

# Family Informational and Support Counseling

Kris English

*You don't really understand human nature unless you know why a child on a merry-go-round will wave at his parents every time around—and why his parents will always wave back.*

William D. Tammeu

Merry-go-rounds and waving . . . a charming image, but what does it have to do with family counseling? Please keep this question in the back of your mind. It will be posed again at the end of the chapter, and at that point, you will have at least one answer.

## Introduction

Pediatric audiologists engage in counseling in virtually every family interaction. But what *kind* of counseling is occurring? It is important to remember that we have two kinds of counseling options available to us. One option is *informational counseling*, which is a formal name for our efforts to educate families about their child's hearing loss. While in "informational counseling mode," we explain to families what their child can and cannot hear, why amplification is needed, the nature of early intervention, and so on. In fact, the content of this textbook represents the body of information the pediatric audiologist will likely want to convey to families at the appropriate time.

However, conveying information is only one aspect of counseling. While adjusting to the diagnosis of their child's hearing loss, families experience a range of psychological and emotional reactions. Those reactions are not easily resolved, nor are they filed away as "finished business" at some point. Rather, these reactions

recur in some fashion throughout their child's development, and can disrupt the overall adjustment process. Because audiologists are the primary service provider for children's hearing loss, their families are right to expect us to provide ongoing *support counseling* for these adjustment challenges.

Informational and support counseling are two sides of the same coin, the coin being "family care." Therefore, counseling should be perceived as a dual-consciousness activity. That is, while information is being conveyed, the audiologist also should watch for reactions to the information. And when support counseling is being provided, the audiologist also must determine if including information will help or hinder the support process.

This chapter describes basic strategies for effective informational and support counseling, including the skill needed to determine which type of counseling to provide.

## Informational Counseling

Conveying information is *teaching*. We teach when we explain and demonstrate new information to family members, an activity that could occur at every appointment. However, audiologists are not always familiar with the science of *teaching effectively*. The fact that something was explained does not ensure that the learner understood it. In fact, research shows that explaining alone usually does not result in real understanding.

So, how do professionals convey information effectively? That is, how do audiologists help families not only understand, but also remember and apply the

information we convey? This section summarizes current research on how adults learn, and how best to facilitate that learning.

## How People Learn

Learning is a specialty area in the fields of neurology, cognitive psychology, and patient education. Learning involves an organized and permanent change in brain function; synaptic connections become more efficient, allowing the learner to create new connections to previously learned information, making it easier to retrieve and use at a later point. These changes most likely will occur when the brain is fully engaged. Here is how Zull (2002) describes a fully engaged brain while in learning mode:

- the sensory cortex takes in new auditory and visual input;
- the back integrative cortex engages in memory formation;
- the frontal integrative cortex engages in problem-solving; and
- the motor cortex carries out plans originating from the frontal integrative cortex.

Effective learning occurs when all of these activities take place. When we only explain, we only engage the sensory cortex, minimizing the likelihood of complete understanding.

Following are two “timeless principles of learning” (Suter & Suter, 2008) with applications for pediatric (“fully-engaging-the-brain”) informational counseling.

### **Knowledge Is Enhanced by Activity: Learners Remember What They Do**

It is quite reasonable for parents to doubt the diagnosis of a hearing loss when their own observations do not support that diagnosis. Indeed, children with mild and moderate loss will still startle to loud sounds and notice voices, so parents become understandably skeptical. They have been told there is a hearing loss, but their observations indicate no hearing problems.

To help parents work their way through this dilemma, in 2002 Anderson created the Early Listening Function (ELF; [http://www.phonak.com/com\\_elf\\_questionnaire\\_gb.pdf](http://www.phonak.com/com_elf_questionnaire_gb.pdf)). The ELF is a “discovery tool” to help parents actively test their child’s age-expected auditory responses to sounds that are loud or soft, near or far, low or high pitched (male versus female voices). As they hold their child, present sounds and

watch reactions, parents begin to understand and remember because they are “doing”—they are cross-checking their own observations to expected behaviors, and they are also learning a concept called the “listening bubble.” The listening bubble is the space around the child where hearing is optimal; beyond that bubble, hearing will be a challenge. The size of the bubble will be different for every child, and it will change when using amplification. The ELF helps parents “learn by doing” and is an invaluable exercise to help parents move forward.

