The Counselling Experience*

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There are a myriad of counselling approaches and therapies currently in vogue, making it very easy for the speech and hearing clinician to become confused. For my purposes, I categorize the therapies into four different approaches:

1. The traditional psychotherapeutic approach—therapy most familiar to clinicians, following the traditional Freudian or neo-Freudian approach stressing the importance of the past in order to gain insight into the present behavior through a knowledge of childhood traumas. Constructs such as Oedipal conflicts and the subconscious are crucial to the therapy.
2. The rational approach—a highly content-oriented, no-nonsense approach focusing attention on the intellect. Emotions and emotional reactions are considered irrelevant or unimportant. The client is taught to employ logical procedures in solving problems. "Crazy" thinking is underscored and restructured to rational thinking.
3. The behaviorist approach—therapy focusing entirely on the present. Its basic tenet is that all behavior is learned; in order to change behavior, the clinician and client, by using selective reinforcement and successive approximation, eradicate the old behavior and develop the desired behavior.
4. The human potential movement—an approach covering a very wide range of therapies and philosophies under which lies a fundamental assumption: that human beings inherit a capacity and a drive for growth which is sometimes thwarted by the environment. The clinician, by providing the environment and contact in which trust and acceptance are high, allows the client to work through the growth blocks and release potential.

The speech and hearing professional has, obviously, a wide choice of therapeutic styles and approaches to choose from. Audiologists, from what I have observed, seem most comfortable with an approach dealing with content, confined to advice-giving and information-providing and rarely use any of the other models. In many cases the audiologist seems afraid to deal with the affective issues. These are

* Formal Presentation given at 1975 Summer Institute, Soquel, California.

thought to be the province of the psychologist. In part, the fear of dealing with affect may be due to the general lack of experience provided by training programs and the failure of many audiologists to see that affect counselling is a necessary component of content counselling.

My particular bias is that counselling, in order to be effective, must deal with *both* affect and content; I do not process information if my affect level is too high. It seems, therefore, that in order for us as professionals to convey information, we must first allow the emotional issues to be worked through. We are not dealing with emotionally disturbed people, per se, but communication problems invariably have emotional components. The effective audiologist must be willing to deal with these emotional issues. I have found the human potential philosophy, and Carl Rogers' non-directive approach to counselling in particular, invaluable in my counselling relationships.

Another strong bias is that my personal growth is a vital component of my professional growth, i.e., that I, as a professional, have a responsibility to work on my personal growth to the same degree that I work on the growth of information and technique in the field of audiology. It is only as my awareness of myself and my confidence in myself in interpersonal relationships increases that I am willing to allow emotional issues in counselling to emerge. I define the counselling experience as a relationship that increases the opportunity for mutual growth. Certain conditions need to be present for this mutual growth to occur:

1. *I must be aware of what constitutes a "helping relationship."* I have realized over the years that my "helping" people was often a reflection of my own feelings of inadequacy, i.e., "I can't be that bad if people need me." As a result of my assuming the "savior" role, people became dependent on me. The role was double-edged. I quickly began to resent the responsibility I placed on myself and the "ingratitude" of the helpees. The people I helped also felt ambivalent. They were dependent and grateful but resentful at being reminded of their inadequacies as reflected by their needing the help. Since I have been able to like myself better without needing others to feed my ego, I have allowed others to take responsibility for themselves and can now live the humanistic precept that each person knows what's best for himself and can find it with a minimum of professional interference. I facilitate a growth, yet no longer assume the responsibility for it or the management of other people's lives. This has led to more satisfactory relationships with the people I am counselling. The relationships are no longer dependent—people come to me to seek information or advice but I have full confidence in their ability to process the information

provided and make the best decision for themselves. I no longer feel burdened by their problems.

2. *Counselling proceeds best when I can learn to listen.* Rogers talks about the therapist's ability to hear and respond to the "faint knocking." By this I think he means the ability to hear what a person is saying or asking *underneath* the surface comments or questions—in short, the affect. I have found that questions in a counselling relationship are usually most revealing and difficult to deal with. Invariably, there is a statement behind each question—if I respond to that unstated statement I am much more effective in my counselling.

I have distinguished three types of questions (or statements). The first is the question that is really asking for content, i.e., a form of "I don't have this particular piece of information and I hope you have it." In my experience, most audiologists tend to respond to questions in this manner. In my counselling experience, very few questions, at least in the initial stages, are content questions.

