

Establishing Counseling Goals in Rehabilitative Audiology

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Goal setting is an integral component of audiologic counseling, and represents the desired outcomes that clients seek to achieve. Process goals are associated with the establishment of facilitative conditions needed for behavioral change. Outcome goals vary as a function of each client's needs and differ from process goals by: (a) specifying the behavior to be changed, (b) indicating the conditions under which the desired behaviors will occur, and (c) including a suitable and realistic level or amount of the desired behavior. This paper presents the principles, concepts, and skills necessary for the audiologist to establish goals in audiologic counseling. A case study of a hard of hearing adolescent who rejected his hearing aid is included to illustrate the concepts and methods of establishing goals.

Goals are the desired outcomes clients want to achieve at the completion of an audiologic counseling program. Goal setting can be viewed as both an extension of the diagnostic process and the initial step in any therapy or counseling program. During an audiologic assessment, hard of hearing clients often focus on specific concerns and issues that are problematic. Most hard of hearing clients are unaware of how to build a bridge between the problem and the desired outcome (Roberts, 1987; Roberts, Bryant, & Wharton, 1990; Roberts & Wharton, 1991). In goal setting, clients identify specific solutions to their audiologic problems and specific actions they can take to achieve these solutions. Goals serve three functions in audiologic counseling: First, goals have a motivational function. Cormier and Hackney (1987) stated that clients are more motivated to work toward and maintain desired changes when they are actively encouraged to specify outcome goals as the indicators of success. Establishment of these goals also reduces potential failure by giving clients greater control over the learning process.

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Second, goals provide an educational function. Well-stated outcome goals provide clients with a template of information and standards by which they can encode and rehearse desired actions and responses (Cormier & Hackney, 1987). Dixon and Glover (1984) stated that once an outcome goal is established by the client, it is likely to be rehearsed in the working memory and stored in the long-term memory to stimulate the client to continue seeking information as he/she interacts with the environment.

Third, goals serve an evaluative function. The outcomes represented by the client's goals assist the audiologist in selecting and evaluating various counseling strategies that are likely to be successful for a client. When outcome goals are established, both the audiologist and client can evaluate the client's progress toward goal achievement, and what methods have succeeded, failed, and/or need further development (Bandura, 1969). Although goals are constantly refined and modified, they provide the schema for initiating and completing an explicit plan of mutually-agreed upon activities that provide accountability (Roberts, 1991; Roberts et al., 1990; Roberts & Wharton, 1988, 1991).

This paper has three purposes. First is to present principles and techniques to establish process and outcome goals in audiologic counseling. A case study will be used to illustrate this process. Second is to describe skills associated with effective goal setting. Third is to describe a step-by-step activity plan to achieve desired outcome goals.

ESTABLISHING PROCESS AND OUTCOME GOALS

Counseling goals vary as much as the theoretical approaches available to generate them. Corey (1991) stated that this diversity can be simplified by considering the degree of generality or specificity of goals. He viewed goals as existing on a continuum from general, global, and long-term to specific, concrete, and short-term. The relationship-oriented approaches stress the former, whereas, the cognitive behavioral therapies emphasize the latter. The goals at opposite ends of the continuum are not contradictory, and vary in how specifically they are defined. Truax and Carkhuff (1967) recommended that an integration of the goals is not only possible, but desirable.

Goal-setting should be viewed as a flexible process, subject to modification and refinement. There are two general types of counseling goals: process and outcome. This section describes the procedures for establishing process and outcome goals as necessary components of counseling in rehabilitative audiology.

Process Goals

Process goals are established by the clinician to provide conditions needed for client change (Cormier & Hackney, 1987). For example, the clinician must actively sense and communicate empathy, genuineness, and unconditional positive regard. These process goals have been reported to facilitate rapport and thus, an effective counseling relationship with deaf and hard-of-hearing individuals (Chermak, 1979; Erdman, Crowley, & Gillespie, 1984; Kodman, 1966;

Luterman, 1976, 1984; Pollack, 1978; Roberts & Bouchard, 1989; Wylde, 1987).

