Beyond speech alone:

GUIDELINES for practitioners providing counselling SERVICES to CLIENTS with disabilities and complex communication NEEDS

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More information regarding The Bridging Project can be found at the Scope Web Page, http://www.scopevic.org.au/ or by contacting:

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Disclaimer: These guidelines have been developed for practitioners who are appropriately qualified in the delivery of counselling services to people with a range of mental health or life issues, and who may be interested in extending these skills for inclusion of people with complex communication needs. These guidelines are not intended as a substitute for training in counselling theory and practice. They have been developed based on the expert consensus of the authors and information from available research and clinical publications. While the material is comprehensive, it is not definitive or exhaustive. Attention has been given to ensure that the information included in these guidelines is relevant to many people with mental health and complex communication needs. However, decisions regarding specific therapeutic approaches remain the responsibility of the practitioners, in collaboration with the person being supported. The information provided through this publication is not intended to provide or substitute for professional mental health services or advice. In no event shall the authors or the various collaborators be liable for any damages or consequences resulting from direct, indirect, correct or incorrect use of these guidelines.
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For some years now, as psychologists working with Scope, we have provided psychological services to people with disabilities, many of whom experience complex communication needs. In reflecting on our practice, we have continued to be inspired, but also challenged, by our work with this client group. A question that we continue to ask ourselves is how we make counselling maximally accessible to people with complex communication needs, whilst not compromising the integrity of the counselling process.

We are able to share some general guidelines that we have based on our collective experience. These guidelines have been developed collaboratively with speech pathologists who have a valuable role to play in terms of aiding our understanding of the functional implication of communication impairment and conversational strategies that can be applied in a counselling context.

CONCEPTS

Counselling is the process by which people are supported to work towards living in a more satisfying and resourceful way (British Association for Counselling and Psychotherapy, 2000). The term counselling includes work with individuals, pairs or groups of people often, but not always, referred to as 'clients'. The objective of particular counselling relationships varies according to clients' needs. Counselling may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crises, developing personal insight and knowledge, working through feelings of inner conflict or improving relationships with others. The clinician’s role is to facilitate clients' work in ways that respect their values, personal resources and capacity for self-determination.

Counselling differs from general help-oriented discussion in that it is a formalised exchange of dialogue, which has at its foundation a therapeutic framework. A range of therapeutic frameworks exists, each of which can be described in terms of a set of structures, processes and content (Nuffield, 1986).

It is not possible to make a generally-accepted distinction between counselling and psychotherapy (British Association for Counselling and Psychotherapy, 2000). There are well-founded traditions which use the terms interchangeably and others which distinguish them. For the purposes of these guidelines, the terms counselling and psychotherapy are subsumed under the same banner, with the term counselling used throughout.
Complex communication needs are experienced by people who are unable to use speech to meet their daily communication needs. They are associated with both developmental disabilities, such as cerebral palsy, intellectual disability and autism, and with acquired disabilities, such as traumatic brain injury, stroke and Parkinson’s disease. People with complex communication needs will rely to various degrees on extant communication methods, including speech approximations or vocalisations, gestures and facial expression. They may also rely on more formal augmentative and alternative communication systems.

Augmentative and alternative communication (AAC) refers to unaided or aided communication systems. Unaided systems include formal gestures, signs, facial expressions and idiosyncratic body movements. Aided systems include communication boards, books and cards; simple technology, such as switches that produce a single spoken message when activated; and complex technology, such as speech generating electronic communication devices that allow the user to type out messages or to have them pre-programmed so they can be accessed by selecting a picture or icon, or the use of macros, that is, messages created using brief letter or icon combinations.

Access to unlimited messages occurs for people who can create any message, given sufficient time. The creation of these messages is achieved through the use of text-to-speech, whereby each message is constructed one letter at a time, and/or the use of abbreviation-expansion, whereby abbreviations letters are typed then expanded to a word or phrase, for example, “IDK” expands to “I don’t know”. Unlimited messages can also be created using pictures that represent words, phrases and grammatical structures, for example, past tense, plurals. Whole sentences can be generated by combining these pictures. People who have access to unlimited messages using any one of these strategies usually do not have significant cognitive delays or impairments. They may have a mild intellectual disability or a specific language difficulty, such as an impairment of naming.

