# Acquiring Counseling Skills in Mid-Career: Outcomes of a Distance Education Course for Practicing Audiologists

Kris English*
Tom Rojeski[†]
Kerri Branham[‡]

## Abstract

Although considered an essential component of audiology service delivery, counseling skills often are not adequately addressed in graduate training programs. One of the many goals of the audiology doctorate is to address this deficit by providing formal course work in counseling for both traditional graduate students and practitioners. This study describes the outcomes of a counseling class taught via distance education to mid-career audiologists, who initially were found to provide informational or technical responses to affective patient comments (a so-called "communication mismatch"). In spite of inherent limitations in electronic instruction, students demonstrated learning outcomes comparable to those obtained from conventional classroom instruction, including an improvement in their ability to respond to the affective nature of patient comments.

**Key Words:** Counseling, distance education

Counseling has long been considered part of the audiologist's scope of practice (ASHA, 1990). However, most training programs have had little opportunity to provide formal counseling courses (McCarthy et al, 1986; Culpepper et al, 1994; Seestedt-Stanford et al, 1996; Crandell, 1997), and, as a probable consequence, a rather limited interpretation of counseling has been generally accepted by the profession. Many audiology textbooks describe counseling as explaining, that is, conveying technical information clearly and accurately. The audiologist counsels by explaining test results, describing amplification options, and presenting communication repair strategies—for example, "The audiologist can allay fears and guilt feelings by explaining everything to the parents about the nature of the hearing loss and its cause if it is known" (Newby and Popelka, 1992, p. 447). This kind of audiologist-patient interaction is called infor-mational counseling, which is and always will be a fundamental component of audiology service delivery.

However, the counseling profession recommends that informational counseling should be used only when patients request information: "How long will these batteries last?" "What is causing all of these ear infections?" Because hearing loss can adversely affect social interactions, psychological well-being, and/or emotional state, individuals with hearing loss are likely to experience personal adjustment problems (Tanner, 1980; Luterman, 1996) and patients may attempt to express these affective concerns as well as ask for information. An affective comment may be obvious ("I'm not going to wear these hearing aids anymore; they make me look ugly and stupid") or relatively subtle ("I can't show up at work with hearing aids; my boss will think I'm not a good worker"), but if an audiologist does not hear the affective message and therefore responds with technical information, patients or parents of children with hearing loss can be left with the impression that the audiologist does not understand or care about the problems they were trying to express (Kroth, 1987; Martin et al, 1987, 1989; Glass and Elliot, 1992; Beazley and Moore, 1995).

*Department of Speech-Language Pathology, Duquesne University, Pittsburgh, Pennsylvania; †Department of Communication Disorders, Central Michigan University, Mt. Pleasant, Michigan; ‡Ear, Nose, and Throat Associates, P.C., Fort Wayne, Indiana

Reprint requests: Kris English, Duquesne University, 403 Fisher Hall, Pittsburgh, PA 15282

Recent textbooks have advocated "expanding counseling beyond the mere transfer of information" (Martin, 1994a, p. 455) to more closely resemble the model used by the counseling profession (e.g., Crowe, 1997; Hull, 1997; Tye-Murray, 1998). A more comprehensive approach to counseling involves a two-step process: (1) listening to a patient to determine if he or she is seeking information or expressing a personal adjustment concern and (2) responding in a way that matches what was heard. Cormier and Hackney (1999) describe this process as "mirroring" the patient's comment: if a request for information is made, information is provided; if an affective message is expressed, the response should indicate that the affect was heard, acknowledged, and respected. Learning how to develop and use effective listening and responding skills are primary learning objectives for most courses designed for "nonprofessional counselors" (Kennedy and Charles, 1991; Clark, 1994).

