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Counseling practices of speech-language pathologists serving persons with aphasia:

Examining training and preparedness within clinical practice

By

Aspen Doud

A Thesis Submitted in
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Graduate Studies

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Counseling practices of speech-language pathologists serving persons with aphasia: Examining training and preparedness within clinical practice

By

Aspen Doud

The University of Wisconsin – Eau Claire, 2018

Under the supervision of Jerry Hoepner, Ph. D.

Purpose: This study examined Speech-Language Pathologists' (SLPs') perspectives on the counseling training they have received, and the counseling skills they are implementing into their practice with individuals with aphasia. The American Speech Language Hearing Association depicts counseling as one of the eight main domains of service delivery of speech-language pathology (2016), however there is a limited research base of counseling within the field. There is evidence that SLPs do not feel confident in their counseling skills, and may unintentionally avoid counseling moments when they arise in practice (Simmons-Mackie & Damico, 2011). *Method:* This study collected qualitative and quantitative data through an online, Qualtrics survey as well as six semi-structured interviews. Participants included SLPs working in medical settings with individuals with aphasia. *Results:* Approximately 47% of SLPs that participated in the survey reported that they took a course on counseling as a graduate student. Despite

some education in counseling that participants have received, only 25% of participants engaged in hands-on training as a part of that education. Five points of emphasis arose from the qualitative coding of interviews, including: ambiguity of scope of practice as it relates to counseling, not being prepared for counseling moments in practice, SLPs being the professionals to typically evoke counseling moments from patients, perspective taking when working with patients, and the need for self-care as an SLP. *Conclusions:* The percentage of counseling courses taken was consistent with the percentage of counseling courses offered found in Doud, Hoepner, & Holland (under revision). However, the small percentage of hands-on training as a part of education suggests the ineffectiveness of counseling training. Feelings of unpreparedness for counseling moments that arise in practice are consistent with that found in Simmons-Mackie & Damico (2011), making the argument for more consistent and effective counseling training for future SLPs.

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CHAPTER 1

LITERATURE REVIEW

Communication disorders often have a substantial impact on the daily lives of those affected. In treating communication disorders, speech language pathologists (SLPs) should use appropriate counseling skills to address the impact on the daily lives of their patients. The American Speech-Language-Hearing Association (ASHA) defines counseling as "providing education, guidance, and support" in relation to an individual's communication disorder (ASHA, 2016). Counseling is included in the scope of practice of speech language pathology, and is also supported by research to improve clinical outcomes. There is a lack of clarity and consistency on how counseling is trained within the discipline and the preparedness of clinicians who are asked to implement counseling as one of their essential skillsets.

Counseling Requirements and Training in Speech Language Pathology

ASHA's Scope of Practice identifies counseling as an aspect of service delivery domains for Speech Language Pathologists (SLPs). "The role of the SLP in the counseling process includes interactions related to emotional reactions, thoughts, feelings, and behaviors that result from living with the communication disorder, feeding and swallowing disorder, or related disorders" (ASHA, 2016). Individuals experiencing communication difficulties often experience a variety of emotions and feelings associated with these difficulties. This is part of what makes counseling crucial in the therapy process. It helps the clinician build an alliance with the client, elicit client-centered goals, and offer effective therapy.

Although this is an integral part of our field, ASHA (2017) does not currently provide specific guidelines on how to incorporate counseling into Speech Language Pathology graduate programs. Counseling is incorporated in Standard 3.1.6B of the Standards for Accreditation, which states that students are to develop "interaction skills and personal qualities, including counseling and collaboration" (ASHA, 2017, p. 23). Although counseling and collaboration are often interrelated, grouping them together in this standard without further expansion could be problematic. Collaboration fits naturally into curriculum: it can be seen through group projects, co-student clinician teams, student clinician and supervisor teams, etc. Counseling practice is not easily incorporated in the same way. It tends to be specific to working with clients, and may arise more frequently with certain client populations. Counseling moments will arise in a graduate student's work with clients, as well as their work as an SLP, but the variable here is whether they will recognize and act on the opportunity. If students are not taught and engaged in guided practice of counseling skills, they will not have the tools they need to address counseling moments that arise with clients. This can be seen as a disconnect between what training SLPs receive, and what they are being asked to do professionally.

McCarthy, Culpepper, and Lucks (1986) surveyed Communication Sciences and Disorders (CSD) programs to determine the amount of counseling training in program curricula. This survey was completed in 1983, and published in 1986 (McCarthy et al., 1986). Doud and colleagues (under revision) examined the current state of counseling training within graduate programs in CSD, as of December 2017, as an update to the research of McCarthy et al. Heads of Graduate Programs were surveyed to report on their program's incorporation of counseling into their curriculum. Details from the

survey included offerings of a standalone counseling course, textbooks used, incorporating counseling in other courses, and a full qualitative analysis of learning outcomes in counseling courses. One of the reports within the survey is a summary of evidence-based counseling techniques across disorder types.

It was found that the percentage of programs with a stand-alone course in counseling has increased from 40% in 1983 to 59% in December 2017 (McCarthy et al., 1986, Doud et al., under revision). As of December 2017, the majority of programs (97%) incorporate counseling into the curriculum, whether or not they have a stand-alone course. It is unknown, however, if this incorporation is effective in preparing students for counseling moments in practice, especially if a stand-alone course is not offered (Doud et al., under revision). For the complete findings of this survey investigation, see the full submitted article following this introduction chapter.

Phillips and Mendel (2008) surveyed SLPs and Audiologists in their first year after graduation to determine the extent of training they received in counseling, and how effective they believed this training was in preparing them for clinical implementation. They found that the majority of SLPs and Audiologists did not feel prepared to fully engage in counseling moments in practice. In fact, 80% of the individuals they surveyed reported receiving no counseling training in their graduate programs. The majority of the participants agreed that counseling is in the scope of practice of SLPs and Audiologists, and that it is the responsibility of the graduate program to provide training (Phillips & Mendel, 2008). This study highlighted the fact that SLPs and Audiologists recognize the importance of including counseling in therapy, but do not feel adequately prepared to do so, due to the lack of effective training. Randolph and Bradshaw (2018) reiterated that

SLPs believe graduate programs should have more effective training in counseling, additionally covering multicultural counseling in assessment and treatment. Along with limited research and guidelines for implementing counseling training within graduate programs, there is limited research addressing implementation of counseling approaches in the profession.

Counseling Methods

A small body of research examines the use of counseling techniques in CSD. There is a higher presence of counseling research in audiology than in speech language pathology. However, this research primarily consists of educational counseling, the ways in which education is provided to clients (English, et al., 1999, Muñoz, et al., 2017, Muñoz, 2018, Nair, et al., 2010, Saunders, et al., 2009, Teymouri, et al., 2009). As described in detail below, the literature on counseling in speech language pathology includes motivational interviewing, positive psychology, Solution-Focused Therapy, Cognitive Behavior Therapy, Acceptance and Commitment Therapy, and coaching.

Motivational Interviewing. Motivational interviewing developed from the transtheoretical model. Van Leer, Hapner, and Connor (2008) describe the transtheoretical model in relation to voice therapy. The transtheoretical model consists of five stages: precontemplation, contemplation, action, preparation, and maintenance. The patient transitions from each stage at a different rate and may cycle back through stages. In this model, there are 10 processes of change, including consciousness raising, social liberation, emotional arousal, self-reevaluation, commitment, counter-conditioning, stimulus control, contingency management, helping relationships, and environmental reevaluation. Self-efficacy also plays a substantial role in the transtheoretical model

through motivating the client to initiate change in behavior and maintain that change as well. The clinician takes a motivational interviewing approach to facilitate a conversation with the patient about change, but ultimately lets the patient control their own decision. Once the patient begins to take initiative, the clinician fills the role of a coach through the process (van Leer et al., 2008).

Van Leer and Connor (2015) outlined how social-cognitive factors can impact therapy outcomes for patients with adducted hyperfunction, in an effort to provide rationale for a transtheoretical approach to therapy. They found that "social-cognitive factors were found to be significant determinants of patient adherence in regression analysis" (van Leer & Connor, 2015, p.171), and that self-efficacy contributed greatly to maintenance of therapeutic behaviors and generalization. However, van Leer and Connor noted that not all factors of adherence were social-cognitive, so a comprehensive approach to therapy is necessary (van Leer & Connor, 2015).

The evidence supporting the transtheoretical model shows the importance of motivational interviewing when working with clients. Hoepner and Olson (2018) drew upon principles of motivational interviewing to elicit self-identification of successes and challenges. Using the framework of OARS (open-ended questions, affirmation, reflection, and summary) they prompted self-identification within joint conversational training of an individual with moderate to severe traumatic brain injury and his partner. While they did not measure outcomes of this motivational interviewing framework directly, the approach did elicit self-assessment, rather than clinician-identified performance. Self-identified change is central to the principles of motivational interviewing and client-centered counseling. Motivational interviewing has also been

shown to improve patient mood after acute stroke (Watkins, et al., 2011). Watkins and colleagues (2011) began their intervention within four weeks following the stroke, and based on their measures, improved mood was maintained up to twelve months post-stroke.

Positive Psychology. Positive psychology is briefly defined as a strength-based approach, that utilizes a person's strengths in order to facilitate growth in the areas of challenge (Peterson, 2006). "The aim of positive psychology is to begin to catalyze a change in the focus of psychology from preoccupation only with repairing the worst things in life to also building positive qualities" (Seligman & Csikszentmihalyi, 2000, p. 5). In this way, therapy with individuals with communication disorders can focus on the positive, rather than the focus on impairment. Using this approach with patients with aphasia has been proven effective (Brown et al., 2012, Holland, 2007, Worrall et al., 2010) in meeting participation-based goals and increasing individuals' quality of life, as well as with individuals with traumatic brain injuries (Andrewes, Walker, & O'Neill, 2014) in improving challenging behaviors. Holland (2007) believes the focus on a patient's strengths through a positive psychology approach allows the SLP to think about the client as a whole and the many aspects of their life that will come into play during therapy.

Solution-Focused Therapy. There is some evidence for using Solution-Focused Therapy (SFT) with individuals with aphasia. This approach emphasizes the patient's positive experiences and presents different options for negative experiences. Boles and Lewis (2000) researched this technique in co-therapy between an SLP and a social worker, working with a woman with aphasia and her partner. In this study, SFT

successfully allowed the couple to realize the strengths in their communication skills (Boles & Lewis, 2000). There is a need for more research on using SFT with individuals with aphasia, however; it may be a successful counseling approach when working with both the patient and their significant other. Solution-focused therapy has also been noted to be effective in fluency therapy. It is being implemented at the Michael Palin Center for Stammering Children in London, in shifting the focus of therapy to the solution, rather than the problem (Botterill, 2011). This focus has allowed clients to take ownership of therapy and goals, increasing adherence and making therapy more client-centered.

Cognitive Behavior Therapy. Cognitive behavior therapy was created by Dr. Aaron T. Beck in 1967 as a technique to help individuals that are depressed come to terms with negative automatic thoughts. This technique relates automatic thoughts to feelings and behaviors that result from the automatic thoughts (Beck, 1967). Since the establishment of this technique, much research has examined how it applies to different populations. Recent research has shown that "older adults can benefit from CBT to approximately the same degree as younger adults" (Sorocco & Lauderdale, 2011, p. 1). It has been shown to be effective in working with individuals with dementia in improving relationships with caregivers (Barnes & Markham, 2018), individuals with post-stroke depression in addressing depressive symptoms (Wang, et al., 2018), as well as individuals who stutter in increasing acceptance and awareness of dysfluencies (Menzies et al., 2009, Menzies et al, 2008, Neilson, 1999).

There are preliminary findings to support rational-emotive behavioral therapy, a subset of cognitive behavioral therapy, in treatment with individuals with dysphagia (Arnold, 2010). The foundation of rational-emotive behavioral therapy is based upon the

difference between rational and irrational thought, and the resulting positive or negative emotions (Ellis, 1994). Individuals with dysphagia present with psychosocial challenges related to changes in their participation in meal times, as well as psychosocial challenges that arise from the comorbid neurological conditions (e.g. stroke, traumatic brain injury). Arnold (2010) found that implementing rational-emotive counseling in combination with dysphagia therapy improved psychosocial outcomes and maintained biophysical outcomes. This study was completed as a dissertation, and was not published, so more research is needed on this subject to draw further conclusions.

Acceptance and Commitment Therapy. Somewhat related to CBT, Acceptance and Commitment Therapy (ACT) has evidence behind its efficacy in clients with communication disorders, particularly fluency disorders. ACT was founded by Steven Hayes in 1994 as a counseling method to help patients reduce avoidance and encourage behavioral change. ACT is commonly used in therapy with patients who stutter to help them develop acceptance of their speech, and actively participate in aspects of their life, rather than using avoidance behaviors (Beilby et al., 2012, Beilby, 2014, Scott & Jaime, 2013). There is promise for using ACT in therapy with patients with aphasia as well, but more research is needed on this untapped potential.

Coaching. In an effort to promote client-driven change rather than a focus on clinician-identified problems, the idea of "coaching" in speech language pathology has become relevant. Holland explains the difference between counseling and coaching as counseling is an emphasis on "why," and coaching is an emphasis on "what is next" (Holland, 2007). Traditional counseling practices are focused on the "why," attempting to find the reasoning behind certain feelings, behaviors, and emotions in clients. Holland

believes the emphasis on "what is next" allows therapy to be more client-centered and puts the client in a better position to take responsibility in the therapy process. "Call it what you may, individuals and families living with aphasia need to be listened to, accepted as partners in seeking solutions, given the benefits of professionals' general expertise, and directly involved in the long-term management of their own chronic aphasia" (Holland, 2007, p. 341).

Counseling Integrated into Therapy

The research above describes specific counseling methods in relation to therapy with individuals with communication disorders. There is also some research detailing how integrated counseling methods result in positive outcomes in speech and language therapy. Wolter and colleagues (2006) examined a counseling and narrative approach to therapy in both children and adults. In this approach, counseling was used to identify the problem the client was facing, the "influence of the problem on the life of the person" (p. 171), and the "influence of the person on the life of the problem" (p.172). They found this integrated approach to be successful for children and adults with language-literacy deficits. Lieberman (2018) details the importance of counseling, specifically taking a humanistic approach to working with individuals with communication disorders to create a genuine relationship with the client and anticipate and prepare for emotional challenges they may experience in the therapy process. Through this, the clinician can really get to know the client, and work collaboratively throughout therapy (Lieberman, 2018). Adler (2017) advocates for a counseling approach to therapy, specifically when working with transgender clients as they have many psychosocial needs that arise in the therapy process.

An additional way to integrate counseling into therapy is through interprofessional collaboration, for example with a social worker (Attard, et al., 2018, Boles & Lewis, 2000). Attard and colleagues (2018) found positive results from a community aphasia group that was led collaboratively by a Speech Language Pathologist and a social worker. They proved that this was a feasible and effective model of service delivery for individuals with aphasia.

Importance of Including Family

A communication disorder can have major effects on the life of the individual affected and their family. Frieche, Bloedow, and Hesse (2003) investigated the grief felt by parents of children with communication disorders. They found "episodic grief plays a central role in the intervention process for the child and family," highlighting the importance of including counseling into intervention with both clients and their families (Frieche, Bloedow, & Hesse, 2003, p. 218). In a similar way, aphasia affects both the person diagnosed and those close to them (Byng, Pound, & Parr, 2000, Kagan, Black, Duchan, Simmons-Mackie, & Square, 2001, Simmons-Mackie, 2000, Wilkinson et al., 1998). Because of this, it is incredibly important that the family is included in aphasia therapy. One way to do this is through communication partner training.

Simmons-Mackie, et al. (2011) completed a systematic review of communication partner training in aphasia. They found that both the person with aphasia and the communication partner benefit from communication partner training (CPT). CPT can be effective with both familiar and unfamiliar communication partners, because the individual will be interacting with both throughout their rehabilitation process. They mentioned in their review that determining whether someone is a good candidate for CPT

"depends on individual needs, wishes, and situations" (Simmons-Mackie et al., 2011, p.1833). The researchers found a lack of data on CPT when the individual with aphasia is in the acute stage and suggested this was due to the fact that "families are likely to be overwhelmed, possibly still in crisis, and not in a particularly strong position for learning new skills" (Simmons-Mackie et al., 2011, p. 1838). Communication partner training and education is especially crucial in these acute stages as the partners are adjusting to the events their loved ones are going through. This is why Holland and Fridriksson (2001) suggest that main priorities in the acute phase should consist of education and counseling of partners, along with meeting basic needs of the person with aphasia.

McVicker et al. (2007) created a research scheme in which they matched individuals with aphasia with trained conversation partners. Their scheme provided "evidence of enhanced well-being and increased participation" in most of the individuals with aphasia involved in the study. The researchers also included opinions from SLPs on the efficacy of the theme, and the majority of SLPs believed it enhanced their treatment (McVicker et al., 2007, p. 67). The trained conversation partners lead to an increase in confidence for individuals with aphasia. Results from these studies provide the evidence to support the need for including family members and loved ones in therapy. Communication disorders in general, including aphasia, are only present when the individual is engaging in communication with another person. The extra support that an individual with aphasia needs in a conversation can put more responsibility on the conversation partner. In this sense, training and counseling becomes necessary to remediate the situation, and allow the individual with aphasia to be successful in communication interactions.

Research shows that CPT is effective for patients and their families (McVicker et al., 2007; Simmons-Mackie et al., 2011; Turner & Whitworth, 2006). There are multiple approaches to CPT, the three main types of CPT used with patients with aphasia are Supporting Partners of People with Aphasia in Relationships and Communication (SPPARC), Supported Conversation for Adults with Aphasia (SCA), and conversation coaching. A general outline of these three approaches is provided below, in Table 1. Boles and Lewis (2000) used a combination of these approaches in their study focusing on solution-focused therapy in combination with CPT.

Table 1

Comparison of CPT Approaches

	SPPARC (Lock, et al., 2001)	SCA (Kagan, 1998)	Conversation Coaching (Hopper, Holland, & Rewega, 2002)
Focus of training (person with aphasia, communication partner, or both)	Both	Both	Both
Proven to increase participation in conversation	Yes	Yes	Yes
Key Aspects of Training	Increasing awareness in conversations, couple identifies areas of conversation to target	Acknowledging and revealing competence in person with aphasia	Encouraging verbal and non-verbal communication strategies (drawing, cueing, summarizing)

An additional way to address counseling needs in caregivers and loved ones of individuals with neurogenic communication disorders is through therapeutic writing. Isaki and colleagues (2015) asked caregivers to respond to prompts detailing how their loved one's communication disorder affected their life. The caregivers wrote on topics

such as onset of diagnosis, chronic grief, and coping. The participants found therapeutic benefit in this method of journaling, and Isaki and colleagues (2015) argue this could be an effective therapy tool to be used, especially considering time restrictions on therapy.