Access to limited messages occurs for people who rely on a limited message set, such as a number of pictured items on a communication book or board. The number of messages to which they have access can vary dramatically from only a few words to quite substantial vocabularies and short messages represented on a large communication board, or in levels within a communication book or electronic communication device. The number of messages that can be accessed depends on a number of factors, including language skills, memory and physical access methods. People who can access only limited message sets usually have significant cognitive delays or impairments; hence, they may have moderate to severe intellectual disability or have particular problems with processing language. They are also likely to have limited or no literacy skills, and will therefore need to rely on picture symbols or a limited set of signs from a sign language such as Auslan. These people may have significant difficulties in comprehending language; if so, they will rely to various degrees on cues such as the context, routines, gestures, and pictures to assist in understanding what is said to them.
BACKGROUND

While a range of techniques is utilised for the provision of counselling, most leading models of counselling are based on speech and listening processes. It is speech that primarily guides therapists in gaining understanding of a clients’ thoughts, feelings and responses. This reliance on speech can result in major challenges when providing counselling to people who have complex communication needs, which can impact on their ability or efficiency in expressing needs, asking questions, conveying information, and participating in conversations.

Research regarding how the presence of complex communication needs impacts on the counselling process is decidedly lacking (Di Marco & Iacono, 2006). The only identified study to examine this area directly is that by Crawford (1987). Crawford provides a description of individual counselling for seven people with complex communication needs associated with physical and multiple disabilities. The participants had been predominantly referred for issues of depression and/or adjustment disorder. The results of the study indicate that the response of these people to therapeutic intervention utilising AAC systems generally was positive. The course of therapy was similar to that observed in other people with disabilities; that is, those with adequate expressive communication skills. The study suffers from a range of methodological shortcomings, such as the absence of robust data, and the failure to describe the psychotherapeutic model and strategies employed. However, the study serves to highlight the potential viability of psychotherapeutic intervention for clients with complex communication needs. Crawford makes the point that despite the challenges that can arise in using AAC in a therapeutic context, access to AAC by clients enables therapy to occur.

In the absence of direct research into the interplay of complex communication needs and counselling processes, there is little guidance we can take from the published evidence base. However, we can certainly draw some inferences from Muller and Soto’s (2002) description of the characteristic conversation and communication patterns of people who use AAC. They note that people who use AAC tend to take a subordinate role in conversation and are less likely than their non-AAC-using conversation partners to initiate new topics of conversation. Conversations are often characterised by question and answer sequences whereby closed questions, requiring a Yes/No response, are often employed by non-AAC-using conversation partners. A disproportionate amount of time is often spent on repairing or averting breakdowns in communication rather than developing conversation topics.

So how do these communication patterns translate to the counselling setting? If counselling is conceptualised as being client-directed and based on a fluid and interactive communication process between client and clinician, the communication patterns of people who use AAC clearly test this notion. More specifically, clinicians’ capacities to utilise advanced counselling skills, such as open questioning, eliciting, probing, challenging and clarifying, can be constrained. For example, the technique of open questioning is simply not an option when clinicians are working with some people whose main form of response is indicating
Yes or No. Similarly, the technique of probing is constrained when someone who uses AAC has access to limited messages that impede their capacity to discuss an issue thoroughly.

The degree to which these counsellor skills are constrained will vary according to a range of factors, including: (1) the ease with which clients’ speech is understood; (2) their language skills; (3) the type of AAC to which they have access, including the use of limited versus unlimited messages; and (4) their competence and speed in using an AAC system. These factors combine to influence the extent to which clients are able to express abstract underlying thoughts, feelings and themes (Di Marco & Iacono, 2006). As a result of communication that is slow and often limited in terms of the abstract level of meaning that can be conveyed, it is common for clinicians working with people with complex communication needs to be pointedly active and directive to ensure interpretations are made at quite concrete levels, and to have an enhanced reliance on external sources, particularly social systems, for information about clients’ psychosocial circumstances (Hoyt, Siegelman & Schlesinger, 1981).

Despite these inherent challenges, it is important to emphasise that the therapeutic process with people with complex communication needs is not entirely dissimilar to that observed in people without disabilities. For one thing, the overall objectives of the counselling process are the same: to facilitate client self-exploration and increase clients’ levels of self-understanding in order to achieve effective and desired changes in behaviour (George & Cristiani, 1995). The main departure from standard process is that clinicians often need to employ modified techniques to help clients reach this level of self-exploration and self-understanding.