To measure the effects of such a counseling course, a study was conducted involving graduate students enrolled in an audiology doctorate program (English et al, 1999). Since a review of available counseling materials suggested a discrepancy between conventional audiologic (i.e., informational) and other counseling approaches, it was hypothesized that graduate students would provide technical responses to hypothetical affective patient or parent statements. On the first day of class, 14 students (seven students in two classes) provided written responses to eight items designed to reflect a personal adjustment concern (e.g., "My family says our daughter was born deaf because I worked until the last week of pregnancy"). The students completed the same task at the end of the semester, and all responses were rated along a scale from highly technical to highly affective in nature. At the beginning of the semester, both classes demonstrated a strong tendency to provide technical responses to these affective comments (e.g., "There are no studies to confirm this assertion"). At the end of the semester, students' responses were significantly more affective (e.g., "You seem very worried that this might be true"). This preliminary study tentatively concluded that graduate students did tend to "mismatch" their responses and that a course in counseling resulted in an improvement in their listening/responding skills.

This study had some inherent limitations: specifically, the small number of subjects, the absence of a control group, and the inability to control for pretest bias (Light et al, 1990). A follow-up study was therefore conducted to address these concerns, this time with mid-career audiologists enrolled in a distance education program. The present study sought to answer the following questions:

1. Do practicing audiologists provide technical information to patients' personal adjustment comments?
2. Does an Internet course in counseling result in a decrease in technical responses and a corresponding increase in affective responses to personal adjustment comments?

## METHODS

### Subjects

Subjects included 23 master's level audiologists enrolled in a counseling course offered via distance education to fulfill requirements for the audiology doctorate jointly offered by Central Michigan University and Vanderbilt Bill Wilkerson Center. These students (7 males, 16 females) averaged 15.9 years in the field of audiology and resided in 17 different states and Great Britain. They worked in a wide range of audiology settings: private practice (n = 6), Veteran's Administration (n = 5), hospitals (n = 4), physicians' offices (n = 4), schools (n = 3), and the U.S. military (n = 1). The majority of the students (n = 18; 78%) indicated that they had had no previous course work in counseling.

In addition to this group, another 10 audiology doctorate, distance education students, enrolled in another class, served as a control group. These audiologists (1 male, 9 female) averaged 14.2 years in the field, resided in eight different states, and also worked in a variety of settings (physicians' office, n = 4; Veteran's Administration, n = 3; hospitals, n = 2; private practice, n = 1). Eight of the 10 members (80%) of the control group indicated having had no course work in counseling.

### Instrument

Five items from an instrument developed in an earlier study (English et al, 1999) were used for a pre-/postcourse measure to determine students' abilities to recognize and respond appropriately to expressions of personal adjustment concerns (Appendix A). Content validity for this measure was provided by two audiologists and one counselor specializing in the needs of persons

with hearing loss, who rated all items as expressing personal adjustment concerns. The same instrument was used for pre- and postcourse measures; however, the specific test items were not discussed during the course.

**Treatment**

In March 1999, students in both the experimental and control groups began their courses. A description of the course can be found in Appendix B; briefly, the theme of the counseling class was taken from Luterman (1996): "Listening is the most powerful skill for a professional to have" (p. 357). To that end, the purpose of the class was to develop facilitative listening skills, that is, to learn to recognize the intent of a patient's communications (differentiate) and to match one's response accordingly.

The course began with a clear distinction between professional and nonprofessional counseling roles (psychotherapy versus counseling), to recognize professional boundaries, and to know when to make referrals (Stone and Olswang, 1989).

The course then reviewed the body of literature describing the social, emotional, and psychological concerns of persons growing up with a hearing loss, acquiring a hearing loss, or adjusting to a hearing loss in their family; covered several counseling philosophies, with a discussion on the development of personal counseling theories; considered personal adjustment counseling skills typically used by nonprofessional counselors, usually described as active or reflective listening (Kroth, 1987; Kennedy and Charles, 1991; Martin, 1994b); and explored applications of these skills in personal audiology practices.