The second kind of question is a confirmation question. In this the asker already has a position but does not want to reveal it and so asks a question in the hope that the answer will confirm it. For example, "Is Clark School a good school for the deaf?" is likely to be a confirmation question in which the person asking the question has some position about Clark School. Confirmation questions are very tricky and when treated as straight content questions invariably result in the phenomenon known as "putting your foot in your mouth."

The third kind of question is the "faint knocking" question which contains an affect the questioner might not be aware of or is not feeling secure enough to reveal. For example, the question, "Do drugs cause deafness if taken during pregnancy?" can be a manifestation of some guilt the mother has about a medication taken during her pregnancy. The counselling audiologist can respond in a variety of ways: with a dissertation on the effects of drugs taken during pregnancy (content); by asking if the parent had taken any drugs during her pregnancy (checking out if it is a confirmation question); or with a statement that it must be easy to feel guilty about having a deaf child (affect). None of these responses is any superior to the others—at any given time each response is appropriate. What I am suggesting, however, is that the practicing audiologist rarely responds to the affect; thus, the counselling experience tends to be entirely content oriented. When I hear parents repeating the same questions over and over again I know that content is not what they need. In order for them to grow I will need to explore the affect with them. As I have been more willing to respond to affect, my counselling experience has been richer and much more effective. Counselling by audiologists should include content, but content is much more readily absorbed when a content question is really

being asked. Most questions, especially in the initial diagnostic phases when affect is very high, are not content questions but either confirmation or affect queries. The effective audiologist must be able to distinguish among the various kinds of questions.

3. *I fail in counselling when I do not trust the wisdom within the individual.* By this I mean that when I assume that I know what's best for an individual and try to convince and manipulate him into a course of action, I then stop listening. If I adopt an adversary relationship with the client and become busy marshalling arguments and strategies while he is talking, I no longer listen for the affect nor am I particularly influenced by his content. I have found that people previously counselled in an adversary relationship adopt strategies to hide their feelings and sometimes even conform to the suggested behavior without enthusiasm or understanding. We have all, as audiologists, I am sure, had experiences with the hard-of-hearing adult who purchases the hearing aid at our and/or relatives' urging and does not wear it. Counselling time with such a person can be better spent listening to him and reflecting back his feelings rather than convincing him of the value of the aid. The hearing aid should be purchased only when he decides he needs one and is ready to wear it. "Pushing" hearing aids on adults who are not emotionally prepared to wear them satisfies an emotional need of the audiologist but does not service the hard-of-hearing adult. I have found that people will learn only when they are ready to learn and behave only in ways they are ready to behave in. As a counsellor, I must be sensitive to a person's readiness and provide him with materials, information and an environment in which learning can be optimized.

4. *Learning procedes best when I cease being judgmental.* Judgments I make about people I am counselling frequently interfere with the learning process. If I make a judgment that a person is difficult, I begin to behave in a defensive and distancing manner, rapidly communicating that judgment to him. If I learn to listen and accept without judgments, I find that there are no "difficult" people, only "distressed" people. When the person being counselled senses the acceptance and lack of censure in the relationship, his growth can take place. He is willing within this environment to take risks and reveal himself. As the person unfolds, the potential is realized.

5. *I fail as a counsellor when I cease to be "real."* In graduate school I was taught to be "professional." "Professional" meant "unreal" in that I was supposed to know all the answers, ascertaining automatically what was best. If I did not know the answers I was probably deficient, but I was not to communicate my uncertainty to the person. I was taught (although it was never put in these terms) strategies to put parents down, to guard against the difficult person, etc. I adopted and

used techniques for distancing myself from the people I was dealing with. My principle weapon was content—if the discussion centered on content the I would always be in control. Although I was being "professional," I didn't feel particularly effective as a counsellor. Since I have dropped my "professionalism" and become more real, I have become more effective.

This paper was written in the hope that another dimension of counselling can be made available to the speech and hearing professional. It is not intended as a prescription but, rather, as a signpost for another way of relating to the communicatively disordered. Because I have allowed myself more freedom in the counselling relationship, I have learned and experienced more for myself. It is my hope that others will also find another and perhaps more satisfying way of relating.