Similarly, the capacity for clinicians to achieve counselling attitudes and behaviours, such as empathy, positive regard and genuineness, remains intact during the therapeutic process with someone with complex communication needs. Perhaps the main barrier to achieving these states will be in terms of the micro-skill or combination of micro-skills upon which states are predicated. For example, it is our experience that the block to achieving empathy is not so much the capacity to be able to tune in to clients’ feelings and to see the world from their frames of reference per se. Rather, it is in terms of being able to gather information about clients’ worlds, and to communicate that understanding to them in a manner that will be comprehended.

In light of the clinical challenges entailed in the delivery of counselling services to people with complex communication needs, it was felt important to develop guidelines to assist clinicians in this area. These guidelines are likely to become increasingly relevant to practitioners working in generalist settings, with an increasing number of clients with disabilities being serviced in their communities. It is important to note that these guidelines are not approached from the perspective of a specific theoretical orientation; rather, they reflect approaches that can be generalised to a number of current models of counselling or psychotherapy. The guidelines are arranged as follows:

1. Factors to bear in mind in the provision of individual counselling to people with complex communication needs.

While a range of techniques is utilised for the provision of counselling, most leading models of counselling are based on speech and listening processes.
2. General considerations for the provision of counselling to people with complex communication needs.

3. Specific guidelines for the provision of counselling to people with complex communication needs.

4. A summary of these and other specific strategies, in table format, for making the counselling process more accessible to clients with complex communication needs than it might otherwise be.

Factors to bear in mind in the provision of individual counselling to people with complex communication needs:

- People who use AAC have the same range of counselling needs as people who have functional speech skills and who may or may not have physical disabilities; however, they have additional challenges that require accommodation in a counselling context.

- People who use AAC because of their disability and the barriers they experience in interacting with others may face isolation, increased vulnerability, dependence on caregivers, demands to comply with authority, and may be medicated, disempowered or devalued. They may have a history of negative experiences relative to respect, relationships, choice, skill development, personal worth and potential.

- Many people who use AAC have compounding issues that impact on their ability to access counselling services; for example, language comprehension difficulties, cognitive impairment. The need for a transdisciplinary approach is often indicated with input required from speech language pathologists/AAC consultants to support clinicians and clients who uses AAC in communicating effectively with each other.

- People who use AAC may lack the knowledge, skill and means to communicate about abuse and rights. They may be unaware of the role of clinicians. Furthermore, they may not be able to locate accessible services and may fear that a clinician will not understand their communication.

- Because of the lack of accessible counselling services, people who use AAC may access friends or support personnel, such as personal attendant care service providers or consumer advocates who may not be qualified to provide the necessary counselling support.

GENERAL GUIDELINES

- Become familiar with clients’ means of expressive communication, including any AAC system they may employ.

- Wherever possible, use clients’ established forms of expressive communication as the basis for counselling-based dialogue.

- Wherever possible, and where appropriate, consider involving a communication assistant, that is, a person who is familiar with, and sensitive to, clients’ means of communication.

- Be prepared to allow the time needed. Communicating with people who use AAC takes time because preparing specific messages takes time. Typical spoken conversations are generally produced at an approximate rate of 200 words per minute. In contrast, even with
Proficient use of AAC, the rate will be limited to 15 words per minute; for others, the rate can be much slower. In addition, conversations involving the use of AAC are characterised by frequent communication breakdowns, that is, when the message is misunderstood. It is vital that both clinician and client agree to take the necessary time, thereby ensuring that the conversation has the same quality it would have if no AAC were involved. Along these lines, it is important to ensure that clinicians are aware of the speed with which topics are changed throughout conversations. People who use AAC need time to prepare for changes in topic.

Strategies for helping a person take a turn in a conversation include:

- Slow down the rate of your own speech, not by talking slowly, but rather by inserting pauses in your conversation. This will give the person time to interject or to take a turn if they want. Note that people often use phrases such as, "I have something to say about that" or "Hold that thought." Clients may also vocalise or use nonverbal means of communicating the desire to take a turn in a conversation, and it is important to be attentive to these.

- Practice overtly giving clients a chance to take a turn by pausing and asking them if they have something they want to add or say.