Importance of Engaging in Counseling Moments

Simmons-Mackie and Damico (2011) investigated missed counseling opportunities in therapy sessions with clients with aphasia. They observed four different sessions with clients with aphasia and found there was at least one missed counseling opportunity in each session. Their research raises the question: are SLPs trained to avoid counseling moments? Simmons-Mackie and Damico comment on a shared experience for many SLPs: "clinical supervisors imploring us to 'get back on task' or 'keep the client on track'" (2011, p. 347). While it is important to keep on track towards therapy goals, counseling moments often arise in relation to functional language therapy outcomes. Along with the perception of needing to be on-task, SLPs also avoided counseling moments due to the awkward social situations and intimacy that surround these moments, and not recognizing counseling as part of their job. Losing control of the session was a key concern of SLPs who did not feel comfortable with clients if they became upset. All of these aspects can be problematic and highlight the connection between lack of preparedness and avoidance of counseling moments. Counseling becomes integral to therapeutic success, especially considering the rates of post-stroke depression (Baker, et al., 2018). Another reason an SLP may not engage in a counseling moment is their self-efficacy of counseling skills. Pasupathy and Bogschutz (2013) identified the connection between SLP self-efficacy, and the effect on clinical performance. Whether or not they feel adequately trained to take advantage of counseling moments and confident in their

skills to do so can affect if SLPs acknowledge counseling moments. Northcott and colleagues (2017) found that while SLPs care about the psychosocial wellbeing of their patients, they do not have the skills to provide the appropriate supports to address the psychosocial needs of their patients. Research has shown the efficacy of embracing those counseling moments to improve patient-therapist relationship, and in turn, patient outcomes (Baker, et al., 2018).

The degree to which the patient believes that what their therapist is doing will help them improve is described as "therapeutic alliance." This therapeutic alliance is essential in ensuring clinician and patient are on the same page, and in turn impacts efficacy of therapy. Worrall (2011) compared what individuals with aphasia want from therapy to the typical goals SLPs set. They found that the individuals with aphasia wanted goals centered around more social and functional aspects of their lives, while the clinician's goals were more impairment-based (Worrall, 2011). Therapeutic alliance bridges the connection between clinician and patient, allowing for them to be on the same page for therapy. To accomplish this, effective counseling assessment is warranted to truly elicit what the client wants. Eliciting clients' wants is challenging for any individuals but becomes increasingly challenging when working with individuals with communication disorders. Examining related disciplines, such as physical and occupational therapy, much research has been conducted on the benefits of establishing therapeutic alliance (Besley et al., 2011, Hall et al., 2010, Lawton et al., 2016, Tickle-Degnen, 2002). Therapeutic alliance can correlate with client buy-in to treatment, and positive outcomes (Hall et al., 2010, Lawton et al., 2016, Morrison and Smith, 2013). Pinto et al (2012) associated therapeutic alliance with patient-centered care in their

systematic review, emphasizing the importance of addressing a patient's emotional concerns in building the therapeutic relationship.

Although research shows the benefits of building therapeutic alliance, it seems that therapists do not always know effective methods to build that relationship. Lawton et al (2018) found in their study that "therapists employed a complex interplay of skills to foster and maintain alliances; however, even experienced therapists reported they did not always know how to motivate patients or demarcate boundaries and were unaware of how cognitive biases may affect their own behavior" (p. 12). When working with patients with aphasia, it can sometimes be even more challenging to establish therapeutic alliance due to the barriers of communication. Therefore, it is crucial that SLPs have the necessary skills to build therapeutic alliances (Worrall, 2011).

Research regarding counseling curricula in the field of speech language pathology (Doud et al., under revision) along with evidence of recent SLP and Audiology graduates' perceptions of preparedness and efficacy (Pasupathy & Bogschutz, 2013; Phillips & Mendel, 2008) suggests that SLPs may be underprepared to demonstrate clinical skills identified as essential to everyday practice, such as counseling (CAA, 2017). SLPs may, unintentionally or intentionally, avoid counseling moments due to a perception that other therapy is more important. This perception may be exacerbated by a lack of confidence in how to implement counseling techniques due to ineffective training. While the lack of specificity in program standards allows programs flexibility in implementation, it may lead to an ambiguity in training of counseling techniques. Therefore, the present investigation seeks to examine the counseling practices of speech-language pathologists who work with people with aphasia across the rehabilitation

continuum (acute, subacute, and chronic phases of recovery). Surveys and interviews of practicing clinicians will attempt to gain knowledge of the counseling training experienced by SLPs in their graduate program, and their perspectives on if the training was adequate in preparing them for a necessary clinical skillset.

CHAPTER 1B

PRELIMINARY INVESTIGATION OF COUNSELING TRAINING PROGRAMS IN CSD

A survey of counseling curricula among accredited CSD graduate student programs

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Under review in the American Journal of Speech-Language Pathology

Abstract

Purpose: The purpose of this article is to examine the current state of counseling curriculum within the discipline. The last systematic survey of counseling curriculum within the disciplines of Communication Sciences and Disorders was completed with data from 1983 (McCarthy, Culpepper, & Lucks, 1986). The Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA, 2017) states counseling should be included in accredited programs but does not specify to what extent. Currently, there are no standards to specify number of credits, need for a standalone course, or guidance regarding content delivered. *Method:* The present investigation collected data on the status of counseling curricula in accredited Communication Sciences and Disorders graduate programs. A Qualtrics survey was distributed to identify counseling curriculum practices across accredited programs. Quantitative data such as percentages and frequency counts were completed to summarize program offerings. Qualitative analyses were used to characterize written responses. *Results:* Of programs currently accredited by the CAA, 42.4% responded to the current survey. 59% of programs offer a stand-alone course, while 41% do not. Quantitative details about requirements, number of credits, and embedding within other courses are compared to data from the 1983 survey. Qualitative analyses identified common learner outcomes and the nature of course or curricular content. *Conclusions:* Investigators found a lack of consistency in incorporating counseling across programs and discussed implications of this in speech-language pathology practice. While more programs include training in counseling practices than in 1983, there is disparity regarding how programs provide training in counseling. Information derived from this study may serve as a starting point for the development of flexible standards that provide direction for achieving consistent preparation of counseling skills. *Key Words:* counseling, standards, curriculum

Background

Standards Regarding Counseling

The American Speech-Language Hearing Association (ASHA, 2016), in a recent update to *Scope of Practice in Speech-Language Pathology*, included counseling as one of the eight domains of speech-language pathology service delivery. Further, two of the remaining seven domains are closely related to counseling, *collaboration* and *prevention and wellness*. Speech-language pathologists (SLPs) provide education, guidance, and support to individuals with communication or swallowing disorders and their family or caregivers. This includes interactional counseling related to emotional responses, thoughts, feelings, and behaviors resulting from living with a communication disorder. Specific clinical counseling skills identified include: empowering decision making, educational counseling, support, fostering self-advocacy, addressing emotional response to communication or swallowing disorders, and making appropriate referrals.
The latest update to *Scope of Practice in Audiology* includes counseling as one of the main service delivery domains for audiologists as well (ASHA, 2018). Audiologists are asked to engage in counseling regarding challenges individuals face while living with

hearing or balance disorders. Specific counseling skills identified for audiologists mirrored those identified for SLPs. ASHA (2008) did provide some guidance to audiologists regarding informational counseling and adjustment to hearing loss counseling. Information counseling includes interpretation of audiograms, amplification options, education options, communication options, and advocacy/public health/education policies. Adjustment counseling is intended to support families as they learn about hearing loss by recognizing and acknowledging the realities of living with a hearing loss.

ASHA scope of practice at the program- and curricular-level is overseen by the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA). The CAA (2017) includes counseling within program standards. Counseling has been included in academic and clinical requirements since the ASHA Educational Standards Board (ESB) added them in 1983. Since the educational standards are broad, they allow flexibility for implementation but limited direction to establish consistency across programs. Standard 3.1.6B indicates that programs must have opportunities for students to develop "interaction skills and personal qualities, including counseling and collaboration." There is no mandate for a standalone course in counseling nor specific content embedded within other courses.

Previous Research on Counseling Curriculum

In 1986, McCarthy, Culpepper, and Lucks published results from a survey, conducted in 1983, of speech-language pathology and audiology graduate programs accredited by the ASHA Educational Standards Board (ESB). Since that time, there has been no systematic examination of the current state of counseling curricula within the Communication Sciences and Disorders (CSD) disciplines. The authors identified concern over a lack of educational standards and expectations across programs. At the time of their investigation (program data from 1983), 40% of the 134 ESB accredited audiology and speech-language pathology programs offered counseling courses within their department, while 36% utilized counseling courses outside of the department. Thus, 76% of programs offered some sort of counseling coursework, while 23% offered none. Less than half of these programs required a counseling course, including only 33% of those who offer a course within the major and 12% who offer a course outside of the major. Interestingly, of those programs who utilize a counseling course outside of their department, 19% included counseling specific to CSD, 52% were not specific to CSD, and the remaining 28% were uncertain. Culpepper, Mendel, and McCarthy (1994) completed a follow-up survey of the 193 ESB-accredited programs in 1992. Unfortunately, few significant changes were seen, indicating a lack of notable change since the 1983 survey. In fact, there were significant decreases in courses offering general principles of counseling, family counseling, and counseling individuals with laryngectomy. Further, only 17% of respondents believed that graduates were prepared to meet the counseling needs of their clients with communication disorders.

A paucity of empirical evidence exists regarding academic preparation for implementing counseling into everyday practice. One study by English, Lucks-Mendel, Rojeski, and Hornak (1999) examined the skillset of listening through pre- and post-measures within an audiology counseling course. The course distinguished between the roles of professional versus nonprofessional counseling roles (psychotherapy versus counseling) in order to identify appropriate roles within scope of practice. Appropriate nonprofessional roles identified included reflective listening, evocative questioning, nondirective information sharing, pause time, and other active listening skills. On the pre- and post-course measure, students were prompted to write down their responses to eight items. The first author randomized response and the remaining three authors rated responses on a scale of 1 to 5. Student responses shifted from more technical sharing pre-training to more affective responses post-training consistently across two training cohorts. The authors were cautious not to identify causal relationships, since a control group was not employed, however; significant increases in the number of affective responses to affective comments were noted. While methodological shortcomings limit generalizations of this training approach, this represents a starting point for critically appraising other training approaches.

In 2008, Phillips and Mendel conducted a survey of speech language pathology and audiology graduates with their Master's degrees, regarding the extent of counseling training they received in their graduate programs and their perspectives on counseling. In their survey, they found "eighty percent of respondents reported completing no credit hours of coursework pertaining to counseling while in graduate school (from approximately 2000-2002)" (p. 47). Sixty percent of the participants in this study reported they did not feel that counseling was an integral part of their graduate program. Phillips and Mendel (2008) found that graduates of speech language pathology and audiology graduate programs accredited by the ASHA ESB "do not feel fully prepared to conduct counseling in the field of communication disorders following graduation" (p. 50).

Evidence for Counseling in CSD

Empirical investigations about implementation of counseling in CSD disciplines are limited but growing. Specific counseling approaches that have been examined are motivational interviewing, solution-focused therapy, cognitive behavioral therapy, wellness, and positive psychology. A handful of studies examine motivational interviewing, including applications to voice therapy (Behrman, 2006; Van Leer, Hapner, & Connor, 2008), hearing aid use (Solheim et al., 2017), cognitive rehabilitation (Hoepner & Olson, 2018; Hsieh et al., 2012; Medley & Powell, 2010), and broadly in SLP/AuD (Macfarlane, 2012). Boles and Lewis (2000, 2003) examined solution- focused therapy in aphasia couples interventions. Cognitive behavior therapy has been investigated among individuals who stutter (Menzies et al., 2009, Menzies et al., 2008; Neilson, 1999), persons with traumatic brain injuries (Douglas et al., 2016), carers of

individuals with dementia (Barnes & Markham, 2018), and those with tinnitus (Kaldo-Sandström, Larsen, & Andersson, 2004). Implementation of wellness and positive psychology techniques have been examined among individuals with aphasia (Brown et al., 2012; Holland, 2007; Worrall et al., 2010), individuals who stutter (Zebrowski & Arenas, 2011), and more broadly in speech-language pathology (Sharp, 2011). Douglas and colleagues (2016) saw significant improvements in implementing coping strategies with individuals many years post traumatic brain injury to reduce stress. While this body of research is growing, present limitations regarding empirical evidence likely contribute to the lack of clarity regarding scope of practice and accreditation/training standards. Past research has identified that practicing SLPs report a lack of training in counseling methods for individuals with communication disorders and their families (Kelly et al., 1997). Likewise, Duff, Proctor, and Haley (2002) report that SLPs would benefit from increased training in counseling to support persons with TBI and their families. Similarly, Rose and colleagues (2014) state that counseling is a big part of practice in aphasia interventions but practitioners report being under trained. Geller and Foley (2009) argued that training clinical supervisors in counseling strategies "would lead to future speech-language pathologists becoming more psychologically minded and relationally informed" (p. 30).

Based on scope of practice and education standards, it is apparent that counseling is an integral skill necessary in the fields of speech language pathology and audiology, however, there is an evident lack of effective training in counseling in graduate programs and beyond. This discrepancy between what SLPs and Audiologists are asked to do, and the training they receive leaves a gap in service delivery. The aim of this study is to examine speech language pathology and audiology graduate programs' counseling curricula, and to initiate a conversation regarding the effectiveness of said curricula.

Research question

What is the current status of curricular offerings of counseling courses in accredited CSD graduate programs?

Methods

Participants

Department chairs or program heads of CSD graduate programs accredited by the Council for Academic Accreditation (CAA) were the targeted population of this study. Universities that had audiology doctoral programs only were excluded from the study, but universities that had both speech-language pathology and audiology graduate programs were included. Of those department chairs and program heads, 255 email addresses were listed publicly and were contacted via email to participate in this study. Potential participants were distributed throughout the United States.

Procedures

A Qualtrics survey link was distributed via an email to the 255 representatives of CSD programs accredited by the CAA. This link was accompanied by an electronic cover letter, which explained the purpose of the investigation, estimated time and contributions of potential participants, and informed consent procedures (see appendix A). By selecting the electronic survey link, participants consented to have their responses included in this investigation, which was approved by the University of Wisconsin – Eau Claire institutional review board (certification number DOUDAK2017). Qualtrics, an online survey software was used to create the survey. The survey consists of 11 questions that were inspired by the McCarthy et al. (1986) survey but expand on different topics (see appendix B for survey). The survey mapped the participants to different questions based on whether or not they offer a stand-alone course in counseling. Participants were not required to respond to all questions they were mapped to while completing the survey.

Analyses

Quantitative analyses. Descriptive statistics, including percentages were calculated for the objective items 1, 2, 3, and 4 from the Qualtrics survey data. Comparisons were made between program offerings in the present survey to the McCarthy et al. (1986) survey. Not all comparisons could be made with the Culpepper et al. (1994) study due to missing data points in the publication.

Qualitative analyses. Because each dataset included different types of qualitative information, different qualitative methods were used for each question. Qualitative content analyses were completed for question five (i.e., addressing how counseling is embedded within other courses), question eight (i.e., learner outcomes), and question ten (i.e., the contexts where counseling is embedded when not present in curriculum). See analysis methods for each question identified by sub-headers of Q# (question and number).

Q5. A simple categorical content analysis sort (Bogden & Biklen, 2003) was used for question five in which statements were grouped by objective categories and tallied. The first and second authors individually sorted the statements into groups revolving around objective categories. A second round of sorting was completed to reach consensus on categories and statements within each category. Because the content was objective and fairly discrete, 100% consensus was reached within the second round of coding. Additional consensus and reliability coding was not necessary.

Q8. Responses to question eight came in the form of learner outcomes. Given the diversity of learner outcome statements, a full qualitative analysis was employed, using open and axial coding techniques (Strauss & Corbin, 1990). In the initial round of coding, the first and second authors independently sorted learner outcome statements,

establishing groups of statements by category. Categories were determined and agreed upon after reviewing the learner outcome statements. Consensus coding was completed in the second round, as the first and second authors compared items within categories they had in common, verifying each statement until consensus was reached. They also negotiated common categories when individual categories differed. This process served as a formative reliability check. Through this process, common categories were established and each of the learner outcome statements were mapped to a category. Some learner outcomes included elements that crossed categories. Because separating segments of the learner outcomes would have lost the context of statements, these statements were double-coded and placed into two or more of the established categories. Note that 100% consensus was reached on placement of statements within categories, including those which were double-coded. A third round of coding was completed to identify subcategories within each of the categories. In the case of some categories, no subcategories were identified, as the statements all shared the same defining characteristics. Within other categories, subtypes of the overarching category were identified to capture the conceptual specificity of those learner outcomes. This process was completed collaboratively by the first and second authors until complete consensus was achieved. Note that the third author reviewed all categorization and subcategorization, given review of operational definitions. This established face validity and served as a summative reliability check.

Q10. This question examined the contexts where counseling is embedded when not present in curriculum as a stand-alone course. These statements were tabulated through a simple topic sort (Bogden & Biklen, 2003). First and second authors sorted into objective categories individually. A second round of sorting was conducted to reach consensus on categories and statements assigned to each category. Again, this content was objective and fairly discrete, so 100% consensus was reached within the second round of coding. Additional consensus and reliability coding was not necessary.

Results

Representatives from 108 graduate programs responded to an online, Qualtrics survey regarding counseling coursework and preparation within their curriculum. Of the 255 accredited CSD graduate programs with emails publicly listed, approximately 42.4% responded. Department chairs or program heads were the primary respondents, although they may have consulted with faculty who instruct a counseling course in their program to complete this survey. See figure 1 for depiction of program regions. Approximately 12% of respondents were from the west region, including Alaska and Hawaii (n = 13), 29% from the mid-west (n = 31), 42% from the south, including Puerto Rico (n = 46), and 17% from the northeast (n = 18).

Figure 1. Regional programs in CSD.

Responses to survey questions yielded both quantitative and qualitative findings. Survey responses are addressed in order, as several questions include mixed data and subsequent questions build upon each other. The present survey yielded a response rate of 42.4%. Note that some comparisons will be made, primarily in figures, between the current data (December, 2018) and data from 1983 (McCarthy et al., 1986) to create a context for interpretations within the discussion section.

Q1) *Do you offer a stand-alone course in counseling within your graduate program?* Of the 108 graduate programs that responded to the survey, 64 (59%) offer a stand-alone course in counseling while 44 (41%) do not offer a stand-alone course in counseling. Figure 2 compares current respondent's offerings of standalone courses to McCarthy et al., 1986 (data from 1983). Note that direct comparisons were not able to be made from Culpepper, et al., 1994 (data from 1992).