### **Learning Is Enhanced by Social Interaction: Learners Need Social Engagement in Learning**

When asked what they need most, parents often will place “contact with other parents” at the top of their list. This request is consistent with the need for social engagement.

Parent support groups should be run by parents, and pediatric audiologists can help by providing a meeting place, childcare arrangements, and other logistical support. Support via the internet is also available, especially through special interest groups or communities of practice (Shirky, 2008). Social engagement helps parents ask other parents “How do you do this?”—for instance, how do you handle discipline, hearing aid problems, questions from strangers, sibling issues, pressure from grandparents? How do you navigate the special education system? How do you help your child develop and maintain friendships?

Whether in person or online, only “seasoned parents” can answer these kinds of parenting questions with credibility. Pediatric audiologists can establish relationships with these groups and keep families apprised about events and membership. See “Resources” at the end of this chapter for the names of some parent support groups.

### **Beyond Audiology 101: Looking Ahead to Literacy**

In addition to providing information about *hearing*, pediatric audiologists also need to help families understand the concept of *listening* as part of their child’s cognitive development. We know (but parents may not yet realize) that a direct relationship exists from hearing to academic success. Specifically:

- hearing leads to listening;
- listening leads to understanding language;

- understanding language leads to using language;
- using language leads to phonemic awareness and other preliteracy skills; and
- preliteracy skills must be mastered before first grade (reading readiness).

All parents want their child to read! We know (but parents may not yet realize) that if hearing is not optimal, the subsequent steps will be delayed, perhaps irreparably (Cole & Flexer, 2007).

"Learning language" is an abstract concept, and early interventionists and speech-language pathologists face the challenge of explaining that concept to parents. However, all parents know what learning to read means (Bus, van Ijzendoorn, & Pellegrini, 1995; Yarosz & Barnett, 2001). Yet, they typically are not aware that *years of consistent auditory input* are a prerequisite to learning to read. For example, children need to clearly hear a phoneme (for example, /b/) literally thousands of time before they are *cognitively ready* to associate the sound of that phoneme ("buh") with its written symbol. This skill is called "sound-symbol association." Children who do not use amplification consistently will not receive the necessary early exposure to speech sounds, and thus will not be ready to make the cognitive connection between sound and symbol when they enter the first grade.

Audiologists should be sufficiently conversant in literacy development to help parents understand the linked relationships from hearing to listening, to phonemic awareness and preliteracy skills (Figure 39-1). Audiologists can and should also provide direction to parents regarding their state's first grade learning standards, most of which rely on age-level listening skills.

Caveat: This topic must be approached differently when families actively identify with Deaf culture. New strategies such as Visual Phonics (Tresek & Malmgren, 2005) are being used to improve reading skills for children who are not accessing the world of sound. Even though 95% of children with hearing loss have at least one hearing parent (Mitchell & Karchmer, 2004), the audiologist cannot predict a family's cultural identification.

How can we help the family focus on helping the child achieve "reading readiness" when entering first grade? The pediatric audiologist should consider this topic as routine as any other issue discussed during appointments. In the United States, every state's Department of Education has a Web site with materials written for parents, describing specific benchmarks for each grade. A section on language arts, for example, will indicate, "what is expected in Grade 1" (from <http://www.OhioAcademicStandards.com>):