The online nature of the course allowed it to be somewhat self-paced, an approach preferred by most adult learners (Knowles, 1970; Cross, 1982). Instruction was designed according to a modified version of Kolb's (1985) Experiential Learning Cycle to include not only abstract conceptualization (a course's content or knowledge base) but also active experimentation and reflective observation. Students were assigned a set of readings each week and were required to write and analyze a case study, evaluate the use of a self-assessment instrument for counseling purposes, and submit biweekly journals describing their reactions to the course material and the applications they were making to their audiology practices. In the interest of creating a sense of community among these learners

(Carnegie Foundation for the Advancement of Teaching, 1990), the course also required students to attend a chat room every other week and facilitate one of the chats as a small-group assignment (Fulford and Zhang, 1993; McLellan, 1998). The course used online readings, textbooks, articles, a listserv and message forum for asynchronous discussions, and a chat room for "real-time" discussions, which included role-playing activities.

**Procedures**

To control for pretest bias, half of the students enrolled in the counseling course (n = 11) were randomly selected from the roster and contacted via e-mail 1 week before the term. They were asked to provide a brief response to each test item and return by e-mail. The control group (n = 10) was also contacted by e-mail and given the same instructions. During the last week of the term, all students in the counseling class (n = 23) completed the instrument, as did all members of the control group. All student responses were confidential.

Pre- and post-test responses from the students were randomly organized by test item by the first author, and then blindly rated by the second and third authors on a scale of 1 to 5 (1 = a purely technical response, 2 = a mostly technical response, 3 = a response considered to be both technical and affective, 4 = a mostly affective response, and 5 = a purely affective response). Inter-rater reliability was high (r = .82).

**RESULTS**

Analyses were conducted for pre- and post-test responses from the control group (n = 10), pre- and post-tests from 11 enrolled students, and post-tests only from 12 additional enrolled students. Mean ratings and standard deviations of each test item by group are reported in Table 1, which demonstrates that pretest responses from both the control group and half of the enrolled students were predominantly technical, even though the stimuli were predominantly affective.

The following example demonstrates the kinds of technical and affective responses that were obtained and rated. For test item 1 ("Other kids are making fun of my child because she wears that FM device"), this response was rated as entirely technical: "The FM system is the best solution to the limitations of her personal

**Table 1  Mean Rating (and SD) of Responses by Group and Test Item, Pre-/Post-Tests**

| | Test Items | | | | | Combined |
| | 1 | 2 | 3 | 4 | 5 | |
|---|---|---|---|---|---|---|
| Control Group | | | | | | |
| Pre | 2.05 (1.24) | 1.65 (0.79) | 1.60 (1.06) | 2.10 (1.13) | 1.25 (0.43) | 1.73(1.02) |
| Post | 2.05 (1.32) | 1.30 (0.45) | 1.85 (1.49) | 1.35 (0.65) | 1.45 (0.66) | 1.60 (1.04) |
| Enrolled Group | | | | | | |
| Pre | 2.36 (1.14) | 1.41 (0.49) | 1.68 (1.10) | 1.63 (0.98) | 1.22 (0.42) | 1.64 (0.96) |
| Pre and post | 3.81* (1.07) | 3.48* (1.15) | 3.62* (1.53) | 3.81* (1.18) | 4.10* (0.91) | 3.78*(1.22) |
| Post only | 3.66* (1.40) | 3.66* (0.89) | 4.20* (0.86) | 3.78* (0.95) | 3.79* (0.91) | 3.82* (1.05) |

1 = very technical. 5 = very affective responses.
*$p < .05$.

hearing aids: distance, direction, and the competition of background noise." In contrast, the following response was rated as entirely affective, or "in sync" with what the parent actually wants to talk about: "I think it would be difficult as a parent to hear my child is being teased. How are you and your daughter doing?"

Item analyses for pre- and post-test responses indicated that each of the five test items were statistically sensitive ($p < .05$).