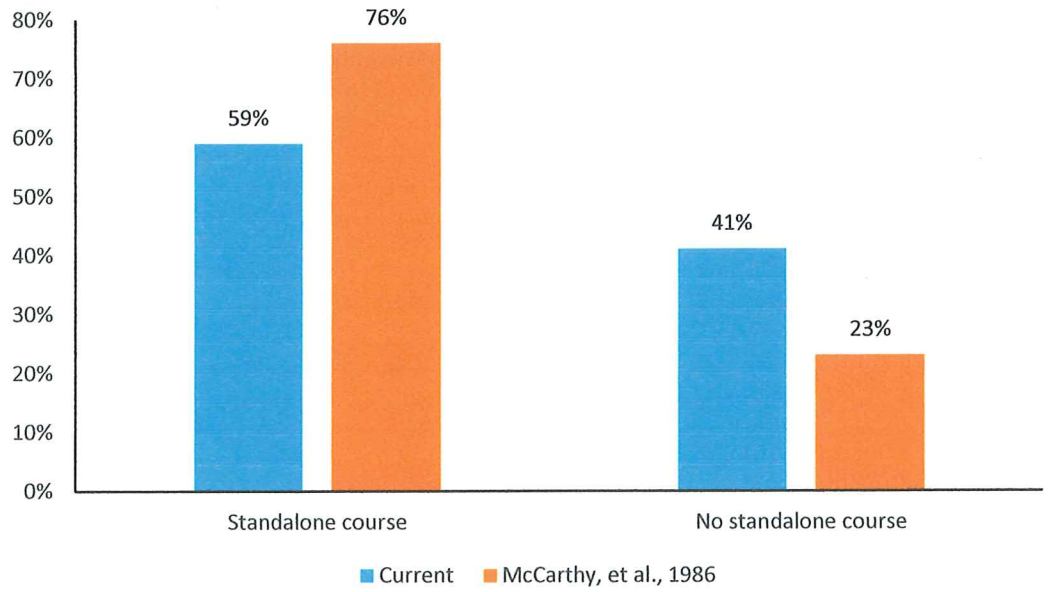

Figure 2. Comparison of standalone programs in current study vs. 1983 (McCarthy et al., 1986).

Q2) *If you offer a course in counseling, is it a required or elective course?* Twenty-six of the programs that offer a course in counseling (52%) reported that their course is required, while 24 (48%) reported that their course is elective. Figure 3 compares required and elective counseling course offerings from the present investigation respondents to Culpepper, et al., 1994 and McCarthy et al., 1986.

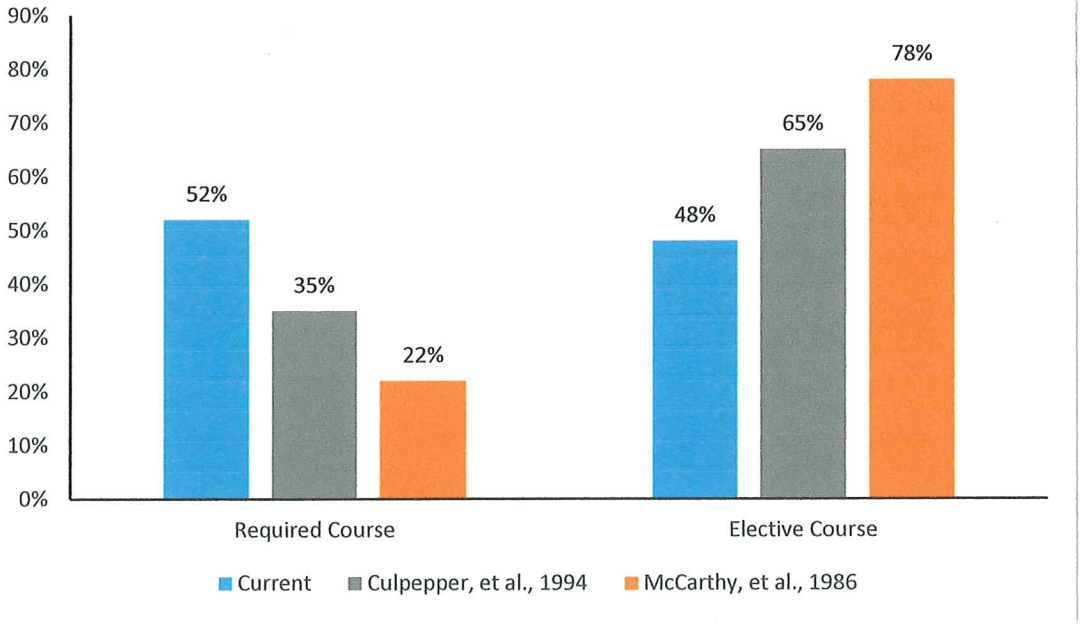

Figure 3. Required versus elective counseling courses comparing current to 1992 (Culpepper, et al., 1994) and 1983 (McCarthy et al., 1986).

Q3) *If you offer a course in counseling, how many credits?* Seven programs reported their counseling course is one credit, one program reported their course is one and a half credits, 19 reported that their course is two credits, 22 reported that their course is three credits, and one reported that their course is four credits. The majority of courses were between two and three credits. See figure 4 for distribution.

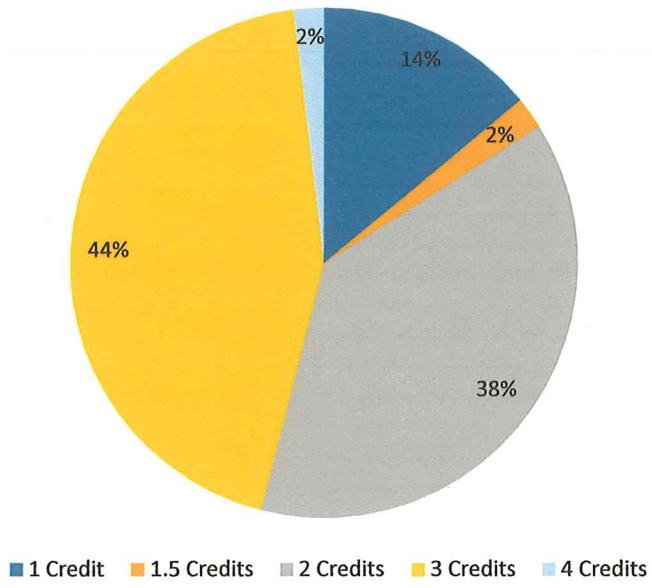

Figure 4. Distribution of credit level for counseling courses across respondents.

Q4) *If you offer a course in counseling, is it offered through the CSD department or another department? If another department, which one?* The majority of programs that offer a course in counseling reported that their course is offered through the Communication Sciences and Disorders (CSD) department (≈96%). One program reported that their course is offered through the Couples and Family Therapy department, and another reported their course is offered through the CSD department but taught by an instructor who is a professional counselor. Figure 5 compares current course offerings to that of McCarthy et al., 1986. Again, note that direct comparisons were not able to be made from Culpepper, et al., 1994.

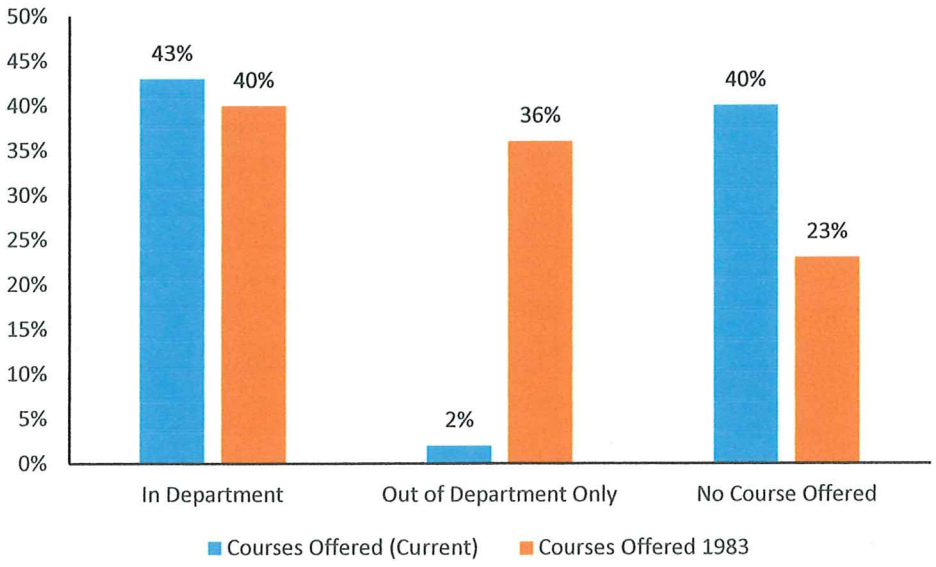

Figure 5. Distribution of counseling course offerings current compared to 1983 (McCarthy et al., 1986).

Q5) *If you offer a course in counseling, is counseling also embedded within other courses within the curriculum?* Eighty-six percent (n=43) of programs also embed counseling in other courses within their curriculum, whereas 14% (n=7) rely solely on the counseling course. Comments regarding how counseling is embedded within other coursework were tabulated through a simple topic sort. Findings from the simple sort are outlined in Table 1.

Table 1. Standalone course: Methods for embedding counseling within the curriculum.

How counseling is embedded within other courses in the curriculum	Number of comments	Percentage
Addressed within disorder-based courses	17	46%
Approach to instruction (e.g., lecture, case-based, service learning, readings, activities, course-embedded clinical experiences)	10	27%
Integrated within clinical experiences	6	16%
Addressed within multicultural coursework and culturally diverse populations	3	8%
Attempts to coordinate with the Department of Counseling	1	3%

Q6) *If you offer a course in counseling, approximately how many years have you offered it?* Program histories ranged from one to 47 years. Twenty-seven percent of the programs have offered a course for 1-5 years, 40% of the programs have offered a course for 6-10 years, 10% have offered a course for 11-15 years, 4% have offered a course for 16-20 years, 13% have offered a course for 21 or more years, and 6% were unsure of how long they have offered a course in counseling.

Q7) *If you offer a course in counseling, what textbooks do you use?* The top four textbooks reported are listed, the rest of the textbooks reported can be found in appendix C. Nineteen percent of respondents reported using various editions of Luterman's (2008, 2017) *Counseling Persons with Communication Disorders and their Family*. Seventeen percent reported using Holland's (2007, 2014) *Counseling in Communication Disorders: A Wellness Perspective*. Fifteen percent reported using Flasher and Fogle's (2012) *Counseling Skills for Speech Language Pathologists and Audiologists*. Thirteen percent reported using Tellis and Barone's (2018) *Counseling and Interviewing in Speech Language Pathology and Audiology*.

Q8) *If you offer a course in counseling, please share your learner outcomes.* Given the diversity of responses across programs, open and axial coding, grounded theory methods were employed. Ten schemes were identified that broadly characterized learner outcomes including: ethics, role of the SLP, counseling fundamentals, interprofessional, self-reflection/assessment, diversity, psychosocial adjustment, educational counseling, families, and skills. Distribution of qualitative coding schemes are depicted in Table 2. This table depicts categories, subcategories, and exemplars within each scheme.

Table 2. Qualitative analysis of learner outcomes

Ethics (5.58%)	Ethical and Legal Standards	Knowledge		P20: Be familiar with legal and ethical standards in counseling.
		Implementation		P2: Learners will demonstrate knowledge of legal and ethical mandates.
		Specific to ASHA Code of Ethics	Knowledge	P27: Identify and analyze operative parameters and their variations in the counseling process, recognizing the inherent legal, moral, and ethical considerations as applicable to communication and/or swallowing disorder(s) and as relevant to ASHA's Scope of Practice (2016), ASHA's Code of Ethics (2016), and the ICF WHO framework.
			Implementation	P9: Standard V-B 3d. Adhere to the ASHA Code of Ethics and behave professionally.
		Specific to HIPAA and FERPA		P29: Be compliant with the regulation of the Health Insurance Portability and Accountability Act (HIPAA), Family Education Rights and Privacy Act (FERPA), and other state and federal laws.
	Mandatory Reporting			P2: Learners will demonstrate competence with mandatory reporting.
Role of the	Role	General		P28: Explain the different counselor functions.
		Across Lifespan, Diversity, Disorder Type		P32: Develop an understanding of supportive counseling appropriate across the lifespan and diverse populations.

		Counseling in Communication Disorders		P11: Students will identify the role of counseling in communication sciences and disorders.
	Scope of Practice			P15: Differentiate purpose and scope of practice of counseling skills needed by speech-language pathologists and audiologists.
Counseling Fundamentals (8.12%)	Framework/ Theories	General Counseling Framework/ Theories	Knowledge	P10: Compare and contrast the basic theories and approaches to counseling.
			Implementation	P32: Describe the concept of sustainability as it relates to health care from an economic, social and environmental standpoint.
		Specific to Communication Disorders	Knowledge	P25: Identify traditional counseling theories and their application to communication sciences and disorders.
			Implementation	P17: Theory and practice in handling the unique problem of individuals with communication disorders and their families.
	Terminology	Knowledge		P12: Students will be able to identify a variety of terms related to collaborative counseling.
		Implementation		P27: Apply terminology basic to the study and implementation of the counseling process.
Interprofessional (7.11%)	Working with other Professionals	Knowledge		P17: Become familiar with importance of interdisciplinary input in the management of this population.
		Implementation		P32: Demonstrate knowledge of interprofessional practice relative to counseling issues in communication disorders.
	Making Referrals	Knowledge		P15: Recognize when a counseling situation warrants referral to a mental health professional and/or medical doctor.
		Implementation		P29: Referral to and consult with mental health professionals and other related service providers.
	Both	Implementation		P29: Referral to and consult with mental health professionals and other related service providers.
Self-Reflection/ Assessment (5.58%)	Reflecting on Self	General Reflection		P16: Participate in discovery of personal qualities/examination of values, attitudes, and behaviors.
		How these Affect Interactions with Clients/Families		P25: Identify and analyze their own beliefs of well-being and how these beliefs affect the client/patient-therapist relationship.
	Reflection on Counseling Skills			P16: Demonstrate awareness of change on their practice of counseling techniques.
Diversity (11.68%)	Cultural Diversity	Knowledge		P6: Describe differences observed among Western and non-Western cultures, and how counseling should be modified accordingly.
		Implementation		P13: Demonstrate a beginning ability to use culturally relevant counseling skills with clients and families from diverse backgrounds.

	Cultural and Linguistic Diversity	Knowledge		P1: Gain knowledge of the influence of cross-cultural across-linguistic differences on people's communication.
		Implementation		P4: Provide services that are sensitive to cultural and linguistic diversity.
	Diversity	Knowledge		P32: Develop an understanding of supportive counseling appropriate across the lifespan and diverse populations.
		Implementation		P5: Acknowledges and values gender, age, geographic, economic, educational, cultural, and linguistic norms and traditions.
Psycho-social Adjustment (13.7%)	Emotional	Knowledge		P21: Describe and identify emotional aspects of communication disorders.
		Implementation		P5: Demonstrate knowledge of the impact of impaired communication on the social and emotional functioning of clients across the age span.
		Grief	Knowledge	P18: Students will be able to describe how grieving processes impact families and individuals with communication disorders.
			Implementation	P11: Students will demonstrate knowledge of the stages of grief.
	Psychological	Knowledge		P30: Analyze, synthesize, and evaluate the basic human communication process with consideration of the individual's psychological, cultural and linguistic differences.
			Disability	P1: Gain knowledge of the process of familial psychosocial adaptation to the onset and condition of disability.
		Implementation		P31: Demonstrate the ability to analyze, synthesize, and evaluate knowledge re: psychological bases of human communication and swallowing.
	Patient as a Whole	Knowledge		P32: Develop an understanding of supportive counseling appropriate across the lifespan and diverse populations.
		Implementation		P23: Communicate effectively recognizing the needs, values, preferred mode of communication, and cultural/linguistic background of the client/patient, family, caregivers, and relevant others.
Educational Counseling (3.55%)	Knowledge			P10: Identify the skills necessary to assist clients and/or families in their understanding of communication problems through effective interpretation, information dissemination, and discussion while considering the feelings of the clients and/or families. *(AP #2, #7, #8, #11 / S III-G, IV-B, IV-G (3)/PO #1, #6, #7, #9).
	Implementation			P24: Describe various counseling techniques and incorporate these clinically through case history interviews, parent/spouse/caregiver education, behavioral management, and making referrals, as appropriate.
Families (12.69%)	Working with Families	Knowledge		P21: Describe basic counseling approaches and when they might be appropriately used with clients and families.
		Implementation		P26: Demonstrate methods for interactions with families, groups, and peers.
	Impact on Families			P21: Describe factors contributing to adjustment for an individual with disabilities and the family.

	Engaging Families		P5: Demonstrate strategies to respectfully share input from caregivers and other collaborators.
Skills (25.89%)	General Skills	Knowledge	P28: Differentiate and explain the importance of the language used within counseling.
		Implementation	P17: Know and practice some basic counseling strategies.
	Specific Techniques	Knowledge	P8: How to facilitate the client's insight/ how to respond to ambivalence and resistance talk / How to foster change talk / How their own upbringing, values, and experiences impact the way they view their clients / how to inhibit the righting reflex and withhold judgments.
		Implementation	P3: Synthesize and apply the knowledge of the inter/intrapersonal communication process to include: self-awareness; perception of events and others; expressing one's self; listening; barriers to communication; hurtful and negative communication; conflict; emotions and loss and grief.
	Approaches	Knowledge	P21: Describe basic counseling approaches and when they might be appropriately used with clients and families.
		Implementation	P7: Motivational interviewing skills.
	Listening	Knowledge	P28: Describe the type of and importance of listening during counseling episodes and its effect on working with clients and their families.
		Implementation	P20: Engage in empathetic listening in various clinical settings.
	Engaging	Knowledge	P8: How to take the client's perspective.
		Implementation	P5: Demonstrate strategies to engage client and family members in the prevention and intervention of communication disorders.
	Client's Feelings	Knowledge	P16: Develop understanding of resistance.
		Implementation	P5: Identify the client's feelings/thoughts concerning his/her functioning when appropriate.
	Disability		P18: Students will be able to describe the role of denial in families with disabilities.

Q9) *If you do not offer a course in counseling, have you offered one in the past?* Of the graduate programs that do not offer a stand-alone course in counseling, five programs (12%) reported that they have offered one in the past, and 37 (88%) reported they have not offered a counseling course in the past.