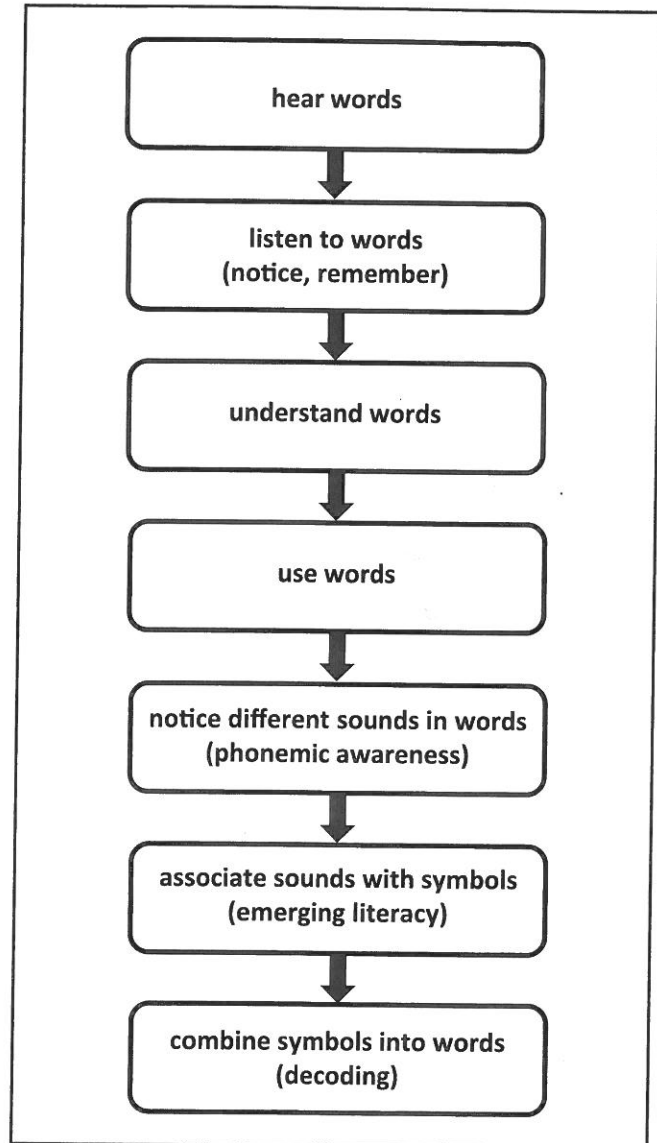


FIGURE 39-1. Sequence of skills leading to literacy.

- being able to read well by sounding out words;
- being able to recognize clues in writing, ask questions, listen, and converse with adults and peers;
- know the meaning of compound words (raindrop, daydream) using what is already known about the individual words; and
- using the steps of pre-writing, drafting, revising, and editing to produce different types of writing.

All of these skills are predicated on age-appropriate listening skills. Families are well served when they are aware of these standards, and also given information on how to support their child's development toward

reaching these standards. Following are some examples, with “enhanced listening components” for children with impaired hearing:

- Gather pictures, alphabet letters, or other objects. Let your child tell you which objects are alike, which are different, and why. *Enhanced listening component:* pronounce two sounds (ay/ee or sh/sh) while covering your mouth (without muffling your speech), and ask your child, Are these two sounds the same or different?
- Say a word or show your child a picture. Let your child write or say the beginning and final sounds. *Enhanced listening component:* pronounce two words (dog, dad) and ask, are the first two sounds the same? Are the last two sounds the same?
- Write four to five words that would make a complete sentence. Make sure the beginning of the sentence begins with a capital letter and the last word ends with a period. Next, have the child put the words in an order than makes sense. *Enhanced listening component:* Say the words in any order and ask the child to organize the words in the order given.

An important note: the suggested “enhanced listening components” are not part of these educational materials. The audiologist will need to add them. We can help families develop their child’s listening skills by building on predeveloped parent materials.

## The Child Connected to These Ears

One mother reports:

When our son was diagnosed with profound hearing loss, we immediately committed ourselves to his success. We kept every appointment, religiously put his hearing aids on every day; we hired specialists to improve his speech. His early years consisted of appointments, therapy, and homework.

We were so focused on helping him with his hearing loss, we forgot to attend to his social development—his development as a person. We arranged no play dates, were oblivious to the other children in the neighborhood, drove right past the park and the local preschool.

Now he is 8 years old. We’ve changed schools to give him a fresh start because his friendship

skills were nonexistent, but that didn’t help. He doesn’t know how to approach other children, share or talk to them, or just be nice to them. The other children actively avoid him.

