

Introduction

I have recently sailed past my 81st birthday, and although my wife has assured me that 80 is the new 60, I know that my boat has sprung a few leaks. I now seem to have two forward speeds—slow and slower (and there are days when I am not sure about “slow”). I have found that one of the gifts of being past 80 is that I have developed the wisdom of using my diminished energy better; I seem able to use it more productively than in my youth. One learns the art of pacing; things that seemed hard then are now easy if I go slow; I just have to nap more. As I get older I also recognize fully how time-limited I am, and, consequently, I want to use that energy and time well. The life cycle continues unabated. Since the last edition of this book we have had several marriages in our family and the arrival of four new grandchildren; and, on the other side of the cycle, several contemporaries have died. I know that shortly I will be joining them, and knowing this leaves me with an intense desire to leave a record of what I have learned; hence my willingness to undertake a sixth edition. Since the last edition I have written several pieces that are summaries of my professional experience; versions of these papers can be found in a new, last chapter called “Summing Up.”

The first edition of this book was initiated more than 35 years ago—as I suspect many texts are—when I agreed to teach a course on counseling persons with communication disorders and found that there was at that time no single, satisfactory text. For the speech pathologist it is becoming increasingly evident that more clinical time needs to be devoted to counseling. A recent survey of public school personnel indicated that as much as 20% of their time was spent in counseling (Flahive & Schmitt, 2004), yet the current course work in preparing speech and hearing professionals still fails to reflect the importance of counseling. The ultimate purpose of this book is to demystify the counseling experience for the professional working within the field of communication disorders. It is my hope that as a result of reading this book, clinicians will feel more comfortable in allowing the affect that is a normal concomitant of having a communication disorder to emerge in their clinical interactions. I hope this book will provide some insight into relationship building and its effect on the counseling process. By allowing more affect to occur in clinical relationships, speech–language pathologists and audiologists will find that their information-providing role will be enhanced and there can be more job satisfaction.

I still have many concerns about the direction of our field. The technological advances in early childhood deafness have had many unforeseen consequences. Newborn screening, for example, has changed the diagnostic model from a parent-driven to an institution-driven one. Now we screen in hospitals because the child is available despite the fact that this is not an optimal time for either parents or children. Ironically, it has often removed the audiologist from being the initial counselor

at the time of diagnosis and left hospital personnel who have no knowledge of hearing loss and perhaps minimal counseling skills as the patients' first contacts. Audiologists are now encountering parents much earlier in the diagnostic process than when the diagnosis was parent driven. This requires especially sensitive counseling, as the parents are more emotionally vulnerable so close to the birth of the child. The counseling paradigm has changed, and yet there is still a paucity of courses in counseling; many audiologists feel unprepared to provide counseling (Crandell, 1997; Phillips & Mendel, 2008).

The cochlear implant has provided professionals, in many instances, with a way to bypass or mitigate parents' initial grief reaction by holding it out as a cure; however, the technology often merely defers their grief to a later time when there is less emotional support for the parents. The implant itself has converted childhood deafness from an overt disorder to a subtle one that is not understood by many professionals and is not seen by parents until much later. Although I think the technology is marvelous, and, when used appropriately, can mitigate the effects of early childhood deafness, it can sometimes have negative effects on counseling issues. I have devoted a section of Chapter 5, "Counseling and the Diagnostic Process," to technology and its impact on counseling. In that chapter I distinguish between the congenital diagnosis and the deferred one, each presenting unique counseling challenges. Newborn screening has converted early childhood deafness into a congenital counseling issue rather than a deferred one.

I also have concerns about the emphasis in our field, as we enter into medical-center settings, on evidence-based practice and billable hours. Of course we have to demonstrate the efficacy of our therapy, but often this leads us to measure only the readily observable and miss the important, less overt therapeutic changes taking place. It is hard to quantify personal growth and happiness. I think, for example, that therapy with a person who stutters can be successful if there is no diminution of the speech blocks but the client is more relaxed and more confident in speaking situations. These features of speaking are much harder to quantify or give credence to than a reduction in the actual nonfluencies. Some of the most "fluent" stutterers I have met are also the unhappiest, as they live with a constant fear of being exposed as stutterers. We need to turn our attention to the softer areas of change and devise appropriate measures.

