

Counseling is a topic that seems to be coming up more and more when we talk about the delivery of audiologic services and the dispensing of hearing aids. You might recall that in March 1999 Robert Sweetow visited Page Ten to review some counseling issues, most of them related to the fitting of and adjustment to hearing aids. One

of the questions posed to Robert in this article was "How do I become a better counselor?"

But maybe we should start with the question, "How good are we at counseling?" I think we're pretty good at giving out a lot of technical information, probably to a fault. But is this really what counseling is all about? How would we know? Most of us have never had any formal training in counseling, even though this just might be one of the most critical skills for anyone involved in direct patient care. But there's hope.

I was intrigued by a recent article in the *Journal of the American Academy of Audiology*, which reported on a group of mid-career audiologists (with an average of 16 years' experience), who completed a counseling course through distance learning.



The results of this study were very encouraging. After a 12-week course, the students' counseling skills improved significantly. Moreover, it appears these skills can be acquired over the 'net.

For some insight into what some of these skills are, and how we can use them in our day-to-day practice, we thought we would bring the senior author of that paper to Page Ten to tell us all about it.

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As Kris explains in this excellent review article, by functioning as a "non-professional" counselor, that is, limiting ourselves to issues related to hearing loss

Personal adjustment counseling: It's an essential skill

By Kris English

1 What's new to talk about in audiology counseling these days?

Maybe the biggest news is that there are more opportunities available for both graduate students and practitioners to take formal coursework in counseling and learn how to integrate advanced counseling skills into their practices. Only about 12% of master's-level programs have included counseling courses in the past, since a 2-year program could rarely spare time for them. Now, most doctor of audiology (AuD) programs are including formal coursework in this area into their curricula. This development is occurring in distance-education programs as well as in residential training programs.

2 Why the concern about formal coursework? If you can explain an audiogram, you've got counseling "nailed," right?

That's a commonly held assumption: that counseling is simply a matter of carefully explaining technical information. That skill is actually only one facet of counseling, called "content counseling." There is no doubt, in my mind at least, that audiologists are generally highly skilled at content counseling.

Let's use your example of explaining an audiogram. In this scenario, I do the talking, while the patient listens and occasionally asks a question. This kind of interaction is our *modus operandi*, an essentially one-way conversation. But what if the patient wants to talk as well? What if the disability she lives with on a daily basis is placing strain and stress on her life, and what if she is trying to tell us about it at almost every encounter?

3 What might she want to tell us?

Chances are high that she is experiencing some degree of psychological stress, social tension, or emotional difficulty. The literature abounds with descriptions of patients experiencing anxiety, vulnerability, guilt, and even depression and despair. Losing one's hearing, or learning that one's child has a hearing loss, or living with a husband or wife who has a hearing loss is extremely upsetting, and most people, when they are upset, want to talk it over with someone.

To help a patient with these kinds of difficulties, an audiologist needs to shift gears from content counseling to personal adjustment counseling—and personal adjustment counseling skills usually need to be taught, practiced, and evaluated. So, getting back to your earlier question, that's why there is a need for formal coursework.

4 Is personal adjustment counseling really so important?

From everything I have read, learned (and continue to learn), and have been told by esteemed colleagues, I think it could actually be the most important of all our skills. Our patients not only have damaged auditory systems, they also present with damaged self-concept, damaged self-worth, and strained interpersonal relationships. For many of our patients, these latter issues are "front and center," and until they feel emotionally supported and understood, our efforts to remediate their auditory systems will be stymied.

Think about the chronically dissatisfied patient, or the persistent no-show patient, or the patient who passively accepts new hearing aids only to return them with no real explanation. Something is going on, and we need to find out what it is and try to address the problem in the hopes of eventually helping with the hearing loss as well.

5 Do audiologists sometimes report that they just don't see a lot of emotional difficulties in their patients?

Sometimes that's to be expected, especially since most new patients wear a "social face" and maintain a polite distance. Disclosure of personal problems requires a certain amount of trust, and that takes time as a relationship develops. If one's practice involves very little on-going contact over time, one may not expect to hear expressions of personal difficulties.

But, as a profession, we should ask ourselves, are we in the habit of listening only for content types of questions and comments? If that is all we are listening for, then that is all we will hear, and as a result we may mismatch our response to a subtle but nonetheless affective (that is, describing how one feels) statement by providing a content-type response.¹

6 Can you give an example?

Sure, something like a patient saying, "I just hate the way this hearing aid looks on me. It seems like everyone stares right at it," and the audiologist responds, "I could order it in a different color so that it would blend into your hair."

What we have here is a mismatch in communication intents. The patient was expressing at least some personal adjustment difficulties (embarrassment, self-consciousness), but the audiologist glosses over that to go straight to a solution.² It's a tough habit to break, but the counseling profession tells us this kind of response leaves patients feeling as if no one is really listening to them. We need to respond to the affective component somewhere along the way—if not at first, at least eventually.