- Signal changes in topics, which, because they occur rapidly in spoken conversations, can be missed by people who use AAC. Changes in topics can be signalled by overt comments, such as, "On a different topic, . . . ." Similarly, give clients time to construct messages about newly-introduced topics.

- Be honest if you have not understood a message. Repeat back what you understood so that clients can confirm or correct your understanding. If you still do not understand a particular message, ask them to repeat it or say it another way.

- Be aware that some people with complex communication needs have had few, if any, opportunities to practice conversational exchange. As a result, they may not understand or use subtle signals and social rules; for
example, knowing how or being able to end a conversation other than through very direct means, such as turning away, or saying, "That’s all I have to say now."

- Use and accept all methods when communicating with a person who uses AAC, for example, gestures and facial expressions. We all use these methods, but they are more integral to the conversations of people with complex communication needs; therefore, it is important to attend to them closely.

- Become comfortable with silence, for example, those which occur while clients are preparing a message or processing your message.

- Be aware that because of differences in muscle tone, for example, too much or not enough, it is easy to misread the facial expressions and body language of people with complex communication needs. For instance, a flailing arm may be a reflex rather than a signal of distress. Spending time with clients and asking them whether you have interpreted their movements and facial expressions correctly will enable you to more accurately read meanings conveyed using modes other than AAC.

- When clients using AAC take their turn in conversation, it is important to provide spoken, for example, "U huh", and non-spoken, for example, head-nodding and/or facial expressions, feedback while messages are being delivered, as a good listener would do in any positive interaction.

- Ensure the physical setting is appropriate and offers adequate space, as well as minimal visual and other distracters. Ensure there is adequate lighting without glare to allow clients to use their AAC system.

- If someone uses writing on a notepad to communicate (which may supplement another system), be sure to hand the notepad back once you have read each message so clients can continue the conversation.

- Be aware of the possible effects of fatigue on clients’ ability to engage in an extended conversation, as is required in counselling. Schedule sessions at times that you know clients are least likely to be fatigued.

- With clients’ permission, involve others in supporting them with homework activities.

**For People with Access to Limited Messages:**

- Determine if the word chosen is exactly what clients want to convey; that is, because of access to only a limited vocabulary or message set, clients may choose a word that is close to, but does not convey, their full intention, for example, “sad” to mean “anxious” “worried” or “nervous”.

- Remember clients’ selections when using a communication book or board, so that you can sequence selections into a whole message.

- Fill in the gaps, in particular, omitted words that provide grammar, but not the key content of the message, for example, being able to interpret the selections of “sad”, “dad”, “sick” to mean “I’m sad because my Dad is very sick.”.

- Check with clients that your constructions are correct, then being prepared to work at getting them right if they are not.
> Be prepared to work with interpreters who know how to co-construct clients’ messages without disempowering them or who know them well enough to link up messages with their life events.

**For People with Access to Unlimited Messages:**
> Ask clients to indicate if they prefer that you anticipate the completion of messages; that is, by completing messages for them, or by waiting until they have finished preparing their messages. Their preference may vary according to how they feel; for example, someone who usually prefers to be able to complete their own messages may prefer that the partner anticipates their completion when feeling fatigued or emotional. Check each time you interact with each client, as well as throughout your interaction if you suspect that they may be fatigued.

> Often, while clients are writing messages, both they and the clinician will be focused on the communication aid. When messages are being spoken out, take your gaze from the device and look at the client who can then gauge your reaction to each message.

> When clients are writing messages, stay focused on them. Do not talk either to them or to someone else, or engage in other activities, for example, flipping through notes.

> Be prepared for technological breakdown; that is, clients’ systems may stop working. If this happens, ask them whether they have a back up – usually in the form of a communication board or book that may be stored in a bag.

**SPECIFIC GUIDELINES**

**Preparing for sessions:**
> Prepare prior to the first session. Beyond establishing what type of expressive communication system the client uses, it is valuable to determine whether the person with a disability will be accompanied by a communication partner; whether the client has any additional support needs, for example, fatigue or personal care, that may impact on the counselling session; whether the counselling room will be accessible to the client; and whether there are any other relevant factors that the clinician may need to be aware of in order to ensure optimal counselling conditions.

