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Helping Clients & Families Attain their Goals: A Basic Counseling Function

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Helping Clients and Families Attain Their Goals: A Basic Counseling Function

Audrey L. Holland, Ph.D,
Regents' Professor Emerita
University of Arizona
Tucson AZ

I'd like to accomplish two things today... I'd like to interweave 3 BASIC Counseling skills with 2 BASIC Direct Approaches

The counseling skills:	The clinical approaches:
LISTENING	WORKING DIRECTLY ON THE IMPAIRMENT OF APHASIA
EXPLAINING	
DEMONSTRATING	WORKING WITH FAMILY TO REACH COMMUNICATION GOALS

Background

We are still “shaking off” our history,
with its focus on impairment
& wishfully thinking
we have enough time to fix the impairment.

WE DON”T!

Even if we see a client every day for a year for ONE hour, that is 365 hours out of a likely awake time of 4,380 hours. That ’s just 1/12 of his or her time

C.A.P.E.

Roberta Elman, 2013

C=Connecting People

A= Alternative & Augmentative Communication

P= Partner Training

E=Education & Resources

Every one of them depends on the counseling skills of Listening, Explaining and Demonstrating.

Elman, R. J. (November, 2013) Making choices in aphasia intervention when intensive therapy is not possible. Presented to the American Speech-Language-Hearing Convention, Chicago, IL.

WOULD ANY OF YOU GO TO A HAIR STYLIST WHO WOULD JUST BEGIN BY HAVING HIS (OR HER) WAY WITH YOUR HAIR?*

Alone we can
do so little;
Together we can
do so much
Helen Keller

The moral: Start by asking!
Then listen!!

Thank you Lisa Milman, Ph.D. for this insight!!!

What does “clinical” (or “hairdresser”) listening involve?

Listening is an active process.
Listening requires attention not only to
what the person is saying but searching for the correspondence
between the words and what somebody is really saying.

It means taking your time to respond:
1. to be sure you have understood what the person is really saying,

2. to be sure you thought your answer through thoroughly
(the 5” rule)

IN EARLY REHAB or in SNFs……

THE ASK:

“I’m Audrey Holland, and I’m going to be working with you and your husband on his speech over the next (????few weeks).

It is important for me to get an idea of what you would like us to accomplish in our time together.”

THE RESPONSE

*Spouse: “I’d like you to get his speech back to normal”
or
PWA: Talk! Talk…..

*Variants on these themes......

What do you HEAR, what did you LEARN from this???

I HEAR that
That these folks think I am a fixer *

How realistic are these expectations in general?
(Full disclosure: I am not a fixer!)
How unrealistic, given the time limitations?
(even if I WERE a fixer!)

I LEARN
What I need to inform this PWA/family about.

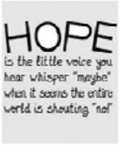
*****MEDICARE Stipulates that
“Counseling can be counted as therapy minutes, as long as the family is present” ….well... DAH!!!

Why do we have to educate close others about the limitations of what we can and cannot do?

Individuals seldom recover completely from aphasia, except when it is initially very mild

We probably will not have enough time
with our clients to reach maximum recovery

Close others have a role to play, now & when benefits run out



HOPE
is the little voice you hear whisper "maybe" when it seems the entire world is shouting "no!"

Listening plays a major role in establishing rapport

Listening allows clinicians to understand the goals and aspirations of clients and their families.

Listening sets the stage for cooperation with client and family members

Listening sets the stage for explaining and demonstrating all of the above.

Listening is the way we learn who the PWA and his family ARE, not what the problem is!

Listening is the FIRST STEP in counseling, of both the person with the problem and families

It is the way you find out what the expectations are,
how realistic they are,
what people believe YOU can do

It sets the stage for cooperation between you and the person(s) you are treating

It sets the stage for how to explain and demonstrate, that follow it.

It is also an ongoing clinical role—
e.g., expectations and needs change as aphasia or other disorders are lived into.

Enough about listening!

A recap: It is the most important counseling skill

As long as we are in clinician-mode, we must be listening.

It involves recognizing that there are both surface and latent (under the surface) meanings.