If even one professional had asked us about his social development, we would have pulled our heads out of the treatment “sand” and realized we were overlooking something. And at this stage in his life, it’s become the most important thing!

Do pediatric audiologists ask about children’s social development? Do we ask parents if their child has a friend to play with, or other social opportunities? We may be the “one professional” who reminds parents that their child needs practice communicating with their peers and support in learning how to make and keep friends.

In addition to adding this topic to our repertoire, we can also suggest reading materials on overall child development, or provide brochures that summarize this topic. For instance, pediatrician Greenspan and colleagues (Greenspan & Greenspan, 1985; Greenspan & Lewis, 1999) write about parents’ roles in supporting their child’s social and emotional growth, and summarizes key points in a functional developmental growth chart. Children with hearing loss may experience some initial delays while finalizing the diagnosis and waiting for amplification; however, if parents are consistent in hearing aid use, they should be able to expect their child to catch up.

### Stage 1: Regulation and Attention

By 3 months of age, infants should be showing an interest in things in the environment. They should be able to focus while remaining calm and regulated. Even with a hearing loss, infants should be visually attentive. Ask families about those behaviors.

### Stage 2: Engaging in Relationships

By 5 months of age, infants should seem happy or pleased when they see favorite people by looking and smiling, making sounds or moving arms and legs that indicate delight. In this stage, infants “fall in love” with their caregivers, and one of the inputs that affect this development is the human voice. When infants cannot hear “the love in one’s voice” because of hearing loss, there is all the more reason to stress the value

of amplification to parents. Focusing on the development of the parent-child relationship and bonding is very meaningful to parents, probably more so than the development of speech and language.

### **Stage 3: Interacting in a Purposeful Manner and Becoming a Two-Way Communicator**

By 9 months, children should be able to show what they want by pointing at something, reaching out to be picked up, and making purposeful noises. Children using amplification should also be developing as communicators, so at this stage we should be asking not only for parents' reports on auditory responses, but also on two-way communication.

### **Stage 4: Organizing Chains of Interaction for Simple and Complex Problem-Solving and Forming a Sense of Self**

By age 14 to 18 months, toddlers are able to show parents what they want by using actions, such as leading them by the hand to the refrigerator, tugging on the handle, and pointing to juice or milk. Toddlers also use imitation to interact, with sounds, words, or gestures.

### **Stage 5: Using Ideas (Words/Symbols) to Convey Intentions or Feelings**

By age 24 to 30 months of age, toddlers imitate familiar pretend actions ("driving" or "cooking"). The toddler's world expands to include peers, and to engage in parallel play with another child. This kind of play is not heavily dependent on verbal communication. This is the time to ask the family about peer play opportunities.

### **Stage 6: Creating Logical Bridges between Ideas**

By 36 months of age, children engage in pretend play and are occasionally able to use feelings to explain behaviors or desires ("Because I'm mad/happy"). Understanding one's emotions and being able to name them is a cornerstone skill to social development; children are not able to understand their peers' feelings until they understand their own feelings.

## **Summary**

Pediatric audiologists should be able to converse with parents about their child's overall development. While not being expected to have a high level of expertise in

child development, we should have enough background to ask parents informed questions about their child's overall development, provide relevant materials, and make referrals when necessary.

## **The Merry-Go-Round**

We started this chapter with the image of a child on a merry-go-round. Has the first part of this chapter helped you understand why child and parent wave? Does the audiologist as an effective *information counselor* help parent and child enjoy this moment? Keep thinking about this dynamic and what it means to families.

## **Support Counseling**

### **Staying in Step with Families**

During each moment that family members process information, they also experience a range of emotional reactions. The reactions cannot be predicted, but they may include shock, fear, confusion, vulnerability, doubt, guilt, and grief (Luterman, 2008).

PET scan studies confirm that we think and feel simultaneously. Typically, one process (for example, thinking) takes precedence over the other (feeling) depending on the circumstance, but the second process is never completely out of the picture.