> Schedule adequate time for sessions. The need to schedule adequate time relates not only to the additional time required for the operation of an AAC system, but may also pertain to a range of practical factors associated with the use of a wheelchair for mobility. For example, a person who uses a wheelchair for mobility may use public transport to get to and from the session; hence, may be delayed. In addition, it may take the individual considerable time to get from a waiting area to the counselling room. The accumulative effect of these factors can result in sessions running longer than would normally be the case. Sometimes, needing to draw a session to a close prematurely because of a client’s fatigue can attenuate this factor. However, in principle, clinicians should be prepared for longer sessions, and schedule time accordingly.

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BECOME COMFORTABLE WITH SILENCE, FOR EXAMPLE, THOSE WHICH OCCUR WHILE CLIENTS ARE PREPARING A MESSAGE OR PROCESSING YOUR MESSAGE.
Dealing with breaks and delays in the conversation:

> Become comfortable with breaks, delays and silences in the counselling process. Breaks, delays and silences are not exclusive to the counselling of people with complex communication needs; they are a feature of the counselling process, regardless of clients’ abilities. However, it is fair to say that breaks, delays and silences occur more frequently when counselling a person who uses AAC than one who does not and the impact can be more obvious.

Be comfortable with these silences. Acknowledge that they are necessary in order for clients to have adequate opportunities to express their thoughts and feelings. Silences can occur because: (a) of the additional time required for the operation of an AAC system; (b) clients are fatigued and are using the silence as a means of refocusing; or (c) clients have cognitive limitations and are using the silence to process information. Silences can also have therapeutic value in that they can allow clients to delve further into their thoughts and feelings and to ponder the implications of what has transpired throughout sessions. Allowing for silences also demonstrates clinicians’ willingness to experience the therapeutic relationship without pressure to be excessively verbal (George & Cristiani, 1995).

Dealing with a limited message set:

> For some people who rely on a limited message set, such as a number of pictured items on a communication book or board, the range of vocabulary items that they have access to and that are relevant to counselling is restricted. For example, although many communication books or boards include vocabulary items that reflect feelings, these tend to be limited in number and restricted to more fundamental feelings, such as happy, sad, angry or frustrated.

Clinicians may need to be involved in the preparation of additional vocabulary items that allow deeper extrapolation of clients’ thoughts and feelings. The development of additional vocabulary items is best handled in a fluid fashion, in a manner that echoes the direction and evolution of the counselling process. Speech pathologists have a particular role to play in this regard, and generally have access to well-known systems, such as Picture Communication Symbols® (a set of 5000 picture symbols).

Reliance on closed questions:

> Accept that there is a greater reliance on closed questions, particularly when clients are using a system containing a limited number of messages. Greater reliance on closed questions, that is, questions that require a Yes/No response, is one way in which the counselling process with people with complex communication needs can differ compared with counselling people with functional speech. When counselling people with adequate speech, the practice of asking closed questions is usually avoided. Instead, the focus rests with open-ended questions that are thought to help clients elaborate on a point without being influenced into the clinicians’ frames of reference (George & Cristiani, 1995).

Even when counselling people with complex communication needs, the first-line approach
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remains with open-ended questions where practical and where appropriate. However, greater reliance on closed questions with people with complex communication needs is a clinical reality that requires clinicians to draw on additional strategies in order to ensure the responsibility for the dialogue remains with clients. One such strategy is that of using ‘closed question openers’. These are questions that open up further client-directed dialogue, using a Yes/No response option format. For example, the question, “Is there anything else that’s worrying you?” provides an opportunity for clients who rely on a Yes/No response to signal to the clinician additional issues that can be tackled as part of the counselling process. Another strategy is providing clients with two carefully-selected alternatives, while gradually narrowing the choice. For example, “Do you feel sad sometimes or all of the time? Only Sometimes?” (Burbidge & Iacono, 2005).

Supporting comprehension, retention and recall:

Be aware of clients’ levels of comprehension. As indicated, people who access only limited message sets are likely to have significant difficulties comprehending language. For clients with comprehension or cognitive limitations, use strategies that assist the encoding, retention and recall of the information presented. These include:

1. using visual aids, such as diagrams, pictures or pictographs;
2. minimising visual and other distractors;
3. having short bursts of counselling dialogue with frequent breaks;
4. keeping counselling objectives simple, meaningful and achievable;
5. supporting recall of information between counselling sessions by summarising the main points of the previous session;
6. minimising the length and complexities of verbal communication;
7. signalling to the person when a change in counselling theme is to take place;
8. giving only one piece of information at a time;
9. repeating information when necessary.