Outcome Goals

Unlike process goals, outcome goals vary as a function of each client's needs. Cormier and Hackney (1987) suggested that outcome goals differ from process goals in three respects. First, a well-stated outcome goal specifies the behavior to be changed. For instance, a client with a severe hearing impairment who complains of difficulty understanding others in group settings may choose to maximize residual hearing, improve self-appraisal, and increase assertiveness.

Second, an outcome goal indicates the conditions under which the desired behaviors will occur. The various situational contexts in which the client will attempt to achieve the desired outcome must be carefully evaluated. One would not want a client to fail by identifying situations or circumstances in which there was minimal possibility for success. For example, a hard of hearing client may wish to initially assert himself/herself in conversations with the family at home or with peers in the workplace, but not in a large public social gathering.

Third, an outcome goal includes a realistic amount of the desired behavior. For instance, a client may choose to become assertive and educate "everyone" in "every group setting" about his/her communicative needs and expectations. Though desirable, it may be an unattainable outcome goal for the client, and lead to failure. A more realistic goal is to become assertive in small group situations 50% of the time. This goal can be modified as the client becomes more competent and self-assured. Each time an outcome goal is reformulated, it is a closer approximation of the desired outcome that meets the specific needs of the client. Successive approximations allow the client to set more attainable goals, experience more success, and make desired changes in life style that facilitate achievement.

In summary, outcome goals should be specific and provide a clear understanding of "what," "when," "where," and "how much" is to be accomplished. Behaviorally-defined goals provide a template that allows the audiologist to select appropriate techniques and strategies for effecting change, identify and monitor progress, and refine or modify outcome goals as necessary.

CASE HISTORY

The following case will be used to illustrate the audiologic counseling principles and techniques to assist the client in formulating well-defined outcome goals and establishing a step-by-step plan to achieve the desired outcome goal.

Michael was a 13-year-old eighth-grade student with a mild-to-profound, high-frequency sloping, sensorineural hearing loss in his right ear, and a profound, sensorineural hearing loss in his left ear. He was diagnosed at two years of age with a hearing loss suspected to be of unknown and congenital etiology. Michael was fitted with a postauricular hearing aid on his right ear. He was seen for audiologic and hearing aid assessments on a semi-annual basis until he was

approximately 6 years of age.

Michael's parents reported that he wore his hearing aid consistently until he was 8 years of age and in the third grade. He stopped wearing it for fear his classmates would tease him. Subsequently, he was fitted with a new postauricular hearing aid on his right ear. At the time of the fitting, Michael denied having a hearing loss and cried and pleaded to his parents not to "make" him wear a hearing aid. Michael's parents acknowledged his need for amplification, but expressed reservations about reinforcing its use. Audiologic counseling was scheduled to address the communicative and psychosocial issues associated with Michael's hearing impairment. However, his parents did not follow through.

Five years later when Michael was 13 years of age, his parents contacted the hospital and scheduled an appointment for audiologic counseling. They stated that he was enrolled in a gifted eighth-grade program; however, they were concerned because he demonstrated expressive speech and language problems, difficulty following classroom discussions, and inconsistent responses to conversations with friends at school and family members at home. The treatment plan recommended a hearing aid evaluation and six sessions of audiologic counseling. Michael was then evaluated and fitted with an in-the-ear hearing instrument in his right ear. Although Michael acknowledged benefiting from amplification, he refused to wear the hearing aid. He said that he was angry and felt that it was not "fair" that he was born with a hearing impairment and had to wear a hearing aid. He did not want to be perceived as being "different" from other kids. Michael acknowledged that his decision to not wear the hearing aid contributed to his expressive speech problems and difficulty following classroom discussions and conversations with friends at school. He began to withdraw and isolate himself. Michael emphatically stated that he did not want his classmates to know that he wore a hearing aid, because he was embarrassed and felt that others would not accept him. Michael's statements indicated that he was dissatisfied with his poor self-image and communicative skills. He desired to improve his situation, but did not know what to do.

Because of the communicative and psychosocial issues that Michael experienced, an outcome-oriented counseling approach was used to allow Michael to develop an appropriate solution to his problem. Michael and his parents attended six one-hour family audiologic counseling sessions. The following section contains paraphrased excerpts of the dialogue that illustrate the principles and techniques by which the outcome goals were developed.