Goleman (2006) describes "emotional intelligence" as the ability to perceive whether someone is communicating with a "thinking mind" or a "feeling mind." Communicating with the "thinking mind" includes discussing data, specific details, and other types of information. Communicating with a "feeling mind" includes recognizing and discussing psychological and emotional states. The pediatric audiologist's challenge is not only to recognize which "mind" a family member is using at a given moment, but also how to respond accordingly. That is, a "thinking mind" comment or question should be given a "thinking mind" response (information). On the other hand, a "feeling mind" comment or question should be given a "feeling mind" response (acknowledging the emotions or psychological reactions that were expressed).

If we are not paying attention, we are likely to "mismatch" our response (English, Rojeski, & Branham, 2000). This mismatch most often occurs when families describe *how they feel*, whereas our response

indicates *what we think*. This mismatch is often a result of training, wherein we are prompted to give information to demonstrate to our supervisor that we indeed know specific information. However, family members are not our supervisors; a different audience needs a different approach. Here is an example of a typical exchange:

### Dialogue #1

- Parent: My in-laws claim that our little boy Aaron was born deaf because I worked until the last week of pregnancy.
- Audiologist: Our research indicates otherwise; there is no reason to worry about that.

In this exchange, listen to the parent's subtext: she is indirectly reporting *how she feels* (guilt, stress, fear). Regrettably, the audiologist did not notice, and instead indicated *what she thinks* (by citing data and research). A "matched" response would have actively addressed the "feeling mind," such as, "That sounds like a difficult situation." Audiologists can learn to avoid communication mismatches by "raising their antenna" to listen at a deeper level to the subtext, and then respond with reflective comments that invite more conversation (Clark & English, 2004; English et al., 2000). This skill is an important one to develop. Mismatching our responses frustrates the family and interferes with the development of a supportive relationship.

How do we prevent mismatches? When in doubt, address both possibilities. After providing content or data, step back and ask the patient about the emotional components of the comment, or inquire if they are not explicitly stated, as we see demonstrated in this exchange:

### Dialogue #2

- Audiologist: Your suspicions were correct, Ms. Watson, your son does have hearing loss in both ears.
- Parent: I should have done something about this much sooner.
- Audiologist: The main thing is, we can do something now. (Stops, recognizes the mismatch). But . . . much sooner? Are you thinking about an earlier time?

- Parent: Yes, back on his first birthday, some loud sound happened and I wondered about it then. But he is pretty hard to read in a lot of ways, you know?
- Audiologist: Sure. You had no real information to work with.
- Parent: That's it exactly. I couldn't be sure of what I saw, and I didn't know what to do when I did see it. But (ready to move forward), here we are, what do we do next?

The "sidebar" conversation took an extra 20 seconds, and yet it made an important and positive difference in relationship-building. The audiologist perceived a clear call for help, and was aware that unacknowledged feelings do not disappear; they fester (Pipher, 2006), so she took the time to ask for an elaboration. When it was provided, she accepted it as a gift, as it were, without judgment. The parent is learning that the audiologist is listening carefully, and will accept whatever the parent has to say. The audiologist has indicated that she trusts the parent, and the parent is starting to decide she can trust the audiologist.

The desired outcome for both kinds of counseling (informational and support) is to establish a therapeutic relationship with the patient. Research shows that relationships are a vital component to health care, as explained in the next section.

## Relationship-Centered Care

Present-day medical care is based on the principle of patient autonomy. That is, patients are recognized to have the "final say" regarding health care recommendations. This reality is a challenge for audiologists. We often see families who, even in the face of strong evidence and their own experiences, still decide against our recommendations. Why?

When a recommendation is rejected, the decisions are often related to fear and distrust. On the other hand, when families adhere to recommendations, they are quite likely to report experiencing a supportive relationship with their health care provider. Studies have examined the variables that affect patients' decisions to adhere to recommendations for diabetes management, smoking cessation, weight control, and other health concerns. Patients who reported a sense of trust and partnership with their health care provider were far

more likely to adhere to their provider's recommendations. The supportive relationship between patient and provider makes the difference. As Taylor (2002) puts it, "Social support is good medicine" (p. 81).