The ability to be a good listener is not innate...it can be learned!

A brief (but relevant) segue.....

Speech and Voice Banking is available for individuals who may lose the ability to speak (eg, ALS)

A system for storing up phrases & sentences that can be accessed by SGDs for use when speaking is no longer an option

To me, this is a GREAT idea, and I think I would do it in a flash.....but

Carl Moore and his SGD

(from NPR)

But....

An early hard sell to people recently diagnosed with ALS

WHY?

Difficulty with acknowledging the diagnosis?
Thinking TOO positively (I'll beat this thing!)?
Depressed?
Scared of technology?
Family/ ALS person doesn't get it?
Some combination of the above?

Do you think some of this might apply to newly-aphasic persons/families?Are these listening/counseling problems?

Assignment for the next couple of days

WHAT WOULD YOU WANT ON YOUR SPEECH GENERATING DEVICE??

If you had severe aphasia,wouldn't your speech/language needs look similar?

BTW.......

What do YOU say when spouse/client asks,

"When can we put this behind us and be normal again?"

My own answer ....
"The truth is I really cannot answer that.
What I CAN
tell you both is that if everything goes as we want it to,
he (or she or you) will only continue to improve.
This is what my experience has taught me."

On to EXPLAINING

This is one of our clinical strengths

but that doesn't mean
we shouldn't practice and polish our descriptions of aphasia, dysarthria, apraxia, ALS, etc for individuals and families with the disorders.

AND

But we also need to explain how
we intend to help our patients/families
meet their goals

So if you HEARD those questions

"I'd like you to get his speech back to normal"
or
PWA: Talk! Talk…..

EXPLANATION BEGINS HERE!
On the direct therapy side

"My job is to get you started on that journey. We'll be taking those beginning steps.
One thing right now is, what is most important for you to be saying..maybe your kids' names?

Maybe questions that you need answers to?
Some things you would like to hear your husband say?

Maybe some words related to things you are interested in?"

*In my book, words that have high personal relevance trump freq, picturability, age at acquisition, etc. as targets

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WELCOME family participation in your sessions

Early treatment is about getting off to a good start

That means concentrating on useful stuff, involving families/friends in treatment

Illustrating, explaining, demonstrating EVERYTHING that you do*

*If you can't explain why you are doing something, and what it is intended to accomplish, why are you doing it?

Very FEW direct therapy approaches cannot be adapted for words/phrases that count as important to the speaker

An Example from Melodic Intonation Therapy

"The flag is tearing."

"How are your puppies?"

"Brother Cyril did it!"

If we have time at the end, I'll explain

The exceptions to using real stuff might be treatments stemming from complexity theory
(Thompson et al for syntax; Kiran et al for word retrieval)

But careful work on syntax or for general word retrieval are probably not the focus of early rehab anyway

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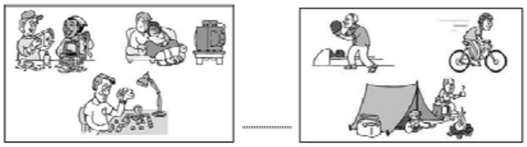
Life Interests and Values Cards (Haley,K, Womack,J, Helm-Estabrooks, N., Caignon, D & McCullouch, K.)

The LIV Cards consist of a boxed set complete with:
Instruction manual;
Reproducible scoring sheets;
(95) ninety-five durable activity cards;
(2) two symbol cards to support sorting the activity cards;
(11) eleven emotion cards to identify mood states;
(7) seven adaptation cards showing alternative ways of engaging in activities;
(6) six composite cards showing conversation category

available through the University of North Carolina
liv.@unc.edu

The LIV Cards:

- Allow direct communication with your client, family member, or friend with aphasia (or other language difficulties) about valued life activities
- Facilitate goal-setting in therapeutic sessions, assessments, and everyday conversations
- Contain engaging black-and-white drawings depicting life activities in four categories:
- Home & Community, Creative & Relaxing, Physical, and Social
- Include materials to communicate about mood states and activity adaptation



Before I move on to including families,

Two Examples from chronic aphasia

Roberta Elman's story

Carol Dow-Richards' story of her son David

What these stories suggest is that in early treatment, somebody missed the boat.