I keep hearing this same report from students (all audiologists with master's degrees and worlds of experience): "I've been working in the VA (or schools or private practice) for 15 years, and just in the last 2 weeks, patients have been mentioning how their hearing loss is affecting their psychoemotional state." I'm pretty sure that patients had been expressing these concerns all along, but it's only now that the audiologist is listening at more than one level and is picking it up.

7 So is it a matter of enhanced awareness?

Very much so. Once we open our own ears, in a sense, we may be surprised at the abundant expression of personal adjustment concerns. Just this morning, I saw two parents, who said to me:

"Will Lorri [age 4] have to get this auditory training stuff her whole life?"

"You see those hearing aids on James, and it just breaks your heart. He could be such a beautiful baby."

Without actually hearing it, you may not perceive the stress and disappointment the first parent conveyed, but I don't think you can miss what the second parent was saying.

8 This kind of counseling—personal adjustment support—is so different from our usual interactions with patients. Is it within the scope of practice for an audiologist?

It is, according to both the American Speech-Language-Hearing Association and the American Academy of Audiology, as long as we understand a couple of parameters. First, at all times we must respect professional boundaries and avoid trying to help in areas that are not within our expertise. For example, when we see a couple whose problems seem to extend beyond the effects of hearing loss, we might feel that marriage counseling would be beneficial. However, we are by no means qualified to provide that counseling. A referral to a professional marriage or family counselor may be in order. Knowing that those boundaries exist helps us feel more confident when counseling in the area we do know about, hearing loss.

9 What's the other parameter?

We also want to be very clear about the differences between professional and non-professional counseling. Of course, we are very familiar with the role of the professional counselor who helps patients work through deeply involved and complicated psychological problems. The idea of a non-professional counselor may be new to us, though.

Kennedy and Charles describe a non-professional counselor as a person in a helping profession who helps patients with a range of psychological, social, and emotional difficulties *as they relate to one's specialty*.³ For us, that would be hearing loss.

Thus, the goal of counseling classes in audiology programs is to give audiologists not only a cognitive understanding of their patients' difficulties, but also to develop some skills that will be of help.⁴

10 How can I tell if a patient is trying to talk about these concerns?

It sounds easy but it's hard to do: Refrain from answering right away; instead conduct an on-the-spot analysis of what you heard. Was it a request for information, or was there more to it? The counseling profession calls this "differentiation," and it is *the* fundamental counseling skill. If you do not differentiate, your response is likely to be out of step with the patient's communication intent. Another term for this process is "listening with the third ear"—a particularly apt phrase for audiologists!

11 You said this kind of listening is hard to do. Why is that?

People are by nature egocentric, and listening this carefully requires us to be the opposite, to align ourselves with what the patient is saying and to try to see things from the patient's point of view. People tend to develop barriers that prevent them from listening carefully: If we start comparing the patient in front of us to the one we saw this morning, or if we start rehearsing our response while the patient is still talking, we have stopped listening.

One of the biggest barriers is the tendency toward habituation: "*I've heard this story countless times. All patients sound the same.*" It always helps to put yourself in the patient's seat: Ask yourself, "*If this were me, would I want my audiologist to make this assumption or have this impression of me?*" I don't think so. Your experiences are uniquely yours, and patients can tell when we don't believe that.

12 Let's say I'm learning to be a listener who can tell the difference between a request for information and a personal adjustment concern. Then what? What do I say in response?

There are two ways to go here, and the first one is easy, one that we already know how to do. If the patient presents an unadulterated request for information,

we provide the information. “How do I know when I need to replace a battery?” “Should I wear my hearing aids while I’m driving?” “Do you recommend an annual hearing test, or should I come twice a year, or what?” As far as I can tell, there is no personal concern being expressed in these statements (but I would not be sure until I heard the tone of voice and observed the body language).

13 But if it’s a personal adjustment concern, it’s not so straightforward, is it?

It’s true that when a patient expresses a personal concern, it is not as easy to describe an appropriate response. There is no script, no formula (which is why practice and feedback are needed). But the main goal is to respond *in an active way* to the affect that was heard, often by acknowledging or describing it. If we don’t actively address what we are trying to understand, it appears that we are ignoring it. The patient cannot read our minds to know that we are attending to them.

Learning to respond appropriately takes a great deal of practice, reflection, and discussion with like-minded peers, and I regret to say I cannot wrap this up in a tidy paragraph here.

14 Say a patient is reticent, not expressing much in the way of communication problems or anything else, just a vague complaint that “I can’t hear as well as I used to.” Are there any strategies that could open the door without appearing intrusive?