Gently confront reasoning blocks. Clinicians may encounter people who have rigid thinking patterns and inflexible approaches to new ideas, and who therefore may find alternate interpretations of their thoughts, feelings or behaviours confronting. Rigid modes of thinking can reflect the interaction of a range of psychosocial factors, including cognitive limitations and social learning factors. For example, a person who over the course of their life has been discouraged from expressing emotions, such as displeasure or anger, may have come to develop the distorted perception that, it is wrong to admit to the experience of unpleasant emotions.

It is important to dedicate sufficient time to confront reasoning blocks. However, this confrontation needs to be managed sensitively, and requires both a sense of timing and an awareness of clients’ receptivity (George & Cristiani, 1995). When mishandled, confrontation can result in defensiveness on the part of clients and, ultimately, can destabilise the therapeutic relationship. Begin with a
validation of clients’ internal frames of reference, regardless of their external accuracy. Reasoning blocks are then often best tackled using an educative approach. For example, in the above instance, the clinician could emphasise that it is normal and healthy to experience a range of feelings, including unpleasant emotions such as displeasure or anger; it is the manner in which these emotions are expressed that is of upmost importance.

> Develop pictorial templates for common action strategies used in counselling. Action strategies are the specific, focused psychological strategies that facilitate behaviour change. The templates clinicians develop will vary depending on the action strategies utilised, which in turn will be dependent on their theoretical orientation.

> Using Talking Mats (Murphy & Cameron, 2001) may be a useful technique in counselling. Talking Mats is a system for exploring thoughts and feelings regarding a specific issue. For

Figure 1 provides an example of a template used for instructing clients regarding adaptive versus maladaptive strategies for managing anger responses, developed along cognitive-behavioural principles. Other templates that may be useful to develop are templates to support clients in identifying underlying faulty thoughts and undertake thoughts disputation, developing assertiveness, relaxation, or problem-solving skills, or setting goals. Templates may also be developed in the interest of reflecting specific counselling themes, such as depression, anxiety, or grief and loss.

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Figure 1: Example of a template for an action strategy: Helpful versus unhelpful ways of dealing with anger (Gulbenkoglu & Hagiliassis, 2006)
The strategy of sourcing information from secondary parties has obvious implications for privacy and confidentiality.

example, a picture representing the issue, such as “Where I live,” is placed at the top of the mat. Pictures representing feelings, such as ‘happy’, ‘neither happy nor unhappy’, and ‘unhappy’ are placed across the top of the mat. Other pictures depicting various aspects relating to the issue are prepared beforehand. For example, these pictures might include ones of people a client lives with, accommodation support workers, rooms in the house, and leisure activities available where they live. The client then places a picture representing each aspect on the mat under one of the pictures representing how they feel. The clinician asks the client to indicate how they feel about their bedroom, the living room, and so on. A photo can then be taken of the completed mat and used to monitor any changes over time in the client’s feelings about the issue. In addition, other mats can be used to explore sub-issues, such as why the client is unhappy about living with certain individuals.

Seeking additional information:
> Use information from other people to supplement information provided by clients. Sometimes it may be difficult to elicit factual information of sufficient detail in order to achieve a reliable and thorough interview. In this circumstance, consider the strategy of gathering information from a range of secondary sources. Secondary sources are individuals who are likely to have a detailed knowledge of issues pertaining to clients and, most critically, represents the best interests of clients. Such people may include family members, friends, staff, professionals and advocates. The strategy of seeking additional information from secondary sources needs to be done at all times in consultation with clients. For example, “Is there anybody else who can tell us more about this?”, and with consent from the client, “Do you want me to talk to this person about this?”.