Relationship-centered care (Tresolini, 2000) is especially applicable to audiologic counseling. Families may wish they could disregard the diagnosis and live the life they had expected to live. Our recommendations ask families to modify their expectations, make decisions, and take on unfamiliar responsibilities. It is human nature to pull back rather than move toward change. However, it is also human nature to "choose growth" (Rogers, 1979) when we perceive we are in an environment of support and genuine care. Hence, families are far more likely to move forward when they perceive a supportive relationship with their audiologist.

The foundation for any relationship is trust. It is difficult to explain how to earn and foster trust, but one example might help us start to understand this process. Imagine an audiologist conveying to a parent (unaccompanied by other family members) that her 1-month-old child has a hearing loss in both ears. The mother becomes distraught and starts to cry. The audiologist politely slides a box of tissues toward her and says, "I'll return when you feel better," and then leaves the room.

What message is the mother left with? "This situation is too personal for me." "Your lack of emotional control embarrasses me." "I am only able to communicate with you when you maintain your composure." Will the mother ever again trust the audiologist with her emotional reactions? Not likely; instead, she will work with the distance that the audiologist has created. The relationship will be stilted and superficial, and the family will be challenged to follow recommendations from a professional who does not seem to care.

Imagine now an alternative response. The audiologist slides over the box of tissues, moves her chair closer and puts her hand on the mother's arm, and waits. The parent may feel embarrassed about crying but knows the audiologist is not embarrassed. The parent may feel forlorn but will not feel abandoned. This time the message is, "We are in this together." The mother feels support, not distance. If she feels she can trust the audiologist in this difficult moment, she will more likely be able to trust her for the course of their partnership.

The audiologist has the ability to set the tone for the relationship, and, if the relationship is deteriorating, the audiologist can at least attempt to repair it. A consultative meeting might be needed, with this type of preamble: "We seem to be at odds lately, would you

agree? If so, I'd like to start afresh, if you are willing. Where should we begin?" For example, imagine receiving this phone call:

### Dialogue #3

- Colleague: I am working with a parent who is especially frustrating. She calls me at least twice a week with the same questions she's asked me before, and I can't figure out why she isn't listening to me. Our exchanges are getting more and more tense. I may need to refer her to you.
- You: Before you make that referral—how would you describe your relationship with this parent?
- Colleague: Not adversarial, but close to it. I'd say it's confusing, stressed, and disconnected.
- You: Trusting?
- Colleague: (Pauses) No . . . I would say I trust her ability to handle things and make decisions, but she keeps challenging me, so I guess she doesn't trust me. I don't know how that happened.
- You: Any possibility of making a fresh start?
- Colleague: Sure, anything is possible. How would I do that?
- You: Maybe visualize it—what would work best for your setting?
- Colleague: I could set aside some time so that we could just talk. I would need to control my tendency to dive in with all those answers. When she peppers me with all those questions, I immediately answer them—using my "thinking mind," as they say. But I actually don't know WHY she is asking the questions.
- You: That's why the relationship is a little confusing?
- Colleague: I think it's part of the problem. I've been implying I'm the "go-to" expert, while also saying she is the "captain" of this team. Mixed messages!

Occasionally, a family member may not know how, or is unwilling, to sustain a trusting relationship, but at least the audiologist can make the attempt. Usually, families will appreciate the genuine effort and will adjust to the new start. Those kinds of conversations would draw heavily on the counseling/listening strategies discussed in the following section.

## Counseling Strategies

Counseling involves a complex skill set, supported by a deep theoretical base and scientific evidence. Three basic skills will be described here: differentiation, reflective listening, and—something *not* to do—refrain from answering every question. For additional information on counseling strategies, see Clark and English (2004) and English (2002).