CHARACTERISTICS OF OUTCOME GOALS

Roberts (1987) identified five characteristics of well-stated outcome goals in audiologic counseling. Outcome goals must: (a) be stated in a positive manner, (b) result in an observable change in the client's attitude or behavior, (c) be applied in a discerning manner, (d) be initiated and maintained by the client, and (e) preserve any existing positive by-products which resulted from the client's

present situation. This section describes these five characteristics of outcome goals in audiologic counseling.

Stated in a Positive Manner

First, the outcome goal must be stated in a positive manner. A hard of hearing client may say, "I am shy and reserved," instead of stating, "I want to be able to assert myself and tell others about my communicative needs and expectations." Krumboltz and Thoresen (1969) emphasized that in most situations, a personal attribute is described rather than the manner in which the characteristic is experienced. The audiologist helps the client describe the ways in which the characteristic could be changed. In Michael's case, a positively stated outcome would not focus on becoming "less angry" or "withdrawing less" in various communicative situations, because that would emphasize the problem. In order to focus on a positive outcome, the audiologist could ask, "What would you want to accomplish?" Consider the following exchange:

Michael: I know I should wear my hearing aid, but I don't want to.

Audiologist: Let me see if I understand your concern. You recognize the need to wear your hearing aid and have chosen not to wear it.

Michael: Yes . . . that's right!

Audiologist: Michael, since we both agree that you need to wear a hearing aid, what would happen if you chose to wear it consistently? What would you hope to gain?

Michael: Well, I would probably understand my friends better. I wouldn't have to ask them repeat so much.

Audiologist: I see . . . What else would you hope to achieve by wearing your hearing aid?

Michael: I don't know . . . Maybe my speech would improve. I'd probably feel better about wearing my hearing aid at school. I guess I need to tell my teachers that I'm supposed to wear my hearing aid during class.

One positively stated outcome goal would be for Michael to become assertive and educate others about his specific communicative needs. A second outcome goal would be for Michael to identify the benefits of wearing his hearing aid at school and during leisure-time activities. A third outcome goal might be for Michael to improve his communication skills in various social situations. A fourth outcome goal may be for Michael to increase positive feelings about himself. These behaviors are antithetical to anger and withdrawal.

Outcome goals can never be more specific than the audiologist's understanding of the problem. During the initial phase of audiologic counseling, goals are likely to be nonspecific and nonbehavioral. In order to translate nonspecific client concerns into specific behavioral outcome goals, the audiologist must understand the nature of the client's problem and the conditions under which it occurs. However, nonspecific outcome goals are better than no goals at all.

Require Observable Change in Attitude or Behavior

Second, the outcome goal must result in an observable change in the client's attitude or behavior. To elicit the information necessary to develop a resolution to the client's problem, one might ask, "How would you know if you had achieved your outcome?" "What would be a demonstration of your having achieved the desired change?" It is essential that the audiologist and the client mutually agree on the types of behaviors or experiences which will be accepted as indicators of success in order for the counseling approach to accomplish its desired purpose. Observable changes might include: (a) wearing his hearing aid at school, during leisure activities, and in selected listening environments; (b) asking people to repeat themselves in communication situations with excessive background noise; (c) informing others about his need to wear a hearing aid and other specific communicative needs; and (d) attending audiologic counseling sessions designed to help Michael cope with affective issues associated with his hearing loss.

The type of goals appropriate to the problem should become clearer as the audiologist and client explore the nature of the client's problem. This clarification will permit both the client and audiologist to move in the direction of identifying specific behaviors that, if changed, would alter the problem in a positive way. These specific behaviors can then be formulated into outcome goal statements. As the audiologist and client continue to discuss the problem and circumstances surrounding the behaviors in more detail, target behaviors can be reconfigured as necessary.

The audiologist can next identify several intermediate subgoals that assist the client in achieving the overall goal. By achieving subgoals in a successful manner, the client's motivation to change may be reinforced and maintained. Since subgoals always represent actions that move clients in the direction of the desired outcome (Carkhuff & Anthony, 1979), successful completion of subgoals also may reduce potential failure experiences by giving the client greater control over the learning process (Bandura, 1969).