Q10) *If you do not offer a course in counseling, is counseling embedded within other courses within the curriculum? If so, how?* Of the programs that do not offer a stand-alone course in counseling, 98% reported that counseling is embedded within other courses in the curriculum. The comments regarding how counseling is embedded within other coursework were tabulated through a simple topic sort. First and second authors sorted individually and then reached consensus on categories and statements assigned to each category. See Table 3 for distribution of methods for embedding counseling within the curriculum. Figure 7 compares programs that offer a stand-alone course in counseling to programs that do not offer a stand-alone course, and the rate at which counseling is embedded into other courses in the curriculum.

Table 3. No standalone Course: Methods for embedding counseling within the curriculum.

How counseling is embedded within other courses in the curriculum	Number of comments	Percentage
Counseling is addressed in disorder coursework	25	50%
Counseling is addressed in clinic or clinic seminars	10	20%
Counseling is addressed in multicultural issues	5	10%
Counseling paired with diagnostics course	3	6%
Counseling is addressed in professional issues and current trends	3	6%
Counseling is addressed in colloquia	3	6%
The program will be offering a counseling course starting next fall	1	2%

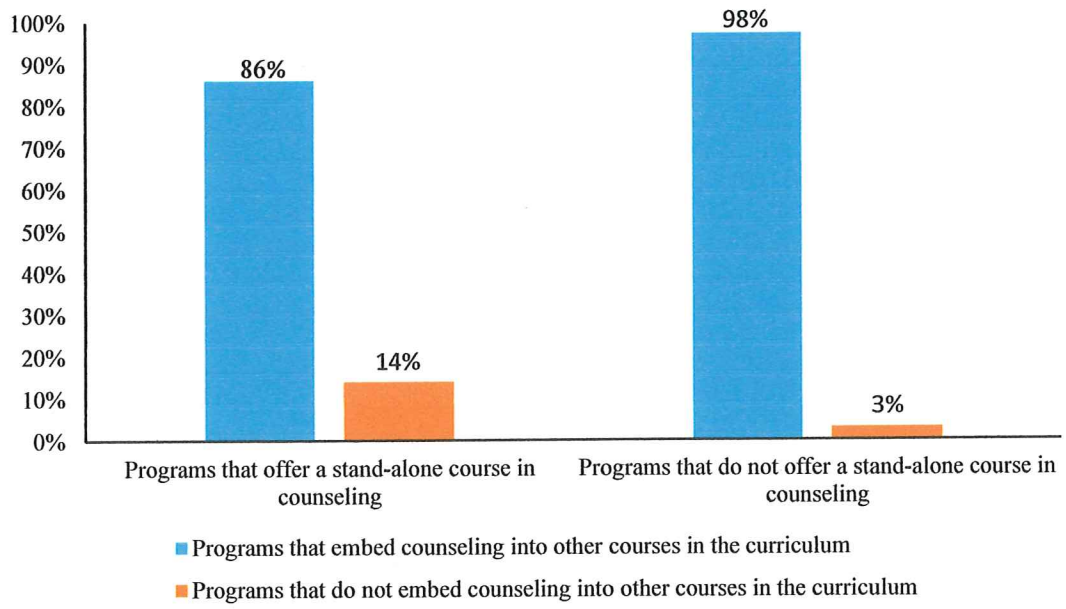

Figure 6. Rate of embedding counseling into other courses.

Respondents made an additional 20 open comments. Several of these comments related to the issue of required versus elective status of the course. Some commented on the timing (i.e., undergraduate or graduate) or the number of credits. A few spoke to the instructional methods and nature of the content. Others spoke to the overall importance of the course and skillsets to working with clients and their families. Examples of these comments are listed below:

- "I wish my program had a counseling course. It is necessary in our field."
- "A grad level counseling course gives our students deeper insight into taking others' perspectives in viewing clients from a systems approach."
- "While the course is elective for our program, approximately ¾ of the students elect to take it."
- "Very critical to clinicians who serve another human being and his/her family. More importantly is that our students got to learn about themselves and gain self-efficacy in themselves."

Discussion

The current investigation provides a much-needed update to data about counseling curricula across accredited programs in CSD. Unfortunately, there has been little change to the inclusion of counseling within programs. Further, no changes to oversight or standards for inclusion of specific elements within counseling coursework have been established. While flexibility regarding implementation of curriculum across program is

clearly important, some standards for best practices in counseling training would be useful to guide programs and improve consistency in training. Hopefully, by assembling data on what current programs include within their curricula, including detailed analysis of learning outcomes, this paper can serve as a starting point for identifying standards in training of counseling in CSD.

Implications

ASHA (2018) identifies counseling as one of the eight core skills of an SLP and identifies the related skills of wellness/prevention and interdisciplinary collaboration as core skills. Counseling is also identified within AuD scope of practice. Students identify counseling courses as a valuable and important part of their education. While counseling is an integral part of the work of SLPs and AuDs on a regular basis, over 41% of programs do not offer a course, there is limited structure to guide content within counseling courses, and there is limited research to support best practices with regards to instruction methods, content, or overall curriculum. Unfortunately, the number of programs offering a standalone course in counseling, within or outside of the department, dropped from 76% in 1983 (McCarthy, et al., 1986) to 59% as of December, 2017. Further, there is virtually no information about continuing education opportunities related to counseling in CSD. On a positive note, of the responding programs that offer a standalone course in counseling, 52% require that course, up from only 22%.

Far fewer programs (2% vs. 36%) report offering their counseling course outside of the discipline as compared to 1983 (McCarthy et al., 1986), which may indicate an increase in comfort or expertise in counseling instruction within the discipline. This answers the call by respondents to the 1983 study, 70% of whom indicated a counseling course should be offered in the CSD department. It should be noted that of the responding programs that offered a counseling course outside of the discipline in 1983, 52% of those courses did not include information specific to counseling individuals with communication disorders. Further, another 28% of respondents were not familiar enough with course content to indicate whether counseling specific to communication disorders was addressed. Only 19% of programs who offered the course outside of the department could verify that content specific to communication disorders was included. Since most departments in the present investigation either provide the course within CSD or an instructor from another discipline teaches in conjunction with CSD, this concern may have been addressed.

Most programs recognize the importance of integrating counseling across the curriculum. A qualitative analysis of the methods for embedding counseling into other courses within a CSD curriculum highlights the manner in which some programs integrate counseling across the curriculum and may highlight the need to be more intentional and systematic in

incorporating elements of counseling techniques into those courses. Programs that do not offer a standalone counseling course recognize, for the most part, that counseling must be embedded within other courses and clinical experiences within the major (98% embed in other courses, 3% have no intentional embedding of counseling). Of programs that offer a standalone counseling course, the majority (86%) also embed counseling within other courses and clinical experiences in the major. Only 14% of programs who offer a standalone course rely upon that course alone to teach and apply counseling knowledge and skills. While this may indicate more intentional inclusion of counseling across the curriculum, it is unclear whether this prepares students adequately to serve clients. In 1983, 70% of programs responding indicated that preparation was insufficient (McCarthy et al., 1986). Likewise, Phillips and Mendel (2008) indicated that 60% of recent CSD graduates reported that counseling was not an integral part of their training, nor did they feel prepared to conduct counseling following graduation. While the present investigation did not examine perceptions of preparedness, from the perspective of programs or graduates, several open comments identified more need for counseling training.

Qualitative analyses of learning outcomes reported across programs provides a framework for the nature and types of learning outcomes within counseling courses in CSD. Prominent elements in learner outcomes addressed ethics, counseling roles and scope of practice, framework and theories, interprofessional collaborations and referrals, reflecting and self-assessment, cultural and linguistic diversity, psychosocial adjustment, educational counseling, families, and skills and techniques. This list of common learner outcomes appears to be a good starting point for identifying core learning in counseling courses. Consistent with the ASHA Knowledge and Skills Acquisition (KASA) framework, most learner outcomes address both knowledge and skill (i.e., implementation) components. Perceived ambiguity of counseling roles and scope of practice can be a challenge for practicing SLPs. As such, training on how to recognize professional boundaries and referrals is important (English et al., 1999; Stone & Olswang, 1989). English and colleagues emphasize the use of role plays, self-evaluations, and reflections to develop counseling skills. Further, there are a number of textbook resources that discuss issues identified across course-based learner outcomes (see Appendix C for a fairly comprehensive list of counseling textbooks in our discipline and related disciplines).

Among the specific counseling approaches identified in learner outcomes are: motivational interviewing, solution-focused therapy, cognitive behavioral therapy, and positive psychology/wellness. A small body of research examines the use of such techniques in CSD. While reviewing each of those techniques is not the purpose of this article, a summary of empirical contributions within the CSD discipline follows. Motivational interviewing has been examined in voice therapy (Behrman, 2006), hearing aid use (Solheim et al., 2017), cognitive rehabilitation (Hoepner & Olson, 2018; Hsieh et

al., 2012; Medley & Powell, 2010), and broadly in SLP/AuD (Macfarlane, 2012). Solution focused therapy has been examined in aphasia couples interventions (Boles & Lewis, 2003; Boles & Lewis, 2000). Cognitive behavior therapy has been investigated for use with individuals who stutter (Menzies et al., 2009, Menzies et al., 2008; Neilson, 1999), carers of individuals with dementia (Barnes & Markham, 2018), and those with tinnitus (Kaldo-Sandström, Larsen, & Andersson, 2004). Positive psychology has been examined among individuals with aphasia (Brown et al., 2012; Holland, 2007; Worrall et al., 2010), stuttering (Zebrowski & Arenas, 2011), and more broadly in speech-language pathology (Sharp, 2011). Given the heterogeneity of counseling needs across the lifespan and breadth of disorder areas served by SLPs and AuDs, there is not enough information to draw any firm conclusions about best practices. There remains a clear need for empirical evidence of counseling techniques within CSD.

Limitations

This study had a relatively low response rate of approximately 42%. Therefore, results may be subject to response bias in the case that programs that do not offer a course in counseling may have been less likely to respond to the survey. Respondents were also not required to answer every question in the survey, and some respondents did opt out of certain questions which again could lead to a bias in results. A clear challenge, even among CAA accredited programs, when discussing counseling curriculum is a lack of common language and terminology surrounding skills and techniques. The diversity of terminology and approaches identified within learner outcomes speaks to the developing state of counseling education within our discipline.

Future Directions

Much more work needs to be completed to generate an empirical basis to guide curricular and instructional methods for counseling in CSD. The present survey is merely a starting point and lacks analysis of instructional methods, preparedness of student clinicians to counsel in clinical contexts, or counseling outcomes in a variety of clinical contexts that speech-language pathologists and audiologists serve. An investigation of counseling practices of practicing SLPs has already been completed as a follow-up to this investigation.

More contemporary information is needed to examine perspectives of programs, graduates, and professionals, especially regarding adequacy of training and specific training/skillset needs. In the meantime, CSD graduate programs can examine their own counseling training and whether or not they believe it to be adequate for new graduates to perform such a necessary skill in their practice.

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Research questions

How much training do SLPs have in counseling, and how comfortable do they feel using counseling in practice with clients with aphasia?

To what extent are SLPs implementing counseling in practice with clients with aphasia and their partners?

CHAPTER 2
METHODS

This study was completed in two parts. Part one consisted of the counseling practices survey, and part two consisted of the counseling practices interview. It should be noted that both parts of the study addressed both of the research questions above. The participants, procedures, and analyses of part one will be addressed first, and the participants, procedures, and analyses of part two will be addressed second.

Part One: Counseling Practices Survey

The aim of the counseling practices survey was to collect data on aspects of counseling training that SLPs have engaged in, as well as frequency of use of specific counseling techniques.

Participants. A general request for volunteers was posted on the *Adult Rehab Speech Therapy* and *Medical SLP Forum* closed Facebook pages, in which SLPs request to join to discuss research and questions that come up in their clinical work. These Facebook groups were selected in an attempt to recruit a sample of potential participants

that is representative of the SLPs working in the field. Ninety-Three participants completed the online, Qualtrics survey. The participants were SLPs who completed their graduate programs across the United States (23.91% West, 21.74% Mid-West, 28.26% South, and 26.09% Northeast).

Procedures. The request for volunteers included a link to an online, Qualtrics survey regarding counseling training SLPs have received and counseling strategies they implement into practice, as well as an electronic cover letter detailing informed consent procedures (Appendix A). The online, Qualtrics survey was anonymous, and asked various questions related to the participants' experiences with counseling training. Questions involved counseling courses taken, information about those courses, continuing education in counseling, and counseling methods used in practice. The survey took approximately 10 minutes to complete and allowed participants to give their contact information if they were interested in participating in an interview. For the full survey, see Appendix B.

Analyses. Data from the online, Qualtrics survey were analyzed both quantitatively and qualitatively. Percentages were calculated for responses to questions 1, 2, 3, 4, 5, 6, 8, 9, 10, 11, and 12. A simple categorical content analysis sort (Bogden & Biklen, 2003) was used to characterize responses from questions 9 (i.e., how counseling was embedded in other courses) and 10 (i.e., describing continuing education or other counseling training). Statements were grouped into objective categories by the primary investigator in the initial round of coding. The primary investigator and thesis mentor completed the second round of coding, in order to reach consensus on categories and

statements within each category. Because coding for both questions was largely discrete and intuitive, it did not require multiple rounds of subsequent coding to reach consensus.

Part Two: Counseling Practices Interview

The aim of the counseling practices interviews was to gather more in-depth data on counseling preparedness and counseling methods used by SLPs. The final question on the counseling practices survey allowed participants to provide contact information if they would like to participate in a qualitative interview. Six participants indicated interest in participating in an interview, and all six were interviewed.

Participants. Six individuals participated in counseling practice interviews. These participants completed the online, Qualtrics survey and noted they were interested in participating in the interview. All participants that indicated interest in participating in an interview were interviewed. Two participants worked primarily with patients in the acute phase, three participants in subacute, and one in subacute/chronic.

Procedures. The structured interview used in this study was developed following the framework of Simmons-Mackie et al. (2007) and Magnus & Turkington (2006). All interviews were conducted via the BlueJeans video conferencing application. Recordings of interviews were set to be completed automatically within the BlueJeans video conferencing application. Individuals participating in interviews were asked five main interview questions, with scripted follow-up questions (Appendix D). Identifying information was removed from the transcripts of the interviews.

Interviews were conducted by the primary researcher: a speech language pathology graduate student. The graduate student was trained in the implementation of

qualitative interviewing via practice interviews with committee members. The interviewer adhered to the five main interview questions, and the scripted follow-up questions were asked when more information was determined to be needed.

Recorded interviews were transcribed by two undergraduate research assistants, designating interviewer questions and participant responses. Transcription checks were conducted on 17% of interviews to assure transcription reliability and accuracy. Inter-transcriber reliability was 93%. The primary investigator segmented transcriptions into codeable statements to be analyzed by herself and the thesis mentor. Codeable statements were defined as a single thought within context, regardless of length or complexity.

Analyses. Data from the interviews were analyzed through manual qualitative coding. Qualitative analyses of interview responses used Strauss and Corbin's (2008) method of non-hierarchical open and axial coding. Open coding breaks data into individual concepts and axial coding groups related concepts together. During the first round of data analysis, the primary investigator independently sorted statements into specific categories using the open coding technique. The primary investigator coded responses to each interview question separately, across participants. In other words, all responses were coded for all six participants for question one, before moving on to code all responses for question two, and so forth – until all open-ended questions were coded. Similar to round one, in round two, the primary investigator coded responses to individual interview questions across all six participants separately. During this round of data analysis, statements were further grouped into mutual categories and broader

ordinates for those categories were identified when evident using the axial coding technique. During the final round of data analysis, participant statements were jointly reviewed by the primary investigator and thesis mentor to: a) assure that they were placed in the correct category (i.e., that individual, codeable statements fit within previously identified categories, given operational definitions), b) further condense and merge similar statements into categories when appropriate, and c) identify overarching schemes that encompass similar categories. For a schematic of how individual statements were grouped into subcategories, categories, and schemes through the open and axial coding method, see Figure x. This iterative process assured integrity and rigor of codes by reviewing the categories and overarching schemes over the course of multiple meetings. Further, the drilling down process of open and axial coding ensures inclusion of unique data points. This iterative vetting process facilitates triangulation and improves rigor of qualitative codes (Lincoln, 1986). It should be noted that the primary investigator's bias towards use of counseling methods could have impacted coding process. The process of employing multiple rounds of coding, across multiple days, and reaching consensus with the thesis mentor helps to reduce bias, acknowledging that all research is subject to bias.

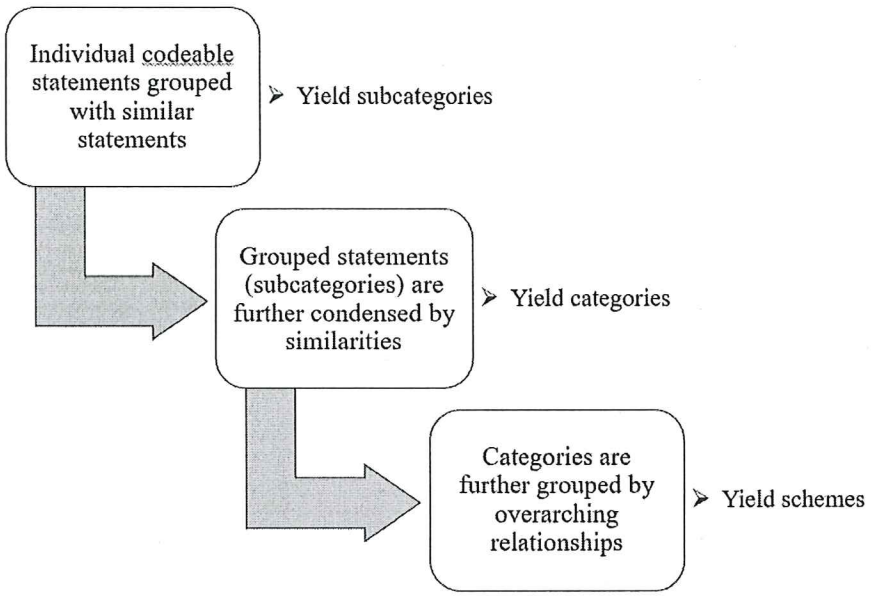

Figure 1. Qualitative Coding Process.

CHAPTER 3

RESULTS

The first section of results will address questions answered in the counseling practices survey. Following the results from the survey, the questions answered in the counseling practices interviews will be addressed.

Part One: Counseling Practices Survey

Question 1: Indicate the context(s) you work in (select all that apply).

Participants were invited to indicate all of the applicable settings that they work in and were allowed to select more than one answer. Results are outlined in Table 2.