The mean ratings of all responses by group were combined (see last column in Table 1) and are depicted in Figure 1. Wilcoxon matched-pairs signed-rank tests indicated no significant changes in the pre- and post-tests from the control group, indicating little or no history, maturation, or Hawthorne effects. No significant differences were found between the post-tests from the two groups of enrolled students, suggesting minimal pretest effects. However, significant differences were found between the pretest cohort of the enrolled group and the post-tests of both enrolled groups ($0.01 < p$ [T ≤



**Figure 1** Mean ratings of pre- and post-test responses by group.

0] $< 0.05$), indicating measurable treatment effects as a result of taking the course. Mann-Whitney U tests also found significant differences between the post-tests from the control group and both enrolled groups ($p < .05$), corroborating the likelihood of treatment effects.

Table 2 presents these data by percentages. Most (79%–85%) of the pretest responses to affective statements were rated as very or mostly technical, whereas 7% to 13% of the responses were deemed to be affective. From the post-test, only 12% were very/mostly technical responses among students enrolled in the course, and very/mostly affective responses increased to 64%. No changes were observed in the control group.

## DISCUSSION

The purpose of this study was twofold: (1) to determine if practicing audiologists were likely to provide informational responses to affective statements and (2) to determine if a decrease in technical responses and a corresponding increase in affective responses to personal adjustment responses could be achieved in an Internet-delivered class.

With respect to the first concern, it was found that, prior to taking the counseling course, practitioners were as likely to "mismatch" their responses to affective statements as traditional graduate students had in an earlier pilot study (English et al, 1999). Approximately midway through the term, several students in the pretest cohort commented informally that they recognized this mismatch and asked if they could repeat the exercise "knowing what I know now." They were not told until the last week of the term that, in fact, the post-test was part of a closing activity. Although significant differences were seen, the changes were not overwhelming: no one
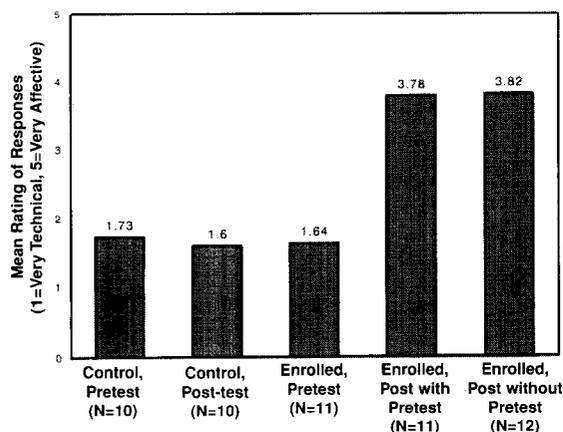
**Table 2  Ratings of Responses by Group, Pre-/Post-Test**

|  | Very/Mostly Technical | Combination | Very/Most Affective |
|---|---|---|---|
| Control Group |  |  |  |
| Pre | 79% (N = 79) | 8% (N = 8) | 13% (N = 13) |
| Post | 85% (N = 85) | 8% (N = 8) | 7% (N = 7) |
| Enrolled Group |  |  |  |
| Pre | 82% (N = 90) | 6% (N = 7) | 12% (N = 13) |
| Pre and post | 12% (N = 14) | 22% (N = 24) | 66% (N = 72) |
| Post only | 10% (N = 12) | 21% (N = 25) | 69% (N = 83) |

student rated many 5's (very affective), for instance. This result should be expected, since the art of listening and responding reflectively is not acquired quickly but takes extensive practice (Parsons, 1995; Long, 1996).

The need for practicing reflective listening skills cannot be overstated, especially for professionals who have spent years providing advice (talking). An example of this well-intentioned but counterproductive type of assistance arose during a chat room role-play situation, when the following remark was submitted to represent a hypothetical 16-year-old female patient: "I've decided I'm not going to wear my hearing aids anymore. And I've also decided to drop out of school and work at the mall. I start Monday." A student volunteered to respond to this statement and proceeded to explain that without hearing aids, the girl would not hear her customers, and then suggested a 2-week plan on returning to full-time hearing aid use. The teenager, although in simulation, had only one option: to take a defensive posture and resist help. Even though the class was in the sixth week, and even though listening skills had been reviewed, it had not occurred to the student to respond reflectively with a neutral comment such as "That's a pretty big decision." The more typical response can be considered a "knee-jerk" audiology response, which, although sincere, did not help the patient talk about what brought her to this situation. Learning how to refrain from providing unwanted advice is a real challenge—hence the need for directed and ongoing practice to listen and respond in a way that will support patients in identifying and solving their own personal adjustment difficulties.