Applied in a Discerning Manner

Third, a well-formed outcome must suggest that the behavior of the client be applied in a discerning manner. It is the audiologist's responsibility to establish with the client the specific situations and circumstances in which the behavior is and is not useful. For example, "How, with whom, when" and/or "where do you want (or don't want) to become assertive?" Cameron-Bandler (1985) stated that the client's well-being is maintained when the desired outcome is appropriately specified.

Initiated and Consistently Maintained by the Client

Fourth, a well-formed outcome must be initiated and consistently maintained by the client. The key word is "consistently." For example, it is appropriate

behavior for Michael to consistently educate others about his communicative needs, wear his hearing aid, ask people for clarification, and take advantage of contextual cues. If Michael fails to maintain this positive behavior, he may regress to negative feelings of anger and negative behaviors of social withdrawal.

The audiologist could ask questions to identify any factors that may be preventing the client from initiating and maintaining positive behaviors. These questions might include: "What prevents you from achieving your outcome?" Conversely, questions to identify any effects of the client achieving the desired outcome might include: "What would you gain if you achieved your outcome?" or "What would you lose if you achieved your outcome?" These questions help identify any issues or cause-effect patterns that need to be addressed and changed prior to achieving the desired outcome. An example follows.

Audiologist: Michael, what would you gain if you became more assertive and told others what your communicative needs are?

Michael: I'd probably feel more comfortable being around other people.

Audiologist: I'm curious. If that were to occur, what will you lose?

Michael: I won't lose anything except feeling so uptight.

Audiologist: Tell me, then, what prevents you from being more assertive and informing others about your communicative needs?

Michael: I'm afraid that most people won't understand. People seem to get upset when I ask them to repeat what they've said.

This fear may prevent Michael from initiating and maintaining the desired change of being assertive. One way to overcome the limitations created by the client is to identify them. Everyone has ways of limiting themselves, strategies for failing, and even sabotaging their best efforts for succeeding. However, recognizing past inappropriate or failed strategies is necessary before the client can obtain the desired change. With assistance in recognizing the need to maintain the positive behavior, Michael can monitor the causes that may lead him to regress to anger and social withdrawal.

Preserve Any Existing Positive By-Products

Fifth, a well-formed outcome assures the preservation of any positive by-products which may have resulted from the client's present situation. For instance, one way to assess the positive by-products of Michael's anger is to ask, "What purpose does your anger serve for you?" or "What prevents or stops you from asserting yourself?" In the case example, Michael is angry, and feels that it is unfair that he was born with a hearing loss and has to wear a hearing aid. His anger and feelings of unfairness contribute to Michael's isolation and social withdrawal from noisy, communication situations. While a negative by-product of Michael's anger is his social withdrawal, a positive by-product may be a more appropriate level of self-reliance. That is, he does not have to depend upon anyone but himself to communicate with others. This can be represented as a strength and may serve as a secondary gain for the client. The same questions that identify factors that may be preventing the client from initiating and main-

taining the desired behaviors in the previous condition will also identify any possible positive by-products. A well-stated outcome goal would preserve Michael's positive sense of self-reliance and self-assurance.

STRATEGIES ASSOCIATED WITH GOAL SETTING

In today's world of cost containment, time efficiency, and high productivity, it may not be unusual for a clinician to expeditiously develop outcome goals with a client before first establishing an effective relationship. The process goal of establishing rapport should be the audiologist's initial focus when developing outcome goals with the client. The strategies described below are useful for facilitating the process goals of conveying empathy, expressing genuineness, and communicating acceptance to clients, formulating outcome goals, and verifying whether the desired changes that a client wants to accomplish during audiologic counseling are available, realistic, attainable, and generalizable into appropriate future contexts.

Attentive Listening

Attentive listening by the counselor/audiologist is crucial in order to hear the client's subtle outcomes or veiled attempts to modify the outcome goal (Cormier & Hackney, 1987). Roberts and Bouchard (1989) described specific techniques to facilitate active listening. Active listening will reveal clients' messages about their goals and desired changes, as well as reflect clients' positive and negative feelings about goal setting.

Asking Questions for Clarification

Asking questions is a necessary aspect of goal setting in order to assist clients clarify and state their desired outcomes. Various open-ended questions were discussed in the previous section, and other questions that the audiologist may ask include, "What would you like to achieve?" "Under what conditions do you want to be able to accomplish this?" "Considering your current situation, what amount of change is both realistic and desirable?" "What do you anticipate will be your first step?"