Table 2

Participants' Work Contexts

Setting Indicated	Number of Participants
Acute care in a hospital	37
Inpatient care in a hospital	37
Outpatient care in a hospital	16
Standalone inpatient facility	10
Standalone outpatient facility	4
Long-Term care facility	27
Other (hospital inpatient pediatrics and rehabilitation, long-term acute care, traumatic brain injury community-based rehabilitation, home health, private practice, university clinic, adult day health)	24

The participants that indicated multiple work contexts were asked to report their primary work setting. Eight of those participants reported their primary setting was standalone inpatient care, eight reported acute, two reported hospital inpatient care, three reported hospital outpatient care, three reported long-term care, and one reported that a university setting was their primary work context.

Question 2: Regardless of the setting you work in, do you feel you primarily work with patients in the acute, subacute, or chronic stage of recovery? Operational definitions created by the research team were provided for each stage of recovery to guide participants in answering this question. The acute stage of recovery was defined as "variability in medical and behavioral stability within each day, swelling in the brain and fragility of neurons." The subacute stage of recovery was defined as "increased stability but continues to vary from day to day." Finally, the chronic stage was defined as "some variability, but relatively consistent from day to day." The participants' responses are outlined in Table 3.

Table 3

Participants' Primary Stage of Recovery

Stage of Recovery	Number of Participants
Acute	38.04%, n=35
Subacute	45.65%, n=42
Chronic	16.30%, n=15

Question 3: How many years of experience do you have working in the field?

The distribution of years of experience in the participants is outlined below in Figure 1. The majority of the participants (48.91%) have been working in the field for 0-5 years.

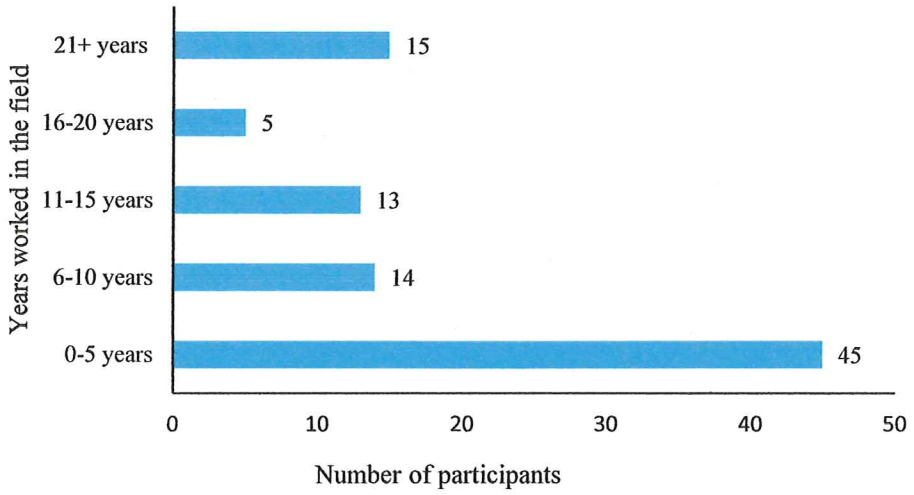

Figure 2. Distribution of Participants' Years Worked in the Field.

Figure 3. Map of Regions of the United States.

Question 4: Given the image above, select the region in which your graduate program was located. Participants were asked to report the region of their graduate program based on Figure 2 above. The participants' graduate programs were relatively equally distributed throughout regions of the United States, with 23.91% (n=22) in the West, 21.74% (n=20) in the Mid-West, 28.26% (n=26) in the South, and 26.09% (n=24) in the Northeast.

Question 5: Did you take a counseling course as a graduate student? Forty-Three participants (46.74%) reported they did take a counseling course as a graduate student, 48 participants (52.17%) reported they did not take a counseling course as a graduate student, and one participant reported they did not know.

Question 6: Was the counseling course through the Communication Sciences and Disorders (CSD) Department, or in a different department? Of the counseling courses taken by our participants, 81.63% (n=40) were offered through the CSD department, while 18.37% were offered through a different department. Those different

departments listed were Psychology, Human Development and Family Studies, and undergraduate elective course offered through CSD department.

Question 7: If you remember, what textbook(s) did you use? Seven participants offered the textbook used in their counseling course. Five of those reported they used Luterman's (2008, 2017) *Counseling Persons with Communication Disorders and their Family,* one reported they used Holland's (2007, 2014) *Counseling in Communication Disorders: A Wellness Perspective,* and one reported they used Flasher and Fogle's (2012) *Counseling Skills for Speech Language Pathologists and Audiologists.*

Question 8: When in your program did you take the counseling course? Sixty of the participants who reported taking a counseling course identified when in their program they took the course. The distribution is outlined in Figure 3 below. Those who indicated "other" expanded by providing the following answers: sometime in graduate program, sometime in graduate year 1, in undergraduate and graduate, and the summer before graduation in a five-year program.

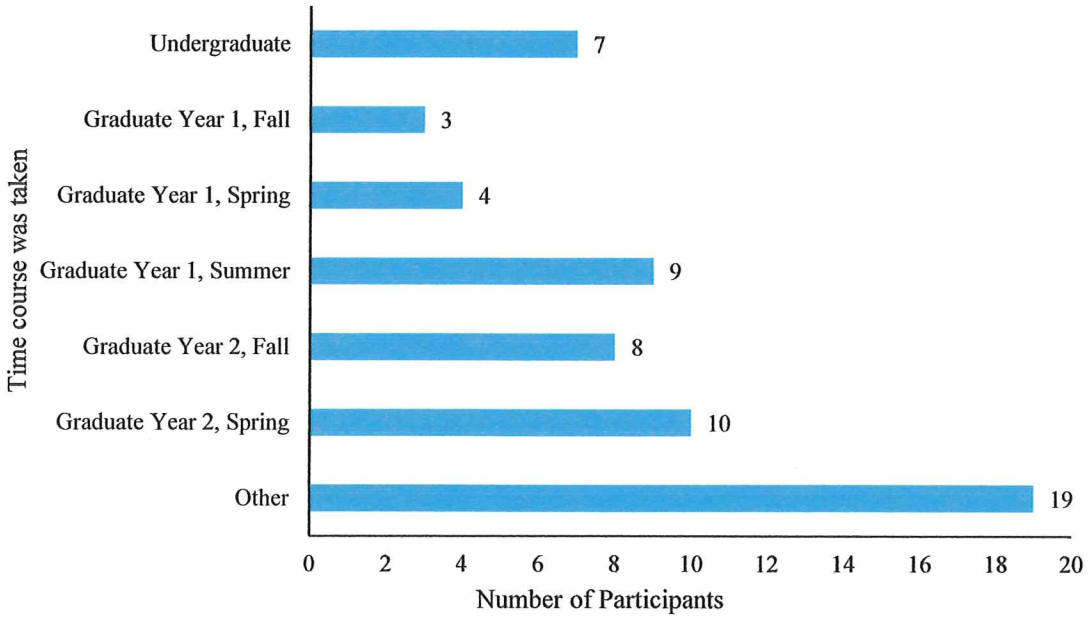

Figure 4. Distribution of Time Counseling Course was Taken.

Question 9: If you did not take a counseling course, was counseling embedded in your other courses? Twenty-four participants (42.11%) stated that counseling training was embedded in other courses they took. Written descriptions provided for this question are listed below. Eight comments mentioned counseling embedded into their other courses, while three comments described counseling embedded into their clinical experiences. On the other hand, 38.60% (n=22) of participants said counseling was not embedded in other courses in their graduate program.

- Basics – comforting patients while dealing with life altering changes setting therapy goals to improve quality of life
- During clinicals
- It was also part of our internships
- When discussing different treatment & family education, counseling discussions/suggestions were common
- Cleft Palate and Cultural Awareness both had counseling sections

- Yes, 1-2 lectures within other courses
- Units in Aphasia and Craniofacial courses
- Too long ago to remember, but the professors would briefly touch on counseling. The counseling course was not a requirement and not provided under CSD program
- Somewhat interspersed but not ever very directly addressed
- End of sessions, this is what you can do if...
- Within a course on Acquired Language Impairments

Question 10: Have you done continuing education for counseling? Do you have any other training in counseling? The majority of participants (66.30%, n=61) stated they have not taken continuing education or other training courses in counseling. Of the 33.70% (n=31) of participants that have taken continuing education or other training in counseling, their responses are listed below. Five comments reported counseling training from continuing education courses, four comments reported seeking counseling training outside the field of speech-language pathology, and one comment reported both.

- I sought training in counseling basics as well as consultation with social work
- Related to ethics Continuing Education Units
- Counseling crisis for sexual assault hotline
- A couple Continuing Education courses
- Saw a patient in the school clinic during my practicum strictly for counseling
- I'm a certified life coach now
- Just professional development
- Continuing Education classes, independent reading
- 2 Continuing Education courses
- Motivational Interviewing
- Bachelor of Arts in psychology, ASHA Continuing Education Units

Question 11: In your training for counseling, either in graduate school or through continuing education, did you engage in hands-on training? The majority of participants (74.42%, n=64) did not engage in hands-on training, and only 25.58% (n=22) did engage in hands-on training.

Question 12: The table below lists various counseling techniques. Check the boxes according to techniques you currently use in practice, techniques you want to use in practice but do not currently use, techniques you do not use in practice, and techniques that you are unfamiliar with.

Table 4

Frequency of Counseling Methods Used

Counseling Technique	I currently use	I want to use	I don't want to use	I am unfamiliar with	Total
Giving advice	85.56%	4.44%	10.00%	0.00%	90
Summarizing	93.55%	5.38%	0.00%	1.08%	93
Open ended questions	90.22%	7.61%	1.09%	1.09%	92
Rapport-building	98.91%	1.09%	0.00%	0.00%	92
Persuasion/direction	52.81%	13.48%	21.35%	12.36%	89
Reframing	67.78%	14.44%	0.00%	17.78%	90
Small talk	90.91%	2.27%	3.41%	3.41%	88
Information dissemination	70.79%	8.99%	0.00%	20.22%	89
Affirmation	84.78%	7.61%	0.00%	7.61%	92
Listing solutions	85.39%	11.24%	2.25%	1.12%	89
Active listening	94.57%	5.43%	0.00%	0.00%	92
Goal-setting	91.11%	6.67%	0.00%	2.22%	90
Finding leverage	19.32%	15.91%	13.64%	51.14%	88
Brainstorming	79.12%	10.99%	0.00%	9.89%	91
Journaling	23.60%	34.83%	16.85%	24.72%	89
Solution-focused therapy	46.07%	22.47%	1.12%	30.34%	89
Restating	85.56%	12.22%	0.00%	2.22%	90
Engaging	85.56%	3.33%	0.00%	11.11%	90
Repatterning behavior	24.14%	17.24%	6.90%	51.72%	87
Planning	81.52%	10.87%	0.00%	7.61%	92

Reflection	71.91%	19.10%	1.12%	7.87%	89
Cognitive behavioral therapy	33.33%	31.11%	12.22%	23.33%	90
Motivational interviewing	28.41%	27.27%	6.82%	37.50%	88
Positive psychology	30.68%	18.18%	3.41%	47.73%	88
Wellness approaches	47.78%	15.56%	4.44%	32.22%	90
Other:	10.00%	0.00%	10.00%	80.00%	10

Part Two: Counseling Practices Interview

Six interviews occurred for a total of 199 minutes, with a mean time of 33 minutes per interview. Each interview question was qualitatively coded and the themes and categories that came from that coding process are outlined in the following figures. Each figure outlines the themes, categories, and subcategories found in the qualitative analysis, as well as an exemplar of a statement. Each exemplar begins with P# S#, indicating the participant number and the statement number. Table 3 below depicts the organization of the qualitative coding figures.

Table 5

General Outline of Qualitative Analyses

Theme	Category	Subcategory	Exemplar (quote from participant)
		Subcategory	Exemplar (quote from participant)
		Subcategory	Exemplar (quote from participant)
	Category		Exemplar (quote from participant)
Theme			Exemplar (quote from participant)
	Category	Subcategory	Exemplar (quote from participant)
			Exemplar (quote from participant)

Question 1: Describe strategies/techniques you use when working with a client with aphasia.

Assessment	Patient and Caregiver Perspectives		P2 S13: Um, so I like to, you know, understand why the patient's here, understand the patient's perception of their communication impairments. And then I like to get the caregiver's perception as well and their concerns, and I administer an assessment and then, based on the results…sometimes it takes two kinds of assessments: um, I tend to do like a quality of life assessment and then I do a standardized assessment more looking at the language impairment itself.
	Strength-Based		P4 S10: Oh, okay. Well, um, when I do their eval, I always try to, like, figure out what they are good at. Um so if it's confrontational naming, I would start there and then build. Um, if they're good at sentence completion, I would start there and build. Um, and then I always talk to their families depending on- if the patient is severely aphasiac, then I will talk to the family and ask, "what do they like to do?" before um and try to get, um, activities or talk about things that they were good at or loved. Um, if they're more on the moderate to severe spectrum, I'll, um, (clears throat) ask the family to bring in a photo album with one or two people per page and then ask them to label on the back so that the patient can't use the visual cue on the front, but I'll use the visual cue on the back um to say, like, who they are, like "Aspen" and then "daughter". Um and then I will illicit conversation surrounding that.
		Functional Communication	P1 S7: Okay so one of my number one goals whenever I start working with aphasia is to figure out what's their easiest way to communicate. Whether it's gestures or um, writing. Um, some of my patients actually do better with texting.
	Assessment Skills		P5 S7: Okay. So, um with patients with aphasia, um obviously I do an initial assessment and see what their skills are. Um, I initially look at verbal expression, auditory comprehension. And then um if I feel like I've got a good handle on that, I will move on to writing and reading skills because I find that those can often be really helpful in cueing and prompting for verbal um expression and auditory comprehension.
Technical Process			P2 S14: And based on those assessments, together we work on a treatment plan, and I try not to overwhelm them with, you know, developing 20 goals. I try to stick to two or three goals.
Getting to Know the Patient			P2 S15: And, um, I...It takes some time to get to know patients so, usually the first two or three sessions we're really trying to get some momentum going in terms of, you know, what is the patient stimulable to use, what effective strategies can he use, identifying what's effective for him or her.
Education			P6 S9-10: Um, I have an aphasia group and my aphasia group members made a list of all of the things that they wanted everyone to know about their aphasia. So, we put that together and I give that to every patient that comes in with aphasia. And I tell them that little story about why-why we have it. Um and then- actually it's a nice local way to kind of explain aphasia.

	Ongoing Learning		P2 S17: And I encourage patients to partake in research studies because we have local universities who are doing great research, and that's a good way for them to get kind of a deeper assessment and learn other things, and have a different perspective.
	Educational Counseling		P6 S12: Um so that where- a lot of counseling comes with education. Then when my patients kind of start to wake up, it's a lot of listening to families, and it's a lot of hope. It's a lot of um, uh- when people are really sick and a family member is critically ill, there is a lot of bargaining and there's a lot of frustration with everything that's going on medically. So, I think as speech pathologists our job is to just sit there and just listen to everything the family has to say about all the aspects of the medical care. And then direct all questions appropriately. But it really- just be, just be the listener.
Skills/ Techniques	Specific Techniques		P5 S10: So really just focusing on that functional communication first and then from there we will do more discrete tasks like um confrontation mapping or generative naming and then we try to get into semantic aspects of language too.
		High Level	P5 S7: Um, I use semantic feature analysis which um usually- it tends to be towards higher level aphasia patients. I haven't found great success with that with lower level aphasia patients.
		Low Level	P3 S7: Um… so I use um, I use… I use some structured tasks, um but mostly um…mostly uh, I guess it depends on the patient. So, I work in acute rehab. Um if I have a really low level patient um I use a lot of singing, a lot of automatics.
	General Principles		P1 S9: Um so I look at writing the one thing I try not to do is allow the family to talk for them until I turn and give the family notice that it's okay to speak, because I've noticed that those with aphasia frequently will turn, Like I'll ask who's your primary care physician? And they'll look at me and Immediately turn their faces. Like you answer for me, I'm not going to do it, I can't do it. And so what I try to do is say, 'no, no, no, I'll let them know whenever I need them to answer. You do what you can, tell me who it is.'

Figure 5. Qualitative Coding of Question 1.

Question 2: Describe specific counseling strategies/techniques you use when working with clients with aphasia.