The second goal of this study, measuring a specific learning outcome of an Internet-delivered class, was dependent on the first goal. Since it was found that practitioners were likely to provide informational responses to affective statements, a primary goal of the course was to modify this tendency and help practitioners

"hear the patient" and respond as a nonprofessional counselor. As reported above, changes were noted in the post-tests but were also charted as a growth process across the term via journal entries. A fairly consistent learning curve presented itself: most students (1) recognized that the conventional response may not be the most helpful response, (2) made attempts to modify responses (while feeling an unwelcome awkwardness, not much appreciated in mid-career!), and (3) began to "find one's stride" with a personal counseling philosophy while observing correspondingly satisfying patient interactions to validate the effort. It does appear that the main learning objective for this course was achieved: students not only acquired a new knowledge base but shaped their practices accordingly.

Notable limitations to this study are the small number of subjects and the fact that the subjects were not randomly selected from a larger population. By virtue of enrollment, all subjects shared an interest in earning a clinical doctorate in audiology—not a common denominator across the profession. However, once enrolled, they were randomly assigned to groups. Caution is needed in the interpretation of pre- and post-test scores since they were obtained by subjective ratings rather than objective measurement, even though high correlation was found between raters.

The results of this study were virtually identical to an earlier pilot study (English et al, 1999), even with the inclusion of a control group and a pretest cohort. It is encouraging to note that the post-test results indicate that counseling skills can be acquired within the confines of an Internet class format. These findings come on the heels of a study conducted by Luterman and Kurtzer-White (1999), who collected parent reports regarding the experience of learning about unexpected hearing loss in their newborn children. The authors pointed out that infant screening programs will identify hearing loss to

parents who had no reason to suspect its presence; the need for sensitivity in subsequent family interactions is only the latest reason for audiologists to develop appropriate counseling skills. Distance education appears to be a viable means for mid-career audiologists to acquire the critical skill of learning how to listen and respond to the affective aspect of hearing loss.

## REFERENCES

American Speech-Language-Hearing Association. (1990). Scope of practice, speech-language pathology and audiology. *ASHA* 32(Suppl 2):1–2.

Beazley S, Moore M. (1995). *Deaf Children, Their Families, and Professionals: Dismantling Barriers*. London: David Fulton.

Carnegie Foundation for the Advancement of Teaching. (1990). *Campus Life: In Search of Community*. Princeton, NJ: Princeton University Press.

Clark JG. (1994). Counseling purview. In: Clark JC, Martin F, eds. *Effective Counseling in Audiology: Perspectives and Practice*. Englewood Cliffs, NJ: Prentice Hall, 1–17.

Cormier S, Hackney H. (1999). *Counseling Strategies and Interventions*. 5th Ed. Boston: Allyn & Bacon.

Crandell C. (1997). An update on counseling instruction in audiology training programs. *J Acad Rehabil Audiol* 30:1–10.

Cross KP. (1982). *Adults as Learners*. San Francisco: Jossey-Bass.

Crowe TA. (1997). Approaches to counseling. In: Crowe TA, ed. *Applications of Counseling in Speech-Language Pathology and Audiology*. Baltimore: Williams & Wilkins, 80–117.

Culpepper B, Mendel LL, McCarthy PA. (1994). Counseling experience and training offered by ESB-accredited programs. *ASHA* 36(6):55–58.

English K, Mendel LL, Rojeski T, Hornak J. (1999). Counseling in audiology, or learning to listen: pre- and post-measures from an audiology counseling course. *Am J Audiol* 8:34–39.

Fulford CP, Zhang S. (1993). Perceptions of interaction: the critical predictor in distance education. *Am J Dist Educ* 7(3):8–21.