Luterman (1984) described the effective use of counterquestions to clarify issues and move the relationship beyond the initial stages. Roberts and Bryant (1988) presented a structured method for gathering information by challenging the verbal discourse clients use to represent their perceptual model of experience. This approach clarifies issues necessary to enhance the client's understanding of the dynamics of the problem and consider outcomes for change that may not have been recognized previously.

Confrontation

Cormier and Hackney (1987) noted that confrontation is useful in helping a client to identify a contradiction, rationalization, or misinterpretation. They

noted that confrontation serves four major functions in goal setting. First, confrontation assists in the client's achievement of congruency; a state in which the client's verbal message corresponds with the client's nonverbal behavior. Second, it establishes the counselor as a role model for congruent communication. Third, confrontation mirrors the client's incongruent behavior. Fourth, it is helpful in exploring conflict associated with change and goal setting.

The audiologist's confrontation response is a compound sentence and establishes a "you said/but look" condition. That is, the first part of the compound sentence repeats the "you said" portion of the client's message; whereas, the second part of the audiologist's responses presents the contradictory "but look" statement.

Michael: I know the hearing aid helps me, but I don't like to wear it.

Audiologist: But you've told me that you don't understand what your friends are saying most of the time and have to ask them to repeat themselves.

The audiologist's confrontational response to the first part or the "you said" portion is implicit and need not be restated by the audiologist. The audiologist's challenging "but look" statement should not contain an accusation, evaluation, or problem solution. The confrontation should describe the client's message, observe the client's behavior, and present evidence.

Ability-Potential Response

The ability-potential response is a strategy in which the counselor suggests to the client that he/she has the ability or potential to engage in a specified activity (Cormier & Hackney, 1987). This strategy reinforces the client's sense of control and communicates the counselor's faith in the client's ability to act independently. The ability-potential response begins with "you could" or "you can."

Michael: I'd like to understand people better, but I don't know what to do.

Audiologist: You could also try and identify some other positive ways to understand more of what other people are saying by identifying how and when your hearing aid is really benefiting you.

Cormier and Hackney (1987) noted that although the ability-potential response sounds like advice, it is used effectively in identifying alternatives available to the client. However, it can be misused, and become meaningless, when the counselor attempts to suggest a panacea. The effect of misuse is for the client to negate or mask his/her feelings of concern.

Reframing

Reframing is a communication tool that has been described in the fields of clinical psychotherapy (Bandler & Grinder, 1975, 1979; Gordon, 1978; Lankton, 1980; Zieg, 1980), family therapy (Bandler & Grinder, 1975; Bandler, Grinder, & Satir, 1976; Grinder & Bandler, 1976; Luterman, 1987), sexual therapy (Cameron-Bandler, 1985), and audiologic habilitation (Luterman, 1987; Roberts,

1987). Cormier and Hackney (1987) stated that reframing is the art of viewing a situation differently, whereas, Gordon (1978) defined reframing as a method of redirecting a previously unwanted and painful experience or behavior so that it becomes useful. That is, the technique of reframing involves changing a negative statement into a positive one by changing the frame of reference used to perceive the experience. Reframing a client's attitude or behavior by increasing the repertoire of available choices for change is a vital first step toward problem resolution (Roberts, 1987).

Two assumptions underlie the technique of reframing: First, no behavior has meaning in and of itself. The clinician can make it mean anything; identifying "what" is content reframing (Bandler & Grinder, 1982). Second, every behavior, symptom, and communication is useful and meaningful in some context; identifying "where" is contextual reframing (Bandler & Grinder, 1982; Cameron-Bandler, 1985; Harmon & O'Neill, 1981).

Content reframing. The audiologist's task in content reframing is to help the client to discriminate between the intention and the undesirable behavior. Once this distinction is made, more acceptable behaviors can be found to satisfy the client's intention. Clients learn to value the positive intention, and inversely, devalue the unwanted behavior.