Education	Prognosis	P6 S20: So absolutely when they are- let's say they got TPA or they got a mechanical thrombectomy, and they're doing well with some mild anomia. Um then we'll just kind of talk about what um what's going to happen in their course of rehab. And that's just kind of a- explaining expectations uh- kind of talking about you know managing expectations, managing what, what the rehab is going to look like.
	Community Resources	P5 S19: but they're also really scared because they've never met anyone who has this problem. And they usually feel like "I am the only person in this world who has this problem and it's so stupid because I can't talk." Um so I usually just start with a whole lot of education that "hey you know, you had" it's usually a stroke "and this is something that happens after a stroke and "look there's a whole community developed to support you." "There's you know, all these aphasia um research societies and there's you know aphasia education online and stuff that your family can look at". And you know "here is what the disorder is and here is why it is happening and here's how we make it better." Um, so really doing that education initially.
	Stroke	P1 S11: so I'm going to take this answer first of all, kind of assuming that it's an acquired aphasia that happened from a recent stroke because that's typically whenever I see them in my hospital is right after a stroke or something has happened. So answering in that mindset, the first thing I do within my first couple sessions is I explain to them what has happened in the stroke, um, I explain to them some of the side effects that may occur,
	What is Aphasia	P5 S19: So, so a lot of what I do has really just been learned on my own and trying to figure out what does and what doesn't work with patients. So usually um, a huge part of my counseling is just 'okay let's start with education.' Let's start with telling you 'what is aphasia?' 'what is apraxia?' So that you actually know there's- I find a lot of people um are really- obviously they're really frustrated by their communication difficulties
Skills / Techniques	Conversation-Based	P3 S14: I do talk a lot on the cuff, or off the cuff, about just um talking about just being comfortable with where they at- where they are at with their communication. Um, putting it all out there.
		P2 S20: Okay, well I try to tailor my aphasia therapy to the patient's needs. And I think in order to do that I really have to understand what's important to them, and

	Caregiver and Patient Perspectives		why they're here, and how their aphasia is affecting their daily life, and, um, trying to target therapy based on their interests and their main concerns.
		Patient-Driven Goals	P4 S11-12: Um and if they're able to, maybe more of a mild aphasiac, um, I'll ask them like what bothers them the most and then if I can, I would turn that into um a therapy task. Um, sometimes it's not always possible. Um, one patient wanted to um- um, I had one patient that wanted to say 'happy anniversary' to his wife, so he worked really hard on that.
	Positive-Focused		P4 S11: Um, again, I think it depends on how severe they are. I think if they're, if they're more severe, um I try to be encouraging with just short phrases like 'you've got this,' you know 'this will get better,' 'keep going.' Um, and then would elaborate a little bit more, um, depending on where they are, like um you know just, just say 'I, I understand this must be frustrating' um, you know 'keep working hard. You will get better.'
		Evoking Change	P1 S21: The flipside of that is there's patients that constantly that they harp on that, that this sucks, why, why did this happen, why did this happen to me, what happened, those patients I kind of go, ya know what? I couldn't tell ya, but ya know what I do know, we can't turn it around now, so now what matters is what will you do about it? What are you going to do today, that is different from yesterday?
	Affirming Patient Experiences		P1 S 19: You know sometimes they just want somebody to look at them and go this sucks, this is not what you're supposed to be doing today.
		Relating to Patient Experiences	P3 S14-15: Um I, I share my difficulties. I always tell them that I'm actually on a medication that gives me word-finding difficulties. So, so I will tell them, 'you might notice that I get stuck on words,' And I use my strategies, so when I do get stuck on a word, I am like 'I'm getting stuck on a word. This is what, I'm going to use a strategy now.' So, uh so they can actually see.
	Emotions		P1 S15-17: one of the other things that I do, is I let them get mad in my sessions, I let them get, I want them to show real emotions, I don't want them to feel like they have to mask with me. And so if they're frustrated, I let them be frustrated. And I say you know what, it sucks, but it's okay, you're getting there.
Therapy Techniques			P1 S24-25: Um, and then, unlocking, once we find a, oh that's the other thing is we celebrate any victory. Not just the little ones but we celebrate all of them, and for instance if a patient finally says their name for the first time, I call the nurse in there and go, Hey! Ask her her name, And the patient will say it and then I'm giving like death glares to the nurse like you better get excited.
			P5 S21: So, um often we'll do a little bit of um- kind of like- we'll try a little bit of community reintegration if they're ready for that. Um, and they can't leave the

	Community Re-Integration		hospital, but usually I'll try to have them do something like um, if appropriate, make a telephone call. So, I might start by having them call down to the kitchen to order their own meal.
		Self-Advocacy	P3 S14: Letting their communication partner know that 'I have difficulty communicating and this is what I need from you. Um so there's, so there's less stress.'
	Motivational Interviewing		P2 S21: I use motivational interviewing especially when patients are having difficulty with using their strategies more consistently or maybe they aren't really doing their home exercises as consistent as we'd like. And I also spend a good amount of time just working with the patient to figure out in their daily schedule where can we fit in time to work on their exercises. Because lot of people don't...you know, this is, they have a ton of other things they are addressing as well. A lot of people have physical impairments, and they've got exercises from their PT, and they've got exercises from their OT, and they are doing all of these things. So, to give them exercises to work on or challenges to work on, it's really overwhelming. And they're also dealing with a huge life change, and so, you have to be really...I have to... I really try to be sensitive to that, and work with the patient so that we can together find time in the day when they can spend a little bit of time working on an Aphasia exercise.
	Listening		P6 S22: So specific strategies um – I, you know, we do a lot of listening.
Not Prepared for Counseling			P5 S17: Yeah. So, I will be totally upfront and say that I felt that I did not have adequate training in actual counseling strategies. And I have been looking, um, for CEU's to help bolster my skills but it's not something- I mean I am sure that why you're doing your thesis in this area. It's not something that we have a lot of support for.
	Insufficient Graduate Education		P3 S14: Um, I don't know if I have any specifics. I was thinking about my counseling. Um I am 15 years out, so my counseling class was about 17 years ago. And I don't remember having any specific counseling um techniques.
System Barriers			P6 S18-19: Yeah. Well usually, so okay- again they're really sick when they're with me. So yeah. Um a lot of times they- to be one hundred percent honest, by the time they are well enough to really understand what I am saying, they're going out to rehab.

Figure 6. Qualitative Coding for Question 2.

Question 2a: We want to get at some things that you might not think of as counseling.

Question 2ai: Tell us about how you provide information/education regarding aphasia.

Educating Staff				P6 S29: And we also do, we do neuro rounds with them every day. We meet with the staff to get like little feedback about how each patient is doing which is so nice at the hospital.
Educating Patients				P6 S30: So being a stroke center, we have to provide education. I mean we have to. So that's the thing about the hospital.
	Written Resources	Standard Resources		P3 S17-18: I, um, will give them print outs. At our hospital, they prefer that we only use their approved education so we use Krame's online. Krame's online has an aphasia worksheet and has like what aphasia is, it has how to treat aphasia, and what aphasia is caused by. So, I will give them those handouts. Um, but I will also print out things from aphasia -uh, the- the national aphasia association.
			Rehab Binder	P4 S15-17: Um, specifically to the clients, um –okay I am in a rehab setting, so everybody in our rehab hospital gets a binder, a completely overwhelming binder full of information. Um, we've tried to ask them to pair it down, but because of CARF accreditation, they can't. It's really, um- okay, so they have a stroke binder um that is- it's actually really well done. I mean, I have a friend who was a patient and was like 'I still haven't read that thing,' and I'm like 'I don't blame you.' You know? Um, so we, we- everybody has a binder. I don't even know where they got this material from, but everybody gets a binder. Beyond that, in terms of patients, um I don't necessarily know that I give them anything.
		Self-Created Resources		P5 S31: So, um I have um I have a couple of written word documents on my computer that I keep just to hand out to families. Cause over the years I've kind of determined what works, what doesn't work, and I've found that what families and what patients need is like a really short simply blurb about 'this is what aphasia looks like and here are a couple of resources.'
	Talking about Aphasia			P6 S26: And then um to the patients themselves that have aphasia, I usually write the word 'aphasia' down, and I talk about it, I draw pictures,
		Methods of Education		P2 S27: Everyone has a different way, has a different preference, has a certain preference on how they want to receive information. That's probably my motivational interviewing training.

Educating Family		Encouragement	P4 S17: Um, I think, sometimes I will write down like 'you have aphasia. It will get better' you know, 'keep going.' Some sort of like word of encouragement.
		Support Group	P3 S18-21: And, and- I do- I do, we'll talk about - if I have younger patients, about different support groups um even Facebook support groups. You know we are always about online things but um I have a previous patient who was um, he was 20 and he started a Facebook group of younger aphasia patients so for younger aphasia patients, I will kind of push them that way.
	Educating Patient and Family		P2 S28: I also have a patient and caregiver website so if they're kind of a text-savvy person, I can tell them about that and they can have a lot of that information whenever they feel like going on the website.
	Educating about Aphasia		P5 S34-35: Um I think um- because I also find too that a lot of education is not just for the patient and their primary caregiver but also their like extended family members and friends. Um, so I try to make a couple of extra copies of the aphasia- the written aphasia stuff and just leave it in their room. Like hang it on their whiteboard or something so that friends and family can grab a copy if they're interested.
	Taking the Patient's Perspective		P4 S17-18: Um, I think the education mainly we do with families. Um, we try to get them in there right away to um- we give them strategies to help them not frustrate the patient as much. Um, I don't know if you've noticed, um but the tendency is to yell at them, like to just speak like they're deaf. That is not helpful.

Figure 7. Qualitative Coding for Question 2ai.

Question 2aii: Tell us about how you approach moments when your client brings forward a challenge (e.g. emotional upset, problem).

Addressing Counseling Moment	Listening		P2 S35: Obviously listening is a part of that as well.
		Evoking	P1 S41: and then help them identify the problem.
	Referring and Parallel Practice		P2 S34: and then if I can, you know, giving them a resource that I may have whether it's, you know, talking to someone who is a licensed counselor or you know, talking to a vocational rehab therapist, or I've had clients who have had problems with harassment at work. And, you know, there are other resources who are much more qualified than I to help them with that. But i try to find opportunities where maybe we can use that to work on their communication as well if they're open for it.
	Empathizing		P3 S22: I'll usually just stop- I'll stop therapy and listen to them and um and just let them know that they are in their acute phase and that it's going to get easier. And um just really reassure them. Let them know that I am hearing them, that I, that maybe I don't understand them, but I hear what they are saying. And then just assure them that, you know, you are two weeks, three weeks, maybe four weeks out from your stroke and this will get better.
	Counseling as Part of Therapy		P2 S34: I had a client who was dealing with being forced to do something when he didn't want to do it for example. And he felt kind of boxed in by the situation. And I thought it was a good opportunity for us to, um, I try to find an opportunity where I could help the patient be more independent in terms of expressing how they feel about a certain situation,
		Speech Therapy as a "Safe Place"	P6 S34-35: So usually um we would start a session off with talking about what happened, how things will go during the week, and then um [inaudible] the lapse of time that we haven't seen each other. And you can always tell when something is off with your aphasiac patient. You can always tell with any of your patients, so usually you are the only one that can really understand them because most people can't understand what they are trying to say. So, they feel like their safe place is in speech therapy.
		Addressing Frustration	P2 S38: I think almost all of the situations involve people with, I kind of compare it to a child - I'm not comparing people with aphasia to children per se, but if you don't have the language to express yourself, there's a whole lot of frustration and a lot of anger sometimes that can results from that. And so, those are real life opportunities to help someone. It's a functional exercise really.
		Counseling as a Priority over Therapy	P6 S36: So, I think counseling and talking is probably just as therapeutic as taking out your little cognitive worksheets and doing some drill and practice exercises.

Not Addressing Counseling Moment	P4 S26: Um and then I will try, um, depending on if their yes / no's are accurate to say "do you want to quit now?" Like, you know, "I can come back in a half hour" you know. Obviously, it depends on my rehab schedule that day. It's not always possible, but it's possible. Sometimes I will literally just leave the room for three minutes because obviously we're timed in rehab with our, our care, so um I will leave and then just come back in three minutes. Um, sometimes we will do two thirty-minute sessions instead of one-hour session.

Figure 8. Qualitative Coding for Question 2aii.

Question 2b: Describe how prepared you feel to provide counseling services to your clients with aphasia.

Prepared for Counseling	Education / Training		P2 S39: Hmm, well, I feel much more prepared because...I'm kind of a fortunate person because my brother is a national consultant for motivational interviewing so he's really helped me a lot.
	Referring		P5 S47: And then now that I've been in the inpatient rehab setting, I have a couple of really great social workers. Who I have been able to partner with. And um, at least let them know when you know "hey this person is really struggling with coping, is there anything that you can do?" Um and they have better counseling skills than I do.
	General / Nonspecific Counseling		P3 S23: I feel pretty comfortable counseling them. I don't know if I am doing any, uh… structured counseling, and I don't know if I'm doing any evidence based counseling.
	Specific Techniques	Empathy	P5 S47: I feel like at least for me um recognizing it in that way makes it so that um I have a least some, some bit of empathy. And then um, so I don't get so frustrated and misunderstand when they don't want to work with me or they just, you know, they just can't deal with it on a certain day.
		Motivational Interviewing	P2 S40: you know we're in the job, one of our job requirements is to prescribe and recommend exercises and offer education. And the way that we do that, I think sometimes we put a lot of responsibility on the patient. And we don't take maybe as much responsibility as we should. And, you know, just because the client doesn't do their exercises, does not mean the client is not compliant. Maybe we are approaching it wrong, maybe we are not listing to the patient's needs or concerns or interests. Why is it always the patient? So, I try to really think about, is the patient not doing the exercises - what are the barriers? And if I can see the barriers, have a discussion about the barriers, and I can really tease out the problems maybe by, okay let's go through your daily routine and let's find opportunities where we can do this. Or maybe this isn't important to you, and that's okay, you know. What is important to you? And let's focus on that because that is going to motivate you to do this. Um, it's, I mean that's how humans work. I mean, I'm not going to the gym to do exercises if this is not important to me. I want to make sure that what I am giving them is important to them. And usually when that happens, there is a good outcome. So, I trust the process in that respect.
Not Prepared for Counseling	Ineffective Training / Education		P1 S54: Um we talk a lot in school about how to counsel the patients, well I say a lot, we talked about half of a three-hour class period about it,
	Dealing with Grief / Death		P5 S47: And again, I still do not feel um at all, that I'm uh- that I have adequate skills to help people deal with grief and loss.

Understanding the Patient's Motivation	P5 S45-46: Like they already tried a lot of therapy and it hadn't really worked, so they weren't able to go home. Um, or they were just that impaired that they really couldn't- it wasn't reasonable to expect that they could get back to where to- um a functional level. So, I had a couple of patients with really severe aphasia there. Um there was one in particular that really stuck out in my mind who had a really, really kind daughter. Um, he was initially very resistant to therapy. But um and I was- I think at that point in my career I still didn't understand when people didn't want to do therapy. Um, like (sigh) I couldn't- I wasn't to the point yet where I could comprehend that somebody would be so frustrated that they just wouldn't want to try. And that's the kinda person he was. He was just so frustrated that it was like "what's the point? It's not going to get any better". Um and with him I did a lot of education, and he didn't understand a whole lot of it.
SLP Self-Care	P1 S55: But, they didn't really talk to us about the idea that we need to be able to take care of ourselves after we provide these services.

Figure 9. Qualitative Coding for Question 2b.

One of the participants made a comment after the interview questions were asked that related to preparedness for counseling moments. It is included here because it applied to the coding of question 2b but was brought up at the end of the interview. This participant stated "most of the counseling strategies I have, I did not learn in school. It's been things I've learned through church."

Question 2bi: What could have been done to make you feel more prepared to provide counseling services to your clients with aphasia?

Counseling Conversations	Active Listening	P3 S29-30: So, you may need to, to be able to do this, um, this type of listening and this type of, um - I guess I do this - it's a um, I forget the word again - It's um a listening where you say 'I hear what you're saying' and it's and yeah. It's, um, a type of listening that the psychologist uses.
	SLP Self-Care	P5 S52-53: I also think it's important to because I've seen so many people like um even just SLP's in the field don't know how to process their own emotions regarding working with patients and its usually patients with aphasia that are like the most heart-wrenching. Um so I think yeah. Even just as professionals, we really don't have the coping skills um to kind of help ourselves and keep ourselves healthy. Let alone help out patients through their grief. Um so I think definitely more coursework and partnering with um with people who are counseling professionals would be really helpful.
	Proactive Counseling	P1 S69-71: or for that matter in these settings have somebody who can come in and talk to the patient. Go ahead and addressing their mental health right away. and the families' mental health right away because we know they're going to be struggling. We know they're going to be having hard times but yet we wait for them to reach out to us.
	Counseling within Service Delivery	P2 S41: People have a lot to talk about in this area, but it's not so heavily emphasized and I think that we're missing a huge component of what we do if we don't explore this more often. It's very important to know how to be a good counselor to your clients because it can make a huge difference. It can be a matter of success or failure really, in treatment.
	Having Difficult Conversations	P6 S41: for me, critical care and end of life stuff is huge. We have a palliative care team, so I got to learn a lot- I got to meet with a palliative care doctor and kind of hear those conversations. Um but really, look at a family member and say, "they can't swallow anymore" or "let's talk about their quality of life" that just a really hard discussion to have, and you have to know your ethical boundaries, and there are major ethical boundaries. And I think that's probably the biggest thing that I think that I probably wasn't prepared for, and I needed education on and an online CEU is not going to do it.
	Engaging in Counseling Moments	P1 S73: But what that means for us again is that when we have 17 other things to do and were the only one they'll confide in. so what happens when they discharge, what happens when I'm not available, they need to be able to have that person on call that they can talk to about this as well.

		Despite Productivity	P1 S63-69: something else that I think needs to be done, and this is more at the company level, it's hard, whenever productivity is at risk, to sometimes spend the time that needs to be spent. Um, because I feel fine about, like I, I'm great with my director, like I will I'll do whatever I need to do for my patients and quite frankly everything else can just go by the wayside it's not as Important as the people. In my life but if you think about the Smith setting where they have, they're told, you will get 37 minutes with this patient and only 37 minutes. Well what do you do if a patient starts having their meltdown at hour, or at minute 24? Do you look at your clock and go alright honey you got 14 more minutes what's aphasia? Get it out. Like it just doesn't work well in those situations so I think sometimes, in a whatever setting we need to be able to offer more time and just accept the fact that yep it's going to be a waste somedays.
Methods to Instruction	Panel Discussions		P2 S41: looking back, I wish that I had a little bit more opportunity to talk to maybe like, other SLPS about… I mean there's no prescription in how to counsel. You know, like so many things in our field, there's no prescription to do, to treat something. There's no, there's no instructions you know? So the tricky part...If there's no instructions you have to really have a deeper understanding of what you're doing and have a lot of opportunities to reflect on why things go wrong or why things go well. Um, I really loved like panelist discussions when I was at the university in school. I think maybe like talking about the barriers and the problems that everyday clinicians see in terms of counseling would be helpful.
	Role Playing		P4 S31: Um, in grad school we did a lot of roleplaying um where our professors or like – my one class, um we had a counseling class. My one class, they brought in like other speech paths from the department and would just role play, and we would, we would practice. Honestly that was probably one of the best things ever.
	Collaborating with other Departments		P5 S51: But I think that there's probably some partnering that um, that the SLP program needs to do with um like psychology and or counseling programs to better skills. Like I feel it would at least be helpful to teach- um to either have recommended and introductory um counseling skills class or you know um some sort of a mini- even a mini class or a mini um seminar, something like that.
Scope of Practice			P3 S29: Um, I think that, think that being told a good line of saying, you know, 'this is the psychologist's job, but you're going to be in their shoes sometimes.'

Figure 10. Qualitative Coding for Question 2bi.

Question 3: Describe specific counseling strategies/techniques you use when working with partners of clients with aphasia.

Conversations with Family	Open-Ended Questions	P1 S82: Um, or try and work with them out loud about how do you really think this is going? What's your thoughts on this, um, have you seen any new things?
	Taking their Perspective	P5 S54: but then also recognizing that a big part of this for them is um- they're switching roles now, right? And they're usually going through a um a change in roles even if they you know weren't the- even if they were you know kind of a caretaker before, the severity is um, is increased.
	"Meeting them where they are"	P4 S35: and um kind of letting them take the lead. I think the best thing that I've learned in all of my years of just experience, and I teach by the bible so just in walking through things with people, I just learned that if you kind of let them take the lead and ask a lot of questions, um, they buy into it more.
Same as Counseling the Patient		P2 S44: It's really not that much different than what I do with the patient.
Involving Family in Therapy		P5 S54: I don't know about counseling specific techniques that I do. Well, so I guess, things that I am doing- and I don't know that'd I'd say these are counseling specific- but so encouraging them to come to sessions when they are available and when they want to,
Motivational Interviewing		P2 S43: I also want to get a feel about what are the barriers for them when they are conversing, when they see their loved one conversing. You know, how much involvement do they want? Are they going to be with that patient doing the exercises? Do they want to do the exercises with them? I need to know what are their expectations as well. So, they are just as important as the person with aphasia really because they work with this person much more than I do. So, they are great resource. And there's a lot of potential and reinforcement in what we're doing in the therapy room. So, I sometimes use motivational interviewing with them as well. It's really all about identifying the barriers and making sure their concerns are being met or at least addressed. I don't really have any specific techniques with names attached to them other than motivational interviewing.
Education		P3 S34: Um, and definitely I educate them on how they can, uh, make it easier for communication-um, how communication and comprehension-both-you know, so they don't get frustrated. I always, I always tell them, especially spouses, I'm like it's hard enough to communicate with your spouse in general,
Referring		P1 S80-81: When they say something like I just don't know how were ever going to go home. you know what let me send a case manager in here to talk to you. That's their job, their um job is to help you let me send them in.