Recently, I had a hearing test as part of my annual checkup. (Even audiologists cannot escape presbycusis.) The audiologist was very efficient. She took a case history, tested me, explained the audiogram, and gave me a sheet of paper with "tips" to compensate for reduced hearing. I felt like I was on a conveyer belt and was in and out of her office in 20 minutes. I know the administration put pressure on her to produce income, and she did have a waiting room full of clients needing to be

tested, but I still wish she had taken some time to get to know me; I might have had a more satisfactory experience. I cannot imagine there is much job satisfaction working in such a milieu. I worry that the pressures on us as a profession will force us to lose the human touch that, to me, has made this profession so worthwhile.

In a provocative op-ed piece in *The New York Times*, Robert Wachter (2016), interim chair in the Department of Medicine at the University of California, noted how measurement in the fields of education and medicine has distorted the altruistic underpinnings of these professions. While he noted, as I do, that we have to hold professionals accountable, he added that “the focus on numbers has gone too far; [w]e are hitting our targets but missing the point.” He concludes his essay with the statement, “Our businesslike efforts to measure and improve quality are now blocking the altruism, indeed the love, that motivates people to enter the helping professions.”

I think this is also very true of our field of communication disorders; however, the emphasis on numbers has also led to a backlash, and currently we are seeing a countervailing trend emerging in our field. We have the pressure of producing income for our organizations by maximizing the number of our billable hours and also proving our efficacy via evidence-based practice. This often means tight scheduling, leaving little time for patient-driven interactions or much family involvement. In institutional-driven models, the practitioner has greater control of time. The economic realities in health care are driving the medical model of service delivery, which mandates more clients seen and less patient time spent. Ironically, this generates dissatisfaction with service delivery on the part of practitioners and leads also to the growth of patient-driven models and family-driven models, which conform more with the idealism that propelled us to seek a helping profession in the first place. It has been gratifying to me to see several recent articles in our literature promoting patient-centered models of care. In patient-centered models, the client is given greater autonomy and decisions regarding the treatment plan are arrived at collaboratively, which conforms highly with the thesis of this text. For example, Ekberg, Greenness, and Hickson (2014) wrote a comprehensive review of patient-centered models in the medical literature and recommended it strongly for aural rehabilitation therapy. Cienkowski and Saunders (2013) recommended a patient-centered counseling model in audiologic diagnosis; Duchan (2004) questioned the overuse of the medical model in audiology; Poost-Foroosh, Jennings, Shaw, Meston, and Cheesman (2011) found improvement in hearing aid adoption and satisfaction with a client-centered approach, whereas Aazh, Moore, and Roberts (2009) developed a patient-centered tinnitus management tool. I think these articles constitute forerunners of the reaction to the medical model of service delivery, and in the future I think we are going to see more patient-centered counseling being described in our literature.

Writing a new edition of a text is often a painful process, akin to running a marathon and moving to a new home simultaneously. It is a long, dogged journey in which you have to examine each paragraph and, at times, let go of cherished materials that you have worked on for many years, to be sure there is joy in this process as well as when disparate elements come together and you can refine what was said previously. I have really enjoyed the experience of getting back into our literature with fresh eyes. It is a rare privilege, and I am thankful to the publisher, PRO-ED, for giving me this chance; but I do feel much like the 90-year-old man, cited in a recent *Boston Globe* article, as he climbed Mount Washington for the fiftieth time, taking 3 days to do it: “This is the last time I do this until the next time.” When my professional epitaph is written, I hope it reads, “He expanded the field to include feelings and families.” This, however, may be a bit hard to get on the tombstone. This volume represents my 80 years of living and over 50 years of clinical work. Fifty years seems like a long time, yet it has gone by bewilderingly fast; it has been a marvelous ride, much better than I ever expected. I am often asked how I have been able to remain clinically active for so long amidst so much pain and suffering without burning out. For me it’s a matter of practicing good self-care, avoiding developing dependent relationships with clients, and, above all, understanding that personal growth is often forged in the crucible of the pain of these disabilities. I see these disabilities not as tragedies but rather as powerful teachers that can promote transcendence. We give to life what life demands, and the disabilities often force clients to develop capacities that would otherwise lie latent. I love being able to participate in promoting growth, and when you love what you do, it is not work. I have often been amazed that they actually pay me to do it. To participate in and facilitate the personal growth of clients provides moments of grace that make our profession so worthwhile. I would love to be around for another 50 years, but I know that the actuarial tables are against me.