There are several steps in content reframing. The first step is to identify the unwanted behavior or emotion. In the case example, Michael does not often ask others to repeat or clarify themselves in various communication exchanges. He stated that he is fearful that others may be inconvenienced and impatient, and he would feel rejected. The unwanted behavior is his lack of assertiveness and the unwanted emotion is the subsequent anxiety.

The second step is to distinguish between the client's intention and the unwanted behavior. Although Michael wants to become assertive, his fear of rejection prevents him from initiating and maintaining his desired goal. One way of changing a client's response is to emphasize that there is not a direct cause-and-effect relationship between a client's emotional or behavioral experience and his/her response to it. If the audiologist can assist in changing what the experience means to a client, the client's response will also subsequently change. Once this distinction is made, more acceptable behaviors can be found to satisfy the client's intentions.

The third step involves developing alternative ways of delivering the reframe once a new content frame for the behavior has been determined. Appropriate and useful behaviors are established to ensure the execution of the original intention (Bandler & Grinder, 1982; Harmon & O'Neill, 1981). One technique is for the audiologist to ask the client to repeat the complaint and deliver the reframe that is thought to have the maximum response; for example:

Michael: If only I wouldn't get so uptight, I could understand more of what people are telling me.

Audiologist: It's important that you realize that your feelings of anxiety can also be perceived positively as a message of preparation from within you. This

feeling will alert you to become more aware of various communication cues.

Michael: That's interesting! Being anxious can actually help me understand people.

Contextual reframing. Identifying a specific situational context in which a client's emotion, behavior, or communication is useful and meaningful is contextual reframing (Bandler & Grinder, 1982; Harmon & O'Neill, 1981). The underlying premise is that people have the necessary resources to make any desired change (Cameron-Bandler, 1985). Counselors assist clients in identifying an appropriate context for the undesirable behavior and thus, learn to discriminate between an appropriate and inappropriate context.

There are several steps in contextual reframing. The first step in contextual reframing is the same as in content reframing: to identify the unwanted behavior or emotion. An illustration of this point may be Michael's unwanted behavior of isolation and social withdrawal from various communication situations.

The second step is to establish a useful context for the unwanted behavior or emotion. The audiologist should suggest various contexts until one is identified in which this unwanted behavior would have value. In a one-to-one conversation or in a small group may be maladaptive. As illustrated in the case example, reframing would assist Michael to discriminate between those situations to avoid and those in which to become assertive and socially interactive. That is, Michael could learn that some contexts actually should be avoided, for example, very noisy room. This style is respectful of clients' integrity.

The third step involves developing alternative ways of delivering the reframe once a new context frame for the behavior has been determined. As with content reframing, the audiologist can ask the client to repeat the complaint and deliver the reframe that is thought to have the maximum response. Appropriate and useful contexts are established to ensure the execution of the original intention (Bandler & Grinder, 1982; Harmon & O'Neill, 1981).

Another premise underlying reframing is that new choices, resources, and learnings are anchored or attached to the stimulus that originally triggered the unwanted and negative behavior. Through a reframing paradigm, the stimulus pattern will trigger the desired behavior established in counseling. Furthermore, this sequence will occur automatically in future contexts (Bandler & Grinder, 1982; Cameron-Bandler, 1985; Lankton, 1980). For example, Michael's original representation of being anxious and panicking when having to assert himself triggered a new series of positive images and pleasant feelings of preparation via a content reframe.

Future Pacing

The true test of successful change is whether the choices, resources, and learnings established through counseling generalize to various contexts (Lankton, 1980). These changes often remain anchored to the counselor or the physical setting rather than being available to the client in needed situations (Cameron-Bandler, 1985; Lankton, 1980). Cameron-Bandler (1985) stated that future

spacing is a guided-imagery technique that is utilized to verify whether the changes that a client accomplishes during counseling are available, realistic, attainable, and generalizable into appropriate future contexts. In goal setting, future pacing can anchor the client's choices, resources, and learnings so that they are associated with representations of anticipated events outside of the audiologic counseling setting. Lankton (1980) stated that both fantasized and actual experiences are effective for changing behavior, and are the most important step in all successful therapy. Cameron-Bandler (1985) also emphasized that future pacing is the final step in any effective therapeutic intervention.