Big Time!!!

There is no paucity of published material on Supported Communication/Conversation and why it matters, beginning with Aura Kagan's first article*

However....in addition to understanding and believing it, Good Clinicians MUST:

Do it themselves---always, except perhaps in impairment based drilling

Teach its principles to others on the rehab team

ABSOLUTELY, share the principles, and practice how it works, with families.

Simmons-Mackie, N., King, J, & Beukelman, D, (2013) Supporting Communication with Adults with Acute and Chronic Aphasia. Baltimore, MD. Brookes

*www.aphasia.ca

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1. Be respectful – know that the person is intellectually competent and fully capable of participating in conversation. Conversation topic, interaction style, and volume of speech should not be influenced by the fact that the person has aphasia.

2. Address the person with aphasia directly. Be sure you do not ask others to speak for him or her.

3. Take the time to listen. People often feel urged to rush conversation and to avoid silence, something that leads to misunderstanding or failure to notice the other person's point of view. By slowing down you have an opportunity to make interactions more meaningful, including those with people who have aphasia.

4. Verify your comprehension. If you are unsure you have understood the person with aphasia correctly, simply state what you understood the message to be and give him or her an opportunity to clarify or correct.

5. Let the person with aphasia tell you if he or she needs help, and what kind of help he or she prefers. Avoid speaking for the person with aphasia except when necessary, and always ask permission before doing so.

6. It is often helpful to supplement spoken conversation with gestures, drawing, and by writing some of the most important words as they come up. People with aphasia can use similar techniques to help them find words.

7. Be mindful about background noise (such as television, radio, or other people). It is usually a good idea to minimize these distractions.

The Aphasia Institute Guidelines

Revealing Competence

There are communication techniques that can help ease the exchange of information and feelings between the conversation partner and the person with aphasia. The key is ensuring messages are taken IN, OUT and VERIFIED by the person with aphasia.

Getting the message **IN** is a matter of modifying the way you converse to ensure you are being understood by the person with aphasia. Some methods to try include:

- Using short, simple sentences and an expressive voice.
- Using gestures when conversing.
- Writing keywords or main ideas down – e.g., PAIN in large or bold print
- Using pictures and focusing on one at a time.
- Eliminating distraction – noises, other people, or multiple visual materials.
- Observing the person's facial expression, eye gaze, body posture or gestures to determine level of comprehension.

Getting the message **OUT** might be a bigger challenge for someone with aphasia.

To help them express their thoughts to you, try:

- Asking yes or no questions.
- Asking one question at a time.
- Asking him/her to gesture, point to objects or pictures, or write key words, such as "Can you show me…" "Can you help me by writing?"*
- Giving him/her sufficient time to respond.
- Asking fixed choice questions such as, "Do you want water or coffee?"
- Phrasing yes or no questions from general to specific.

*Audrey edit

Verifying the message is important to making the person with aphasia feel understood and valued. Summarize slowly and clearly by saying, "So let me make sure I understand" and using the following methods:

- Adding gestures or written key words.
- Repeating the person's message.
- Expanding on what you think the person might be trying to say.
- Recapping the conversation if it was a long one.

National Aphasia Association Guidelines

Communication Strategies: Some Dos and Don'ts

The impact of aphasia on relationships may be profound, or only slight. No two people with aphasia are alike with respect to severity, former speech and language skills, or personality. But in all cases it is essential for the person to communicate as successfully as possible from the very beginning of the recovery process. Here are some suggestions to help communicate with a person with aphasia:

1) Make sure you have the person's attention before you start.

2) Minimize or eliminate background noise (TV, radio, other people).

3) Keep your own voice at a normal level, unless the person has indicated otherwise.

4) Keep communication simple, but adult. Simplify your own sentence structure and reduce your rate of speech. Emphasize key words. Don't "talk down" to the person with aphasia.

5) Give them time to speak. Resist the urge to finish sentences or offer words.

NAA guidelines (cont'd)

6) Communicate with drawings, gestures, writing and facial expressions in addition to speech.