Managing privacy and confidentiality:
> The strategy of sourcing information from secondary parties has obvious implications for privacy and confidentiality. The confidentiality of counselling sessions underpins the trust between clinician and client, and is an ethical obligation for any psychologist working under a code of professional conduct. These same principles apply when clinicians are working with people with complex communication needs. In addition, a range of health acts in Australia hold that personal and health information cannot be released or disclosed to anyone without clients’ consent. The only exceptions to these procedures are those required by law, by which in some circumstances, information can be released without clients’ consent. These laws apply to working with all clients, regardless of their disability status. Strategies designed to achieve a balance between the need for communication between clinicians and secondary parties, and clinician’s confidentiality obligations include:
1. releasing or exchanging information to secondary parties only where appropriate and necessary;
2. having clients nominate the secondary parties to be consulted;
3. obtaining permission from clients to release or exchange Information, preferably in written format;
4. releasing or exchanging only what is required, that is, ensuring the transferring of minimal but sufficient information.

**Ensuring client-directed counselling:**

> Be aware of the values that clients hold. Values are the standards of choice that clients have demonstrated over a period of time (Patterson, 1989). Also, clinicians need to be aware of clients’ preferences, tastes, likes and interests. Clients’ values will steer the course of decision-making in the counselling context. For example, when choosing the means that will most effectively achieve established goals, the means must be consistent with client values (George & Cristiani, 1995). Clients with complex communication needs may have difficulty defining and/or expressing the values they possess (Values are difficult to define in any case; Patterson, 1989). One strategy is that clinicians ‘check in’ with secondary parties regarding clients’ values. Questions that yield this type of information include, “What does the person usually approve or disapprove of?” or “How does the person usually behave in this context?” However, as a cautionary note, it is important that clinicians remember that there can be substantial variations in the opinions provided by secondary parties regarding clients’ values. Hence, these will need to be assessed for contextual accuracy, and invariably confirmed directly with clients.

> Check in regularly with clients to confirm the accuracy of interpretations made by clinicians. Interpretations are a process of imposing meaning on behaviours (Brammer & Shostrom, 1982), and may vary depending on a range of clinician factors, including clinicians’ theoretical orientation, their personal values, and the information that is available to them. Subsequently, clinicians may draw interpretations that have a particular slant, which may or may not be congruent with clients’ internal frames of reference. Hence, it is good practice to confirm directly with clients the accuracy of any interpretations made. For example, “Am I heading down the right track?” “Am I missing anything?”

Alternately, clients may be offered a limited set of interpretations and asked which interpretation they are most in agreement with. Notably, it is important that clients be given explicit, but also implicit, permission to communicate to clinicians any inaccuracies in interpretations. This may seem awkward or be new territory for some clients with a history of passivity in communication with professional figures. Hence, the message of ‘permission’ may need to be repeated during the counselling process. For example, “Feel free to tell me if I’ve got it wrong.”

> Employ clients’ own words and phrasing wherever possible. Normally, in restating the content of clients’ messages, clinicians feed back the content of statements using different words (George & Cristiani, 1995). When clinicians are working with people with complex communication needs, there appears some value in restating the content of messages, using the person’s own key words. The prime benefit of using clients’ own words is that it
Notably, it is important that clients be given explicit, but also implicit, permission to communicate to clinicians any inaccuracies in interpretations.

helps to assure that clinicians portray clients’ meanings accurately. Conversely, by restating content using different words, clinicians may be introducing a different meaning to what was intended by clients. Clients may agree with this different meaning simply because it is easier to do so, rather than because it is entirely accurate.

Ensuring accuracy and congruency:
> Check congruency between what clients communicate directly, for example, using an AAC system, and how they behave non-verbally. For example, a client may communicate ambivalence regarding a particular issue, but then become teary in the face of the issue’s discussion. There are various reasons why this may be the case. The client may simply be evading discussion of the issue. However, it may also be that they are not aware of the impact of the issue because they have not had opportunities to explore such thoughts and emotions in the past. It may also be that, through past negative experiences that have discouraged self-disclosure, they may posses the distorted perception that they cannot speak up about such issues.

When there is incongruence between what clients ‘say’ and how they ‘behave’, there is a role for further inquiry, and delicate confrontation. When properly done, confrontation can assist clients become more integrated and consistent in their behaviour (George & Cristiani, 1995).

There is also a role for gathering further information from secondary sources in order to confirm whether what clients express to clinicians is consistent with how they really are in natural environments. However, this strategy will need to be implemented in consultation with, and with consent from, clients with complex communication needs. In some instances, it may simply be the case that the client is making an explicit decision that they do not wish to discuss the issue with the clinician. This decision will need to be respected. Once again, it is essential that clinicians be aware that the views expressed by secondary sources may not necessarily be those held by clients. Hence, any information that is provided by secondary sources will need to be presented to clients, and checked against their own view of their situation. For example, “I've had a discussion with Tomas, and in his view, you become very angry at home. What do you think?”