In goal setting, via future pacing the client is encouraged to imagine (i.e., visualize) and describe how, where, when, and with whom he/she perceives himself/herself attaining the desired outcome. The technique of future pacing involves several steps. First, the audiologist asks the client to visualize how he/she would perceive himself/herself when a "specific" outcome goal has been attained; for example:

Audiologist: Michael, you've stated that one of your desired goals is to feel confident when expressing your communicative needs with other people. I want you to imagine and describe how your life might change when you are assertive in educating others about your specific communicative needs. Please tell me what you see.

Michael: Well, I see myself wearing my hearing aid, of course, and asking my friends to repeat themselves.

Audiologist: I'm interested. Tell me how you picture others in viewing your assertiveness, wearing a hearing aid, and using some of the speech reading skills that we've discussed to help you understand better.

Michael: Well, they see me in control. My friends aren't mad at me.

Audiologist: I'm curious. What do you hear yourself saying to others in those communicative situations when you don't understand them?

Michael: Ummm . . . I'm telling them to look at me when they're talking and talk clearly.

Audiologist: Michael, I want you to step into the picture that you see. Tell me, how do you feel when you see yourself becoming more assertive and telling others about your communicative needs?

Michael: I feel good! I don't feel so uptight!

Second, the audiologist asks a few leading questions to encourage the client to project the perceptual experience with as much sensory-specific imagery as possible. Questions should specify the perceptual experience and guide the client to see, hear, and feel the effect of attaining the desired outcome.

Audiologist: Michael, I want you to imagine in some future time and place that you are being assertive with others. Tell me how, where, when, and with whom, do you first see yourself realizing your desired goal?

Michael: Well, I see myself wearing my hearing aid in class at school. My teacher is talking, but I don't understand her. She's talking very softly and there are other kids talking in the class around me.

Audiologist: Since you've met your goal of being assertive, what do you see yourself doing next?

Michael: I see myself raising my hand and telling her that I can't understand her. I see myself asking her to look at me and repeat what she said.

Audiologist: O.K. . . . and what do you see your teacher doing next?

Michael: She looks surprised!

Audiologist: What do you think would cause her to look surprised?

Michael: She's smiling now. I think she's pleased that I've asked her to repeat herself. Now she's talking and I can understand everything that she's saying.

That's interesting! I can see that the class is quiet too.

Audiologist: I'm curious. How does this surprise you?

Michael: Well, I didn't realize that everyone would be so willing to help me.

As illustrated, the client is encouraged to describe what he sees, says, hears, and feels when the desired outcome is achieved in some future context, and helps to verify whether the outcome can be generalized in various future contexts.

Third, the audiologist should ask the client to estimate when he/she expects realistically to achieve the desired outcome. For example, Michael may perceive realistically that he can achieve this goal within 6 weeks.

Identifying Resources and Strategies

Before a client can construct a guided image of attaining his/her outcome goal, the client must be aware of the various strategies and resources available, through future pacing for desired change. One strategy is for the audiologist to ask the client to describe the characteristics, skills, attitudes, beliefs, and/or behaviors that one needs to successfully attain the desired outcome.

Another strategy is for the audiologist to encourage the client to develop an inventory of his/her strengths, skills, and resources available to meet the goal in an estimated time frame. In the case example, Michael may incorporate the knowledge of using his hearing aid, speech reading skills, communication skills, and coping strategies. Subgoals can be established by identifying those specific resources that the client lacks to achieve the overall outcome goal.

The audiologist can also ask the client to describe any number of previous times when these resources were effectively used and outcomes successfully achieved. For instance, Michael was asked to describe three times when he wore his hearing aid, and asserted himself by asking family members and close friends to repeat themselves. Subgoals can be established by identifying those specific resources that the client lacks to achieve the overall outcome goal.

The audiologist and client should develop a plan together to attain the desired outcomes, including the necessary action steps to produce the desired results. The old adages "Hindsight is the best foresight" and "Hindsight is 20/20" illustrate the premise underlying the technique to assist clients to determine the necessary steps to achieve their desired outcome. This approach begins with the client visualizing that he/she has attained the desired outcome goal. After the client has detailed his desired outcome explicitly and how, when, and where he anti-

cipates attaining it, the audiologist can ask him to describe the various steps that were necessary to arrive at the outcome. That is, the client plans backwards, starting with the visualized successful outcome and working back sequentially to his/her present situation.