### Differentiation

In an earlier section, we discussed the concept of communicating with a “thinking mind” versus a “feeling mind.” The pediatric audiologist needs to determine which “mind” the family is using at any given time, in order to avoid a communication mismatch. The skill used to perceive the difference is called *differentiation* (Cormier & Hackney, 2008). Differentiation is the cognitive act of listening carefully and asking oneself, “Is this a request for information or support?” It takes perhaps one second to ask oneself this question, so it would seem that differentiation is an easy skill to acquire. In fact, it is easy to learn but hard to maintain: almost anyone can demonstrate its use when asked to, but applying it on a regular basis throughout a busy workday, as an internal dialogue, is an ongoing challenge. See “Suggested Learning Activities” #4 and #5 for structured practice.

### Reflective Listening

If our differentiation leads us to conclude that the comment or question was from the “feeling mind,” our challenge is to match our response with a “feeling mind” comment. This skill is more formally called reflective listening (Rogers, 1979). Some principles of reflective listening include these three subskills:

- More listening than talking;
- Responding to what is personal rather than to what is impersonal or abstract;

- Restating and clarifying what the other has said, not telling what the listener feels or thinks.

The first subskill (more listening than talking) is much harder than it sounds. We may feel obligated to fill the “talk time” with our professional direction and advice, because is not that why the family is here? We will need to use mature professional judgment to determine if in fact that assumption is true; at any given point, the family may actually want us to listen, and share the talk time more than we expect.

The second subskill (responding to what is personal) again is a challenge in settings that value science, research, facts, and test results. Audiologists seem to need to be routinely reminded that the “ears belong to a person,” and that the person is struggling with quality of life issues. Families seek help expecting an improvement in the quality of life, not a 50% improvement in recognition of single-syllable words per se. Responding to what is personal requires us to develop a comfort level with families’ emotional states, and a willingness to discuss them.

The third subskill was “restating and clarifying what the other has said, not telling what the listener feels or thinks.” An example of this strategy can be found in Dialogue #3, when the audiologist says, “You had no real information to work with.” Restating the parent’s point tells the parent: (1) “I am following you (and please correct me if I am not following you),” and (2) “I am waiting for the next thing you want to tell me.” The parent can continue her train of thought, and is not obligated to answer distracting questions.

Reflective listening has been described as a figurative sounding board (Clark & English, 2004). If you have played the piano or violin, you already know that a sounding board is a piece of wood that is especially porous. It is built into those instruments in order to enhance the quality of the music being produced. It makes all the difference—and yet it does not actually create the music itself. It only resonates to the music.

### Do Not Answer Every Question

You might have noticed in Dialogue #2 that when the colleague asked, “How would I do that?” a direct answer was not offered. Instead, another question was submitted: “What would work best for your setting?” And with that prompt, the caller answered his own question. His friend trusted his colleague’s ability to manage the situation. In most counseling situations, the person with the problem does have his or her own answer—but at the moment when the question is asked,

the person lacks clarity. The challenges are not well understood, and possible solutions are elusive. However, given an opportunity to verbally organize one's thoughts, explore options, weigh consequences, and sort out good and bad ideas, the speaker gains clarity and begins to understand the problem and hence the solution. For over 100 years, this process has been called "talk therapy," and recent neurologic evidence indicates that talking out one's problems helps the brain shift from chaotic random activity to focused and specialized activity (Friedman, 2002; Vaughn, 1997). When we say, "Now I understand!" our brains have literally changed its patterns and have found a way to operate more efficiently.

## Summary

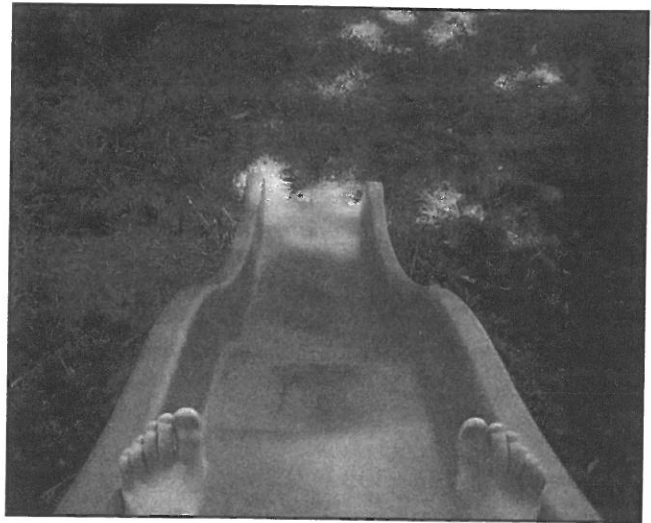
The second part of this chapter presented the concept of support counseling and its philosophical underpinnings as well as a few practical applications. Developing these skills requires practice and feedback. Evaluation tools designed to provide practice and feedback are listed in a subsequent section ("Evaluations for Counseling Skill Development").