Figure 11. Qualitative Coding for Question 3.

Question 4: At the (acute, subacute, chronic) stage in the recovery process, what do you think is top priority for your clients?

Acute	Complex Medical Needs		P6 S57: At that point um swallowing typically is.
	Telling Loved Ones they Love them		P6 S59: And then telling their loved ones they love them like that's their life priority like knowing that their family member is there and that they love them.
	Knowing Someone Cares about them		P6 S61-62: Yeah top priority- top priority is living. And then they really want to know that there is someone there that cares about them and that they have dignity and that they have respect and yeah. Um and that someone that really, that really cares about them. Because they're scared.
	Education and Counseling		P1 S93: Counseling, education, because you know aphasia, well not in the fact that home program style education,
		Communication Partner Training	P1 S95: And so what I do is I try to bring the families and alright here's some strategies. Here's what you should do, when you ask them a yes or no question ask the litigation of that yes no question, do you want this band aid on? Blink if you don't. Or blink if you do, okay they blink. Do you want the band aid off? Hmm they also blink. I think that's not a, I think that, that strategy will work quite as good as we want it to be, let's try something else.
Subacute	Medical Needs / History		P4 S37: Um, I mean by definition, most of them would be sub-acute cause it's been longer than three days, but um what I have noticed in the past 11 years is that-I've done acute care as well as rehab. I started in rehab, did acute care, then went back to rehab. Um, I've noticed the acuity of the patients-and we just had a staff meeting last week that demonstrates that the acuity of our patients has increased um a great deal. So, um, I mean we're getting people, I mean – the lady who came to us two days after having her stroke, she was medically stable, but a lot of these folks end up having a lot of medical issues, and we have a really high um rate of what we call acute-outs. They go back to the hospital and then come back.
	Getting back to Prior Level of Functioning		P4 S41: um… driving.
	Communicating Wants and Needs		P3 S39: at that point, what do, what do I think? I think communicating their basic needs is where, where I see them. Um, communicating and communicating their frustrations. Communicating their, their- for my low level patients,
		Collaborative Goal Setting	P5 S60: So usually with people with aphasia, even you know something like 'okay let's figure out if you- key phrases that you know you can say reliably so that you know when you're in that situation, you don't feel helpless.' You know, that kind of thing.

Subacute / Chronic	Increasing Confidence	P2 S49: Hmm, nailing down a top priority would be very difficult, but I'd say that um confidence in their communication is probably a big one. That's kind of an overarching theme of what we do with aphasia therapy.

Figure 12. Qualitative Coding for Question 4.

Question 4a: Are there any specific issues or priorities related to counseling in your work setting (e.g. acute care, inpatient rehabilitation, outpatient, long-term care). Address all settings or scenarios that apply to your work.

Acute	Reinterpreting other Disciplines' Education		P1 S108: Um, I would say that one of the main priorities because I think that's where were best utilized at the acute setting. um but I think so much is just active listening, um trying to um how to explain this one, I feel like sometimes we cause an interference for the two minutes the doctors allot for that patient.
	Time		P6 S63: I never have enough time um to do all of the things I would like to. I mean um in acute care, you are kind of like running around like a crazy person from like one thing to the next. So, you know you're doing instrumentals, and you're um running around, and you get called to the ER and- you know, you run around all day pretty much.
Subacute	Caregiver / Family Burden		P4 S47: Um…I would say that the time they get to rehab, they've gotten little to no education, everybody's extremely overwhelmed. Um, you know families may have taken some FMLA to be with them in the hospital, but a lot of these folks need to go home with 24-hour supervision. Um, and, and so you see the data- um, oh gosh, at our meeting last week. 76% of our patients go home, and I'm like 'yeah but one of our patients had to go home with her daughter who has 7 young kids!'
		Stigma	P4 S49: And culturally I feel that we, as a whole, accept people with a physical disability like 'no problem you're in a wheelchair,' but when you can't communicate well, um it's a real stigma, and I have found that that tends to be kind of a tipping point for families where they're extremely uncomfortable, um feel helpless, overwhelmed. 'How long is this going to be?'
		Cultural Expectations for Care	P4 S54-55: Well I will tell you, to be honest, when you say urban area, I mean you're totally right. We are in a more- where I work is an urban area. I will say in general and um I don't know if there is a research article on this, black families tend to take WAY better care of their families than white people do. Black families and Latina, the Latino community, we have a decent size Laotian, people from Laos, they always take their family home. White people suck. They never want to take their families home. I'm serious. My mom was a nurse um 45 years, she's like – my mom told me when I was going to grad school, she's like 'just pay attention. Your minorities always take their family home. White people are like go to a facility.'
		Discharge Plan	P3 S46: Um, I mean, I think acute rehab is, there is a lot of counseling that goes in because our patients are expected to go home from our, from the unit. So, they were in the hospital, and they um, and they are medically stabilized and now it's time for rehab. So, they are in intensive rehab five days a week.

	Interprofessional Collaboration	P5 S71: I feel like it's one of the things that I really um enjoy about where I work. It's that the, the other professionals in my field- um so the PT's and the OT's and the social worker and the nurses, everybody is really collaborative. That actually ends up coming into to play a lot with people with aphasia. Usually the um the physical therapist and the occupational therapist will ask me for like 'hey what are some communication strategies we can use?' or 'how can I help?' so that, you know, we can focus on working on balance and not being so frustrated by communication.
	Groups	P4 S50: So, I would say um yes and we have counseling services at our facility, um, and we have a great stroke support recovery group.
Subacute / Chronic	Life Participation Approach to Aphasia	P2 S55: Or maybe they don't want to do that. I really try to do a life participation approach to aphasia and that builds in with our functional goals. I'm always trying to find specific goals. One person had to do a speech so we did script training and using specific techniques to do that. One person is working on advocating for their communication needs after they introduced themselves. So those are very specific functional goals, so I think the more specific, the better for these chronic patients.
	Slow Progress	P2 S53: I think probably one barrier that I see often in this setting is that people, because we make some gains, maybe a little progress but it might be slow and steady, they, I can see clients sometimes for 6 months to 6 to 8 months and people sometimes become complacent with you know, just what we're doing in therapy and the exercises. It's a real challenge to keep progressing and keeping the patient interested in what we're doing and you know relevant to their needs. We are known for being a functional clinic so we like to have functional goals, you know, any specific goals on what you want to achieve, and um sometimes people just lose momentum when you can just keep going in therapy like that I don't know how to describe it but.

Figure 13. Qualitative Coding for Question 4a.

Question 5: We know that the scope of practice is a difficult thing to determine when encountering challenges that arise in a communication context. Tell us about your approach to determining if a scenario fits within your scope of practice or to refer.

Using other Resources	Online Forums	P6 S70: And I'm also very careful to utilize the online forums because um they are- they get a little bit shady sometimes. Like you know they'll offer- they'll tell you to do things that you know really aren't evidence based like these crazy oral mech programs, and you're like 'what in the world are you guys talking about. This isn't even a thing.' Um so they do have to research it on your own, so I'm very careful to avoid- I mean I, I- I have one on my Facebook profile, and I peruse it every once in a while, and I answer some questions. But I don't rely on those for information. I usually just look it up myself or I call ASHA.
	ASHA	P6 S67: That- those kind of things. That's tough. But with scope of practice, if I have any questions I just call ASHA.
Not Feeling Fully Prepared and/or Avoiding Counseling Moments		P4 S60: In terms of like, scope of practice um I feel like our, our ASHA stance is pretty darn broad. Um, and so I don't find that um I mean I think that if it's into like, like counseling techniques, I would stop there. Um, but just your general like deep breathing and you know trying to think before you say something. Those are all within our scope.
Within Scope of Practice		P6 S65: Yeah so generally, I'll answer questions that are within my, my general scope of knowledge and my scope of practice.
	Counseling as "Non-Billable" Time	P3 S50-54: Um. My approach. I've been really fortunate. I've been in acute rehab for most of my career, and because I am in an acute rehab that's in a hospital setting, it's kind of an all-in-one. I don't have to worry about billing as much. I can't just see a patient because I want to, if they're not appropriate. But if I have a patient on the case load who, who is appropriate for speech therapy, and I find myself doing counseling, it's okay. I can just, um, I can document that I was doing education, I was doing counseling, and I can just mark it up to um, to uh -word-finding- to um, non-billable time.
	Mandated Reporting	P6 S66: Sometimes we have to report, and we are mandated reporters. So sometimes you have to report like abuse at home.

Interprofessional Collaboration	Referring / Outside of Scope	Creating a Network of Professionals with Skills in Aphasia		P2 S63: I've learned to create a multi-disciplinary team of referrals that I have at my disposal just based on my experience. I have a referral for a licensed counselor who has been trained In communicating with people with aphasia. I have a vocational rehab therapist who is very educated in aphasia. I have, um, let's see what else, I have...like when patients have a stroke, and they are not able to drive but they are wanting later to get back into driving, I have a driving coach who is educated in aphasia. I'm trying to think of all of the other people. You know we've got the aphasia therapy group for support down the street. I have referrals that I know I can use with these clients for certain situations. And if I don't have a referral, if I don't know who to refer to, that's when I talk to my supervisor.
		Post-Stroke Depression		P5 S74: The physician also um- our physician, our pediatrist is really good about um talking to people about post-stroke depression.
		Pre-Existing Mental Health Factors		P5 S74: Um but then also recognizing too that people with aphasia, you know, they're still people and they bring their own kind of baggage too. You know, everyone has their own background stuff. So, I've had patients with aphasia before who like clearly have PTSD from domestic violence or you know other things. So then in that case, I'll definitely refer to the social worker as well to the physician.
		Medical		P3 S58: Yeah. Lots of patients ask about medications and things, so I will say, you know, 'I'll ask the nurse for you.' You know, I will just kind of interrupt and say 'I'll ask the nurse for you.'
			Evoking Self-Referral	P1 S127-129: I will hit that fine line for a long time until I finally go okay this is definitely outside of it, so I'll never say I think you should go hospice, that's the physicians job. That's their job completely but will I say are they comfortable are they do you feel like this is appropriate? What are your goals for them? and I, I ask them guarded questions in such a way to make them start thinking about the answers.

Family	P5 S74: Um so my, my thoughts are that I you know I provide support and um education within the realm of communication disorders but then once it starts to- and actually I have- this happened recently where I've had a person who was presenting with kind of aphasia. She was kind of um- she was an interesting presentation, an atypical presentation. Um so we were working through the communication stuff but as we started working through communication stuff, um she would all of a sudden like blurt out these really fluent, lengthy descriptions of how she was concerned about her home life. She was concerned about going home with her husband and she was concerned about fighting with the kids. Um so what's it started getting to that point, um then you know I listened, and I you know provided feedback in the moment. But then I immediately called the social worker like "hey I think there's some other stuff that we need to work on here um that I'm not comfortable providing support in." And I can't do anything about it. Um, so I think that's kind of where I draw the line when I recognize that it's a um social issue. Like maybe it's either like a family stressor or a um stressor about having um about you know financial status at discharge. You know, that kind of stuff.
Working with other Professionals	P5 S78: So, we often have kind of a, have kind of a paired um, you know a paired thing going on. Where we're providing um therapy where the social worker is involved, but then also the physician is talking with them about it and providing um pharmaceutical intervention if appropriate.

Figure 14. Qualitative Coding for Question 5.

A comment related to this question was brought up by a participant regarding scope of practice and the prevalence of depression after stroke. It is included here because it applied to the coding of question 5 but was brought up at the end of the interview. This participant stated "We need to normalize even some of those negative aspects and learn to straight up ask some of those difficult questions, are you depressed because of this? Are you considering ending your life, have you ever considered ending your life?"

CHAPTER 4
DISCUSSION

General

Counseling Requirements and Training in Speech Language Pathology.

Counseling is an integral aspect of SLP service delivery, and training in counseling is required for accredited graduate programs (ASHA, 2016, 2017). However, there is some preliminary research to suggest that the counseling training received in graduate programs is not effective in preparing SLPs for moments that arise in practice (Phillips & Mendel, 2008). Further, the theme of inadequate training has arisen in several other investigations, not seeking directly to address preparedness to deliver counseling (Duff, Proctor, & Haley, 2002, Kelly, et al., 1997, Rose, et al., 2014). The survey in this study allowed for comparison between what graduate programs state they are offering in terms of counseling training (Doud et al., under revision) and what SLPs' perspectives are on the counseling training they received.

The participants in the counseling practices survey were distributed across the United States, and across the variety of medical work settings available to SLPs, working with patients in the acute, subacute, and chronic stages of recovery. Slightly over half of participants stated they did not take a counseling course as a graduate student, which is comparable to the findings of counseling courses offered across programs in the United States (Doud, Hoepner, & Holland, under revision). The textbooks provided were also included in the top four listed in Doud, Hoepner, and Holland's survey, reiterating the limited textbooks available on this topic. There was a slight trend (44%) in counseling

courses being taken later in graduate careers, but there were also seven participants (17%) that took a counseling course in their undergraduate career.

Of the participants that did not have a course in counseling in their graduate career, only 42.11% reported that counseling was embedded in other ways in the curriculum, while it was found that 98% of programs that do not have a course in counseling state they are embedding counseling in other ways in the curriculum (Doud, et al., under revision). The reason behind this discrepancy could be the ineffectiveness or uncertainness of counseling training without a direct course in the subject. If accredited programs state they are training counseling techniques through clinical moments or through discussions in other courses, but SLPs don't report receiving this training, it makes the argument for a more consistent, direct training in counseling. Students' perceptions of the counseling training they received suggest that programs may not completely know best practices in terms of training future SLPs to be competent in counseling.

The majority of participants (66%) reported they have not taken any continuing education or other training in counseling outside of graduate education. Additionally, almost 75% of the participants stated that in any counseling training they received they did not engage in hands-on training. The training SLPs are receiving in counseling is few and far between, and if they are not engaging in hands-on practice, it may not be very effective as well. Randolph and Bradshaw (2018) found that counseling training is more effective when hands-on practice is utilized, specifically with multicultural counseling. Counseling is a skill that requires direct practice in order to master, and this lack of

hands-on training could be a large part of why SLPs do not feel prepared to engage in counseling moments (Simmons-Mackie & Damico, 2011).

Counseling Methods. Participants were asked about specific counseling skills, and the top counseling skills used by participants were open-ended questions, rapport-building, small talk, affirmation, listing solutions, active listening, goal-setting, restating, engaging, and planning. Many of these principles are common to several counseling frameworks (van Leer & Connor, 2015, Hoepner & Olson, 2018, Peterson, 2006). It should be noted in this section of the survey, both specific counseling techniques and general counseling methods were listed (e.g. aspects of motivational interviewing were listed, and motivational interviewing itself was listed).

Open-ended questions and affirmations are aspects of the OARS framework in motivational interviewing, proven to increase self-identified change (Hoepner & Olson, 2018). Open-ended questions and affirmations are aspects of the framework that had some of the highest percentage of use. Reflection and summary, the other two aspects, also had relatively high percentages of use. Engaging and planning are also aspects of motivational interviewing (van Leer & Connor, 2015) that had high frequency of use among SLPs. These methods allow the client to take the lead, and therefore increase client buy-in to therapy.

Restating was a method used in high frequency that comes from positive psychology. This method changes the focus of therapy to positive growth and can be beneficial in motivating patients and giving them hope. Positive psychology has been

proven to be an effective counseling method with individuals with aphasia across a few studies (Brown et al., 2012, Holland, 2007, Worrall et al., 2010).

Two of the methods used most frequently by SLPs relate to solution-focused therapy, include listing solutions and goal-setting. By listing solutions and setting goals with clients, the focus is switched to attainable benchmarks to motivate clients in therapy. There is limited research on solution-focused therapy with individuals with aphasia, but there is preliminary research to suggest success in use with a person with aphasia and their partner (Boles & Lewis, 2000).

Finally, rapport building, small talk, and active listening were listed as counseling skills frequently used in therapy. These skills apply to all counseling methods, and typically are skills that come naturally to empathetic, helping professionals. These skills especially relate to therapeutic alliance with the client, which is a necessary skill when counseling clients (Hall et al., 2010, Lawton et al., 2016, Morrison & Smith, 2013, Worrall, 2011).

The top counseling skills SLPs do not use but want to use included journaling, cognitive behavioral therapy, motivational interviewing, and solution-focused therapy. Journaling has been proven effective, especially in counseling caregivers (Isaki, 2015). Cognitive behavioral therapy has a research base for use with individuals with communication disorders (Barnes & Markham, 2018, Menzies et al., 2009, Menzies et al., 2008, Neilson, 1999, Wang et al., 2018). However, this is a specific counseling method that requires explicit training to be competent in, which is a possibility as to why SLPs are not currently using it with high frequency. Specific motivational interviewing

skills and solution-focused therapy skills were included in the skills used with high frequency, however the names of these methods were rated with low frequency of use. This suggests a lack of explicit knowledge of counseling methods and the skills contained within each method. While SLPs may be using some counseling intuitively or may have a limited basis of counseling that they are relying on, evidence is showing this lack of explicit knowledge of counseling methodologies and the research behind them. This suggests an inefficiency in training, and is also problematic, because it suggests a lack of evidence-based, counseling interventions being implemented.

The top counseling skills SLPs do not want to use were persuasion/direction, finding leverage, and journaling. Persuasion/Direction and finding leverage are aspects of solution-focused therapy. Journaling was listed with high frequency in both wanting to use and not wanting to use, which may suggest a discrepancy in the understanding of what journaling entails.

Counseling Integrated into Therapy. There were several points of emphasis that arose throughout the interview questions in regards to implementing counseling into therapy. These points were drawn from recurrent comments and emphasis from specific participants, identified within the primary investigator's field notes. Those points of emphasis, number of participants that commented on them, and frequency of comments are outlined in Table 4 below. It should be acknowledged that frequency does not necessarily directly relate to relative importance of each concept.