CASE ILLUSTRATION OF GOAL-SETTING

Following is an outline of the outcome goals present in Michael's aural rehabilitation treatment plan. The major headings (I through V) represent the five main outcome goals for Michael. The subheadings (A, B, and C) reflect the activities that Michael might perform to achieve the overall goal gradually.

Outcome Goal I: Michael will identify the benefits of wearing his hearing aid in at least three daily activities or relationships at school and at least three leisure-time activities in which he engages.

- A. To monitor and record all daily use of hearing aid for one week and to categorize the usage into "beneficial" and "not beneficial" situations.
- B. To list "how" or "in what way" the hearing aid has proven to be beneficial during those identified school and leisure time activities or relationships.
- C. To list "how" or "in what way" the hearing aid has proven to not be beneficial during those identified school and leisure time activities or relationships.

Outcome Goal II: Michael will increase his assertiveness in various communication situations by 50% over the next 6 weeks.

- A. To monitor and record all daily activities during school and leisure time in which Michael felt the need to (a) tell others about his hearing aid, (b) request others to repeat or clarify themselves, and (c) inform others about his communicative needs and to categorize these activities into "assertive" and "withdrew" outcomes.
- B. To list "how" or "in what way" Michael's assertiveness has proven to be beneficial during those identified school and leisure time activities or relationships.
- C. To list "how" or "in what way" Michael's social withdrawal has proven to not be beneficial during those identified school and leisure time activities or relationships.

Outcome Goal III: Michael will increase his receptive communication skills by 50% in various communication situations over the next 6 weeks.

- A. To monitor and record all daily activities during school and leisure time in which Michael felt the need to (a) adjust the volume of his hearing aid, (b) actively attend to visual and auditory cues, and (c) move physically closer to the speaker and to categorize these activities into "improved speech reception abilities" and "failed to understand"

outcomes.

- B. To list "how" or "in what way" Michael's improved speech reception skills have proven to be beneficial during those identified school and leisure time activities or relationships.
- C. To list "how" or "in what way" Michael's "failed to understand" activities have proven to not be beneficial during those identified school and leisure time activities or relationships.

Outcome Goal IV: Michael will increase instances of positive feelings about himself by 50% over the next 6 weeks.

- A. To recognize and stop at least four negative or self-defeating thoughts about himself each day during the next 6 weeks.
- B. To develop a list of two different positive or self-enhancing thoughts each day during the next 6 weeks.
- C. To substitute a positive or enhancing thought for at least one negative or self-defeating thought each day during the next 6 weeks.

Outcome Goal V: Michael will identify at least two long range communication goals (i.e., 1-to-3 years) and at least two short-term communication goals (present-to-1 year) to pursue at school and during leisure activities.

Michael met the five outcome goals outlined in his treatment plan. He telephoned the rehabilitative audiologist at least once weekly to report progress and discuss any issues or problems that he had meeting his goals. In addition, he followed through with his weekly rehabilitative audiology appointments at the hospital. His parents were supportive and did not interfere with his treatment plan throughout the 6-week program.

SUMMARY

The importance of goal setting in audiologic counseling and the process by which the audiologist and client can participate mutually to formulate goals has been described. Goals include both process goals that facilitate conditions needed for client change and outcome goals that specify the desired changes for the client.

There are several advantages of establishing goals: First, goal setting encourages the client to make relevant decisions and choices that represent the most significant values and priorities. Second, selecting and defining goals can contribute to desired changes, particularly when clients are heavily invested in the goal-setting process. Third, the client feels a sense of accomplishment during and after the goal-setting activity.

The concepts and strategies presented in this paper are useful for facilitating the process goals of conveying empathy, expressing genuineness, communicating acceptance to clients, formulating outcome goals, and verifying whether the desired changes that a client wants to accomplish during audiologic counseling

are realistic, attainable, and generalizable into appropriate future contexts. Outcome goals vary as a function of each client's needs and provide an explicit understanding of "what," "when," "where," and "how much" is to be accomplished. Goals provide a schema of clearly defined activities that allows the audiologist to select appropriate techniques and strategies for effecting change, identify and monitor progress, and refine or modify outcome goals.

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