## Conclusion

We began this chapter with a quote about children and parents and waving (Figure 39-2). Visualize the situation and ask yourself: How does the child feel about his parent as he circles around and around? And how does the parent feel as he keeps his eye on the child and watches for that wave? If the child had a hearing loss, does that change how child and parent feel? Is the essential parent-child bond at risk? If so, what can pediatric audiologists do to support its development?

## Suggested Learning Activities

1. Choose a typical topic of family informational counseling and design a teaching strategy that gives the learner something to do, or includes social interaction, or both.
2. Develop a sample parent brochure describing the "hearing-listening-reading" connection, including information drawn from your state's Department



**FIGURE 39-2.** Child on the playground. Photo credit: Michael Donovan, age 7.

- of Education on expected preliteracy skills for first grade.
3. Prepare a short presentation on general child development principles and describe how a pediatric audiologist can incorporate this perspective into family care.
4. Over the course of a semester, complete three or four "Listen For It" exercises. Open your ears, increase your attention to notice and write down comments heard from patients or family members that reflect adjustment concerns (e.g., "Are my daughter's processing problems caused by the year I home-schooled her?"). In addition to writing down the comment, describe possible emotions underlying the comment.
5. Perform the "Watch for It" exercise (similar to #4 above, developed by John Greer Clark, Ph.D., University of Cincinnati). Over the course of a semester, watch for and write down examples of effective communication "matching." When a patient or parent makes a "feeling mind" comment (e.g., "The kids at school make fun of me when I wear this FM thing"), make note of the audiologist's "feeling mind" response.
6. Download Tresolini's (2000) monograph on relationship-centered care ([http://www.futurehealth.ucsf.edu/pdf\\_files/RelationshipCentered.pdf](http://www.futurehealth.ucsf.edu/pdf_files/RelationshipCentered.pdf)) and read pages 1-37. Write a paper on the apparent applications of relationship-centered care to the practice of pediatric audiology. Discuss with peers and instructors.

## Resources

Alexander Graham Bell Association for the Deaf and Hard of Hearing, Parent Section:  
<http://www.agbell.org>

Boys Town: <http://www.boystown.org>

Early Listening Function (ELF):  
[http://www.phonak.com/com\\_elf\\_questionnaire\\_gb.pdf](http://www.phonak.com/com_elf_questionnaire_gb.pdf)

Hands and Voices:  
<http://www.handsandvoices.org>

John Tracy Clinic: <http://www.jtclinic.org>

Karen Anderson, Pediatric Consultant:  
<http://www.kandersonaudconsulting.com>

## Evaluations for Counseling Skill Development

### Audiologic Counseling Evaluation (ACE)

Described in English, K., Naeve-Velguth, S., Rall, E., Uyehara-Isono, J., & Pittman, A. (2007). Development of an instrument to evaluate audiologic counseling skills. *Journal of the American Academy of Audiology*, 18(8), 675–687. Available at <http://gozips.uakron.edu/~ke3/ACE.pdf>

### Audiologic Counseling Growth Checklist (ACGS)

Described in Clark, J. G. (2006). The Audiologic Counseling Growth Checklist for student supervision. *Seminars in Hearing*, 27(2), 116–126.

### The 4 Habits Counseling Skills Rubric

Described in: English, K. (2008). Counseling issues in the delivery of aural rehabilitation services. *Contemporary Issues in Communication Sciences and Disorders*, 35, 93–101.

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