Table 6

Points of Emphasis Found across Interviews

Concept	Participant Comments on Concept and Frequency
Not prepared for counseling moments	6/6 participants commented 18 times
Referrals / Scope of Practice	6/6 participants commented 24 times
SLPs evoking feelings from patients	3/6 participants commented 4 times
SLP Self-Care	2/6 participants commented 3 times
Perspective Taking	4/6 participants commented 13 times

Importance of Engaging in Counseling Moments. All participants made at least one comment about not feeling prepared to engage in counseling moments when they arose in therapy, which is consistent with past reports (Duff, Proctor, & Haley, 2002, Kelly, et al., 1997, Rose, et al., 2014). This theme was commented on 18 different times throughout the six interviews, such as the quote below.

> And again, I still do not feel um at all, that I'm uh- that I have adequate skills to help people deal with grief and loss.

Considering counseling is stated as an integral aspect of SLP service delivery (ASHA, 2016), and counseling has been shown to increase effectiveness in therapy (Wolter, et al., 2006, Liberman, 2018, Attard et al., 2000), this lack of preparedness is problematic. The discrepancy between what is expected of SLPs and what they are being trained in is evident across these interviews. SLPs want to address the psychosocial needs of their clients, they just do not have the appropriate skills to do so (Northcott, et al., 2017), and are therefore either intentionally or unintentionally avoiding counseling moments in practice (Simmons-Mackie & Damico, 2011). On a related note, the scope

of practice in SLP regarding counseling is intentionally vague, which can also lead to avoidance of counseling moments.

Every participant commented on the broadness and ambiguity of SLP scope of practice when it comes to counseling. This was the most prevalent theme across all interviews, arising 24 different times. Flexibility and broadness in scope of practice (ASHA, 2016) can be beneficial to account for clinical preferences and style, but the flexibility in the SLP's role in counseling may lead to counseling needs going unaddressed. One participant specifically commented:

> In terms of like, scope of practice, um I feel like our ASHA stance is pretty darn broad. Um, and so I don't find that, um I mean, I think that if it's into counseling techniques, I would stop there.

This quote suggests that SLPs may not be familiar with ASHA's scope of practice, because stating that counseling methods are out of scope is directly in contrast with ASHA's scope of practice (2016). Avoiding counseling moments not only contrasts scope of practice, it has a direct effect on clients' rehabilitation as well.

Another theme that arose was SLPs evoking feelings from patients.

> And you can always tell when something is off with your aphasiac patient. You can always tell with any of your patients, so usually you are the only one that can really understand them because most people can't understand what they are trying to say. So, they feel like their safe place is in speech therapy.

This meaning that SLPs are the professionals most skilled in conversational supports and increasing communication. When working with an individual with a communication disorder, and specifically with aphasia, they are going to have related feelings and worries as that communication disorder is having a direct impact on their life. Therefore, when they have the needed supports to express themselves, these emotional upsets will arise in therapy. The SLP needs to be prepared to address these in

the moment (Simmons-Mackie & Damico, 2011), needs to have the relationship with the client to have difficult conversations (Hall, et al., 2010, Lawton, et al., 2016, Morrison & Smith, 2013, Pinto, et al., 2012, Worrall, 2011), and needs to understand their role in counseling and when an event requires a referral.

Many of the participants stressed the importance of collaborating with other professionals when moments extend outside of scope of practice, as well as the importance of those professionals being skilled in aphasia.

> I've learned to create a multi-disciplinary team of referrals that I have at my disposal just based on my experience. I have a referral for a licensed counselor who has been trained in communicating with people with aphasia.

Individuals with aphasia have communication challenges that make it difficult for them to express their thoughts. Typical counseling occurs through speaking, therefore if an individual is not skilled in supporting persons with aphasia, they are not likely to be successful in evoking thoughts and feelings from the person with aphasia.

Two participants stated the lack of training in self-care for SLPs as an area that should be addressed. The patients and families SLPs are working with are processing grief and death and other heavy topics. The SLP needs coping mechanisms to be able to process this information and take care of themselves as well. To date, there is a lack of research on this topic, but it could be another aspect as to why SLPs are avoiding counseling moments. Consider the following comment by a participant that had training in counseling, but that training lacked emphasis on self-care.

> But, they didn't really talk to us about the idea that we need to be able to take care of ourselves after we provide these services.

Finally, four of the six participants commented on perspective taking as a way of building rapport with their clients and keeping their therapy client-centered.

> I try to tailor my aphasia therapy to the patient's needs. And I think in order to do that I really have to understand what's important to them, and why they're here, and how their aphasia is affecting their daily life, and, um, trying to target therapy based on their interests and their main concerns.

In this way, they are using a counseling approach to their therapy (Wolter, et al., 2006, Lieberman, 2018), and maintaining their clients' adherence to the therapy process (Pinto, et al, 2012).

The SLPs interviewed in this study all mention using evidence-based practices and demonstrating competent clinical skills. This is of note, to show that even seasoned SLPs do not always feel comfortable engaging in counseling in their practice. Overall, this is an area of the field that there is just not enough emphasis and research on for clinicians to be as competent as is expected of them. Many SLPs carry natural traits of good counselors, as empathetic, caring individuals. However, they may not possess the specific counseling skills needed to be an effective counselor to their clients with aphasia.

Implications

Clinically, if SLPs are not feeling confident enough in their counseling skills (Pasupathy & Bogschutz, 2013) to engage in counseling moments when they arise, they are missing a large piece of service delivery. Therefore, the patients are not receiving this aspect of therapy that they are expected to have. This could be due to ineffective training in counseling, leading to SLPs only utilizing a small portion of counseling skills and methodologies, and not necessarily following the evidence behind them. SLPs may

not be purposefully avoiding counseling moments, but a lack of effective training in counseling may encourage an SLP to implicitly to avoid sensitive topics their patients bring up (Simmons-Mackie & Damico, 2011). Communication disorders do not happen out of context. Individuals with aphasia are typically recovering from a stroke or other brain injury, and therefore have accompanying feelings and worries resulting from that event. In order to conduct effective speech and language therapy, all aspects of communication need to be addressed, and counseling skills are crucial to this process in working with people with aphasia. SLPs are uniquely positioned to elicit and respond to counseling moments in context. SLPs may be the only professionals with counseling skills who do elicit and respond to those moments in context. This is true, not just of individuals living with aphasia, but of any individuals living with communication disorders. It is imperative for the profession of speech language pathology and the people served to develop and implement systematic training in the area of counseling techniques.

Limitations

There are a few limitations to this study worth noting. The response rate on the survey was not as high as was expected. Our participant sample was likely biased, considering individuals inclined to take the survey and participate in interviews were likely more aware of counseling practices. That being said, even those who responded shared clear deficits in their preparation and confidence to deliver counseling in the moment. As for the interest in the interviews, the low number of potential participants led to interviews of all of the potential participants, so randomization of this sample was

not achieved. The investigators had anticipated a higher response rate on the survey, which would garner more interest in the follow-up interviews, so that interview participants could be randomly selected. That being said, six in-depth interviews provided a wealth of qualitative data. Further, despite their interest to participate in the interviews, they identified challenges to implementing counseling in everyday therapy and shortcomings in their preparation. This is particularly important, as they were all seasoned clinicians with a clear foundation in use of evidence-based practices in their daily work. The fact that they identified limited explicit knowledge of counseling techniques and a sense of under preparedness is concerning. Overall, this research is meant to serve as an exploratory study in a relatively untapped area of research in the field of speech language pathology. This study can serve as a lift-off to future research on how to functionally apply counseling as an SLP.

Future directions

More research is needed on counseling within the field of speech language pathology. There is relatively limited research articles, textbooks, and other resources on counseling in the field, which parallels the inadequate counseling training many SLPs have received. The lack of preparedness and competence in counseling in SLPs is likely related to the limited evidence in counseling in the field. To improve upon this training, there is also a need for research on effective ways to teach counseling in speech language pathology. This could include aspects such as when in the program to offer a counseling course, topics to cover in the course, ways to measure whether counseling skills have been mastered, and methods of instruction and practice. Besides a counseling course,

programs are indicating that they are training counseling skills in other courses and experiences in their curricula (Doud, et al., under revision). Counseling is related to everything an SLP does, so it is important and logical to continue counseling training in other courses. However, to do this effectively, it is important for the professors of these courses to have training in counseling as well.

Besides education within graduate programs, more could be done to educate SLPs in counseling. This could be made possible through continuing education courses, seminars, and other professional development related to counseling in speech language pathology. These researchers believe that an organizational policy (e.g. position statement by ASHA or CAA) advocating for counseling in the field is warranted at this time. If this is a skill that SLPs are expected to clinically utilize, then they should be trained appropriately.

Future directions for this research could include evidence into how to improve counseling training for future and current clinicians, including but not limited to some of the aspects listed in the implications section. An initial improvement that could be made is increasing the amount of hands-on practice to occur in counseling training (Randolph & Bradshaw, 2018). Another possible direction for this research could be to interview patients and family members living with aphasia to see their perspectives on counseling within their therapy and whether they feel their psychosocial needs are being met.

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APPENDICES

Appendix A

Cover Letter for Counseling Practices Survey

University of Wisconsin
Eau Claire

Department of Communication Sciences and Disorders
Human Sciences & Services 112 | 105 Garfield | PO Box 4004
Eau Claire, WI 54702-4004
csd@uwec.edu
715-836-4186 | 715-836-4846 fax

Summer 2018
Dear Speech-Language Pathologists,

Graduate student Aspen Doud, in the Department of Communication Sciences and Disorders at the University of Wisconsin – Eau Claire, is conducting a 2018 Masters Thesis research study entitled "Counseling practices of speech-language pathologists serving persons with aphasia: Examining training and preparedness within clinical practice." This study is being conducted under the supervision of Dr. Jerry Hoepner. The primary purpose of this survey research is to gain a better understanding of speech-language pathologists' perspectives on the training in counseling they have received, and the counseling methods they use in clinical practice. This survey will be beneficial to the field of Speech Language Pathology by identifying current levels of counseling training in the field, and how it is implemented in practice. The survey asks one question about the region you are located. The survey then asks a variety of questions relating to counseling training you have received, and counseling methods you use. The last question allows you to provide your contact information if you would like to participate in an interview. The survey should take approximately 10 minutes to complete.

You are seeing this post because you are a speech-language pathologist involved in the *Adult Rehab Speech Therapy* Facebook group. Below is a link to the Qualtrics survey. By clicking on the anonymous link to the survey, you are giving your informed consent to participate. You must be at least 18 years old to participate. You must also be a Speech-Language Pathologist with your Certificate of Clinical Competence working in

the United States. No identifying information is solicited and your participation will remain anonymous, unless you are selected to participate in an interview. Benefits of participation in this survey include improving knowledge in this subject area of our field, and helping structure future research. No risks are anticipated. Participation is completely voluntary and you may withdraw from the survey at any time. The survey will close on August 1, 2018.

Participation in the Qualtrics survey will involve answering several multiple choice and short answer questions about the counseling training you have received, and the counseling methods you use.

I understand that if I have any questions concerning the purposes or procedures associated with this research project, I may call or write:
Dr. Jerry Hoepner
(715) 836-3980
hoepnejk@uwec.edu

I understand that if I have any questions or concerns about the treatment of human subjects in this study, I may call or write:
Dr. Michael Axelrod, Chair
Institutional Review Board for Protection of Human Subjects
University of Wisconsin – Eau Claire
Eau Claire, Wisconsin 54702
Telephone: (715) 836-5020

If interested, please respond to the following questions of the Qualtrics Survey that is linked below.

https://uweauclaire.qualtrics.com/jfe/form/SV_3myQeoLnfUr2OoJ

Thank you for your time and consideration.
Aspen Doud, B.S.
doudak@uwec.edu

Dr. Jerry Hoepner, Ph.D., CCC-SLP
hoepnejk@uwec.edu

Appendix B

Counseling Practices Survey

Thank you for taking this survey of counseling practices in speech-language pathology. Along with responding to the questions here, there is an option (in the final question) to participate in an interview (via web conferencing) regarding your counseling practices. All survey responses are confidential, unless you choose to participate in an interview. There are no anticipated risks associated with participation in this research. Participation in the survey portion of the study is voluntary and subjects may withdraw at any time.

Indicate the context(s) you work in (Select all that apply)

- ☐ Hospital - Acute Care
- ☐ Hospital - Inpatient Care
- ☐ Standalone - Inpatient Care
- ☐ Hospital - Outpatient Care
- ☐ Standalone - Outpatient Care
- ☐ Long-Term Care
- ☐ Other: Explain
- ☐ If you work in multiple settings, please indicate your primary setting:

Regardless of the setting you work in, do you feel you primarily work with patients in the acute, subacute, or chronic stage of recovery?

- ○ Acute: variability in medical and behavioral stability within each day, swelling in the brain and fragility of neurons
- ○ Subacute: increased stability, but continues to vary from day to day
- ○ Chronic: some variability, but relative consistency from day to day

How many years of experience do you have working in the field?

- ○ 0-5 years
- ○ 6-10 years
- ○ 11-15 years
- ○ 16-20 years
- ○ 21+ years

Given the image above, select the region in which your graduate program was located

- ○ West
- ○ Mid-west
- ○ South
- ○ Northeast

Did you take a counseling course as a graduate student?

- ○ Yes
- ○ No
- ○ Don't know

Was the counseling course through the Communication Sciences and Disorders (CSD) Department, or in a different department?

- ○ In CSD department
- ○ Other department:
- ○ Don't know

If you remember, what textbook(s) did you use?

When in your program did you take the counseling course?

- ○ Undergraduate
- ○ Graduate Year 1, Fall
- ○ Graduate Year 1, Spring
- ○ Graduate Year 1, Summer
- ○ Graduate Year 2, Fall
- ○ Graduate Year 2, Spring
- ○ Other

If you did not take a counseling course, was counseling embedded in your other courses?

- ○ Yes
- ○ No
- ○ If so, how:

Have you done continuing education for counseling? Do you have any other training in counseling?

- ○ Yes
- ○ No

In your training for counseling, either in graduate school or through continuing education, did you engage in hands-on training?

- ○ Yes
- ○ No

The table below lists various counseling techniques. Check the boxes according to techniques you currently use in practice, techniques you want to use in practice but do not currently use, techniques you do not use in practice, and techniques that you are unfamiliar with.

	I currently use	I want to use	I don't want to use	I am unfamiliar with
Giving advice	○	○	○	○
Summarizing	○	○	○	○
Open ended questions	○	○	○	○
Rapport-building	○	○	○	○
Persuasion/direction	○	○	○	○
Reframing	○	○	○	○
Small talk	○	○	○	○
Information dissemination	○	○	○	○
Affirmation	○	○	○	○

	I currently use	I want to use	I don't want to use	I am unfamiliar with
Listing solutions	○	○	○	○
Active listening	○	○	○	○
Goal-setting	○	○	○	○
Finding leverage	○	○	○	○
Brainstorming	○	○	○	○
Journaling	○	○	○	○
Solution-focused therapy	○	○	○	○
Restating	○	○	○	○
Engaging	○	○	○	○
Repatterning behavior	○	○	○	○
Planning	○	○	○	○
Reflection	○	○	○	○
Cognitive behavioral therapy	○	○	○	○
Motivational interviewing	○	○	○	○
Positive psychology	○	○	○	○
Wellness approaches	○	○	○	○

	I currently use	I want to use	I don't want to use	I am unfamiliar with
Other:	○	○	○	○

If you work with clients with aphasia and are interested in participating in an online (web conferencing) interview, please consider include your contact information below (Name, and email or phone number). You may be contacted for an interview if you are selected randomly. By choosing to share your contact information with the researchers, your responses will be linked directly to that contact information. However, the researchers will separate your contact information from your responses prior to data analysis and dissemination. That is, your data will be de-identified before data analysis and no identifying information will be disseminated with the results.

Appendix C

Consent for Counseling Practices Interview

Graduate student Aspen Doud, in the Department of Communication Sciences and Disorders at the University of Wisconsin – Eau Claire, is conducting a 2018 Masters Thesis research study entitled "Counseling practices of speech-language pathologists serving persons with aphasia: Examining training and preparedness within clinical practice." This study is being conducted under the supervision of Dr. Jerry Hoepner. The primary purpose of this research is to gain a better understanding of speech-language pathologists' perspectives on the training in counseling they have received, and the counseling methods they use in clinical practice. This interview will be beneficial to the field of Speech Language Pathology by identifying current levels of counseling training in the field, and how it is implemented in practice. The interview consists of five main questions, with scripted follow-up questions regarding your practice with clients with aphasia. The interview should take approximately 30-40 minutes to complete. The interviews will be conducted via BlueJeans video conferencing, in which the audio and video is encrypted and will be stored on a secure server.

Below is a question for you to provide your informed consent to participating in the interview. You must be at least 18 years old to participate. You must also be a Speech-Language Pathologist with your Certificate of Clinical Competence working in the United States. No identifying information is solicited. Benefits of participation in this survey include improving knowledge in this subject area of our field, and helping structure future research. No risks are anticipated. Participation is completely voluntary and you may withdraw from the interview at any time. I understand that if I have any questions concerning the purposes or procedures associated with this research project, I may call or write:

Dr. Jerry Hoepner
(715) 836-3980
hoepnejk@uwec.edu

I understand that if I have any questions or concerns about the treatment of human subjects in this study, I may call or write:
Dr. Michael Axelrod, Chair
Institutional Review Board for Protection of Human Subjects
University of Wisconsin – Eau Claire
Eau Claire, Wisconsin 54702
Telephone: (715) 836-5020

Do you give your informed consent to participate in this interview?

- ◦ Yes
- ◦ No

Appendix D

Counseling Practices Interview Questions

1. Describe strategies/techniques you use when working with a client with aphasia
2. Describe specific counseling strategies/techniques you use when working with clients with aphasia
    a. We want to get at some things that you might not think of as counseling...
        i. Tell us about how you provide information/education regarding aphasia
        ii. Tell us about how you approach moments when your client brings forward a challenge (e.g. emotional upset, problem).
    b. Describe how prepared you feel to provide counseling services to your clients with aphasia.
        i. What could be done to make you feel more prepared to provide counseling services to your clients with aphasia?
3. Describe specific counseling strategies/techniques you use when working with partners of clients with aphasia
4. At the (acute, subacute, chronic – depending on interviewee's primary work experience) stage in the recovery process, what do you think is top priority for your clients?

a. Are there any specific issues or priorities related to counseling in your work setting (e.g. acute care, inpatient rehabilitation, outpatient, long-term care). Address all settings or scenarios that apply to your work.

5. We know that the scope of practice is a difficult thing to determine when encountering challenges that arise in a communication context. Tell us about your approach to determining if a scenario fits within your scope of practice, or whether to refer.