7) Confirm that you are communicating successfully with "yes" and "no" questions.

8) Praise all attempts to speak and downplay any errors. Avoid insisting that that each word be produced perfectly.

9) Engage in normal activities whenever possible. Do not shield people with aphasia from family or ignore them in a group conversation. Rather, try to involve them in family decision-making as much as possible. Keep them informed of events but avoid burdening them with day to day details.

10) Encourage independence and avoid being overprotective.

Okay, is handing out your favorite of these guidelines enough?

If Roberta's couple and Carol's experience is relevant, certainly NOT...

But finally they benefitted from Explanation and Demonstration---Carol directly, and by Roberta's example.

A lesson there for us
BE supported communication to benefit
both PWA and family.

AND

TRAIN PWA and family members
To USE strategies

Conversational Coaching

Goal is to provide practice with communication strategies that appear to work for the speaker

Extend that practice to include family members, and ultimately strangers.

Clinician's initial job is to provide coaching on using strategies as training material is being practiced

Training may utilize scripts or videoclips

Hopper, T., Holland, A., & Rewega, M. (2002). Conversational Coaching: Treatment outcomes and further directions. Aphasiology, 16, 745-762

Some PWA talking strategies
writing (whole or part)
gesturing/pantomiming
trying again
signaling/asking for more time
signaling/asking for help
circumlocuting
drawing/diagramming

Some partner talking strategies
Speak slower
Say again
Say another way
Speak louder

Some PWA comprehension strategies
Speak slower
Say again
Say another way
Speak louder

Some partner comprehension strategies
reading partial or whole word
checking accuracy ("let me see if I got that..)
providing honest feedback
Say "I understand" only if you do

When strategies are in place, then family member is invited in to listen to the script as their PWA uses it with clinician present

NOW...clinician coaches PWA, AND suggests strategies family member can use to promote their understanding

With written scripts, clinician checks understanding on sentence-by-sentence basis

With video vignettes, comprehension is checked at appropriate places in story line..provides suggestions for both PWA and family member.

Strategies trained for Dyad Y (Hopper, Holland & Rewega, 2002)

Mr. Y(aphasic)

- Main idea first
- Draw
- Gesture
- Gesture+ draw
- Write (whole or partial word)
- Tell Mrs. Y when she has wrong info
- "You're close!!"

Mrs. Y

- Ask for main idea
- Write down information
- Avoid wild guessing
- Write questions
- Confirm yes/no IN WRITING
- Ask for "try another way"
- Give time to respond
- Summarize info frequently, and at end

The hard data for 2 Dyads in Hopper, et al.

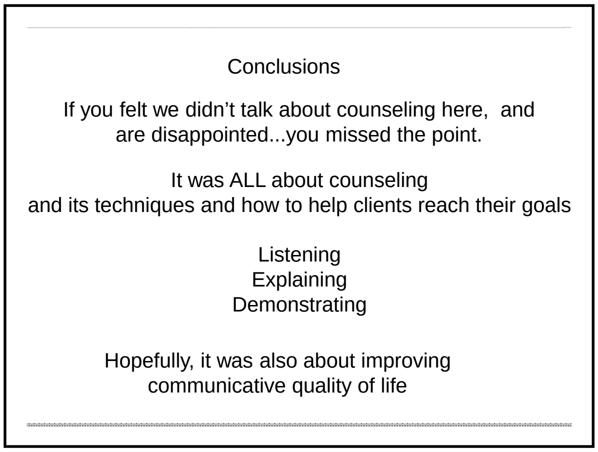
Although variable, both dyads had positive outcomes.

For both PWA post testing = more main concepts present

One PWA showed significant improvement on CADL-2

Naive students discerned which were pre- and which were post- treatment samples, and wrote qualitatively more complete summaries of the post-treatment dyads.

But, a personal story.....



Conclusions

If you felt we didn’t talk about counseling here, and are disappointed...you missed the point.

It was ALL about counseling
and its techniques and how to help clients reach their goals

Listening
Explaining
Demonstrating

Hopefully, it was also about improving communicative quality of life

THANKS FOR LISTENING!