to be damaging.

If a person insists he is guilty, the therapist should respect these feelings rather than insist he is such a *good person* that he could not possibly be guilty; such an approach only compounds the guilt. It is easy to categorize the patient by his outward ap-