Glass L, Elliot H. (1992). The professionals told me what it was but that was not enough. *Shhh* 13(1):26–28.

Hull RH. (1997). *Aural Rehabilitation: Serving Children and Adults*. 3rd Ed. San Diego: Singular.

Kennedy E, Charles SC. (1991). *On Becoming a Counselor: A Basic Guide for Nonprofessional Counselors*. New York: Continuum.

Knowles MS. (1970). *The Modern Practice of Adult Education: Andragogy vs. Pedagogy*. New York: Association.

Kolb D. (1985). *Learning Style Inventory*. Boston: McBer and Co.

Kroth RL. (1987). Mixed or missed messages between parents and professionals. *Volta Rev* 89(5):1–10.

Light RJ, Singer JD, Willett JB. (1990). *By Design: Planning Research in Higher Education*. Cambridge, MA: Harvard University Press.

Long VO. (1996). *Communication Skills in Helping Relationships*. Pacific Grove, CA: Brooks/Cole.

Luterman DM. (1996). *Counseling Persons with Communicative Disorders and Their Families*. 3rd Ed. Austin, TX: Pro-Ed.

Luterman D, Kurtzer-White E. (1999). Identifying hearing loss: parents' needs. *Am J Audiol* 8(1):13–18.

Martin FN. (1994a). *Introduction to Audiology*. 5th Ed. Englewood Cliffs, NJ: Prentice Hall.

Martin FN. (1994b). Understanding, building, and maintaining relationships with patients. In: Clark JG, Martin F, eds. *Effective Counseling in Audiology: Perspectives and Practice*. Englewood Cliffs, NJ: Prentice Hall: 18–37.

Martin FN, George KA, O'Neal J, Daly JA. (1987). Audiologists' and parents' attitudes regarding counseling of families of hearing-impaired children. *ASHA* 29(2):27–33.

Martin FN, Krall L, O'Neal J. (1989). The diagnosis of acquired hearing loss: patient reactions. *ASHA* 31(11):47–50.

McCarthy P, Culpepper B, Lucks L. (1986). Variability in counseling experiences and training among ESB-accredited programs. *ASHA* 28(9):49–52.

McLellan H. (1998). The Internet as a virtual learning community. *J Comput Higher Educ* 9(2):92–112.

Newby H, Popelka G. (1992). *Audiology*. 6th Ed. Englewood Cliffs, NJ: Prentice Hall.

Parsons RD. (1995). *The Skills of Helping*. Needham Heights, MA: Allyn & Bacon.

Seestedt-Stanford L, Weddington G, Rojeski T. (1996). The audiologist as counselor: are we prepared? *Feedback* 7(1):15–17.

Stone JR, Olswang LB. (1989). The hidden challenge in counseling. *ASHA* 31(6):27–31.

Tanner DC. (1980). Loss and grief: implications for the speech-language pathologist and audiologist. *ASHA* 22:916–928.

Tye-Murray, N. (1998). Foundations of aural rehabilitation: children, adults, and their family members. San Diego, CA: Singular.

## APPENDIX A

**Pre-/Post-Test Items**

1. "Other kids are making fun of my child because she wears that FM device."
2. "I think I can get by without hearing aids. I'm only 52, not some old lady."
3. "My family says our daughter was born with a hearing loss because I worked until the week she was born."
4. "Your tests have got to be wrong. I'm sure my child hears much better than you say; he's just being uncooperative. I think he doesn't like you."
5. "I can't wear hearing aids; my boss will think I'm no longer a good worker."

## APPENDIX B

**Weekly Topics of Counseling Course**

1. Introduction: psychosocial implications of hearing loss
2. The "Hearing Aid Effect" and other external stressors
3. Self-concept and hearing loss
4. Counseling approaches
5. Building patient relationships
6. Conveying diagnostic information (or how to impart bad news)
7. Counseling families
8. Pediatric counseling
9. Counseling adults
10. Counseling elderly persons and their families
11. Helping people cope
12. Counseling efficacy