An easy strategy is to use our time-honored self-assessment instruments a little more creatively, especially when a few items tap into personal difficulties or social stresses. For instance, in their questionnaire, Self Assessment of Communication, Schow and Nerbonne suggest posing the question, “Does any problem or difficulty with your hearing upset you?”⁵ If the patient answers in the affirmative, one could simply add that value into the score, or one can address the issue directly: “You indicated feeling upset sometimes because of your hearing loss. Could you tell me more about that?”

If an audiologist gives permission to patients to talk about these things, they may just take up the offer. (Even if they

don’t, at least they should be less likely to complain that their audiologist is inattentive.) Some self-assessment tools also have a parallel version for significant others to complete as well, and when discrepancies occur, we automatically have something to talk about.

15 So we can use a self-assessment tool for more than its designed purpose, right?

As a counseling tool, self-assessment can’t be beat. It gives the patient and the audiologist a neutral “third thing” to talk about, which seems to ease the discomfort that can come with self-disclosure. If a patient is having a difficult time, it may be hard for him to say so while looking the audiologist in the eye. However, if both of us direct our attention to a standard form, the patient may be more inclined to reflect on his difficulties and explain them. And at the same time, we obtain the more conventional information we are seeking (outcomes, expectations, etc.).

16 If you tried to pinpoint the most common counseling error, what would it be?

I can only identify what patients report, and a primary complaint seems to be about time and timing. Audiologists may forget how long it took them to understand an audiogram, so they try to teach all its nuances to patients and parents at the first opportunity—often at the very moment when the patient or parent is least likely to understand what is being said.

Did you see that episode of *ER* where Dr. Benton was having his baby’s hearing tested? He had his baby on his lap, and realized there was a problem because the baby was not responding to the warble tones. As soon as he stepped out of the booth, the audiologist dived into a detailed explanation of the speech banana, while he simply tried to get away from her. It was painful to watch that scene because it looked so familiar.

17 So we rush when patients need us to slow down?

I’m just saying it’s possible. It’s easy to forget a couple of things. First, different people process new information at different rates, so we need to check on that rather

than assume anything. Secondly, most people are not in optimal learning mode when they have been given difficult news.

I’m thinking of parents in particular here. Our gut reaction is to urge immediate action, but often, for parents, time has come to a screeching halt. Their world is never going to be the same, and they need time to adjust. Hurrying on our part will not help that, and it could potentially impede adjustment by creating resentment and confusion.

18 Speaking of time, I get the feeling that all this counseling will eat up the clock, and I know it is not billable time. Isn’t it difficult or even impossible for anyone with a tight schedule to work counseling into his or her practice?

Counseling should not be viewed as an “added-on” activity, but rather as something to integrate into conventional practices. That is likely to involve “doing the same things differently” so as not to cause drastic changes in allotted time frames. It takes a great deal of thought to determine how to modify one’s existing practices and to attempt to improve one’s counseling skills. However, as audiologists develop these skills, they report that they actually find themselves saving time! This seems to be because they make a concerted effort to find out what the patient wants at that meeting instead of assuming they want the full menu of complicated explanations.

For example, why spend precious minutes covering detailed test results assistive devices if the patient, at the moment, is not interested in them? Not only are we spending time on a topic they don’t care about, we haven’t yet found out what they *do* want to talk about.

This brings us to a huge question—that of control. In the final analysis, in counseling, we eventually ask ourselves, “Who owns this hearing loss?”

19 “Who owns this hearing loss?” What kind of question is that?

I guess it’s a philosophical one. I can only describe what I have observed. Somewhere along the way, audiologists seem to grapple for control over a patient’s hearing loss. By virtue of our involvement, our assessment, and recommendations, we may begin

to develop a feeling of ownership of the patient's problem—which is why we take it personally when a patient rejects our recommendations. “*If he didn’t want a hearing aid, why did he come here in the first place?*” (If we are asking this question at the end, it means we didn’t listen carefully enough in the beginning.) If all support was provided, and the patient still makes this choice, do we still feel as if we have failed?

Suppose an audiologist says, “This parent just won’t make her child use hearing aids at home.” The only real answer to that is, if we have offered every support we can think of and the parent still makes this choice—well, it’s her child. We also hope parents will have their kids wear seat belts and safety helmets and take their vitamins, but ultimately they make the choice and are responsible for the consequences. We can only help people who let us help them, but it seems to anger us when people reject our help. We may actually judge them harshly for that, instead of accepting their right to decide what kind of help they want.

We say we want patients to manage their hearing loss aggressively. Well, they may elect to exercise their independence by not following our recommendations. Can we accept that? If we are uncomfortable with the prospect, it may mean that, deep down, we feel we at least partly own the hearing problem. To best help our patients, we have to understand our own motivations and our role as a helper.

20 Well, our time is about up. Any closing words?

Just to thank you for the opportunity to talk about what personal adjustment counseling can mean to audiologists and their patients. Developing these skills takes a lifelong learning commitment for audiologists, and I value the opportunity to be involved in it.

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