> Use confirmation checks regularly.

Confirmation checks have a dual purpose when clinicians are counselling people with complex communication needs. First, they seek to clarify communications that are not entirely clear. For example: “I'm not sure if I've got this right. Do you mean that you are angry?”. Second, they serve the purpose of communicating to clients the clinicians’ interest in understanding exactly what clients are experiencing, and from that perspective, can build on the therapeutic relationship.

Managing one’s own values and beliefs:
> Maintain an awareness of one’s (the clinician’s) own values and beliefs. Many theoretical orientations of counselling hold that clinicians should not impose their values or value system on clients. However, it is also recognised that clinicians cannot help influencing the values of
their clients (Patterson, 1989). For example, the response of the clinician may reveal something about their own values, and may reinforce certain behaviours in the client. This is a particular issue for those working with this group. Through learnt behaviour, some people with complex communication needs may possess passive communication styles and be eager to please clinicians by aligning their values to those they perceive as important to clinicians. Additionally, if one also considers that clinicians may take on the role of the dominant communication partner, there is a potential imbalance of power that may arise in the therapeutic relationship, which functions as another source of possible influence.

The manner in which clinicians may influence client values may be quite subtle and implicit. For example, when a clinician suggests a set of solutions to a particular problem the client is facing, does that clinician only suggest mainstream problem-solving options?

Acknowledging that the values of clinicians cannot be avoided in the therapy relationship, it is imperative that clinicians remain aware of their values and clear about how these may impact on the therapeutic relationship (Patterson, 1989). Peer consultation and supervision are valuable strategies in addressing this issue.

> Acknowledge that there may need to be an enhanced reliance on general or intuitive knowledge. Despite clinicians’ reliance on factual information that is provided directly by clients or secondary sources, at times, the level of this information may be insufficient. Gaps in information may be readily apparent. There is certainly value in clinicians augmenting their factual knowledge of clients’ circumstances, with astute, general or intuitive knowledge. For example, a client who presents with a depressed mood may not be able to readily articulate the psychosocial factors that may be contributing to their lowered affect. What the clinician knows about that client’s psychosocial environment can be formative in terms of the hypotheses that the clinician draws to account for why the client may be feeling that way. These hypotheses can then be checked back with the client for congruency and accuracy. Once again, peer consultation and supervision can be valuable in terms of assisting to ensure that the types of intuitively-based hypotheses are not unduly prejudiced by the clinician’s own values.

Attending to the client:

> Ensure optimal client physical positioning. Some people will experience postural difficulties and may need to be supported in order that they are seated in the position that is most conducive to maximizing personal comfort, as well as achieving optimal communication. For example, a person who is positioned awkwardly in a wheelchair may need physical assistance to sit optimally. This need can usually be ascertained by asking questions such as, “Are you sitting comfortably?” or “Can I assist you to sit more comfortably?”

> Ensure optimal eye contact. Some people with physical disabilities experience difficulties in establishing or maintaining eye contact. This may result directly from their disability, may be a learnt communication style, or may reflect their...
disinterest or fatigue, discomfort with trust and closeness, or lack of confidence. Clinicians may need to make extra effort to sustain eye contact without necessarily demanding it from clients, but should also employ this strategy sensitively, particularly if this is felt to result in clients feeling uncomfortable.

> Develop an understanding of clients’ idiosyncratic non-verbal communication. There will be great variation in the physical characteristics of people with complex communication needs. For clients with complex physical movements, there may be a range of reasons for specific physical responses. For example, athetosis leads to difficulty in controlling and coordinating movement. People with athetoid cerebral palsy can have many involuntary movements that affect the hands, feet, arms or legs. These movements often increase during periods of emotional stress (United Cerebral Palsy of Central California, n.d.). In a clinical setting, client responses may simply be one or a set of involuntary movements, but such movements may also say something about clients’ emotional state. When clinicians become familiar with their clients, physical responses can provide additional information above and beyond the information that is yielded through direct interviewing techniques.

Moving beyond the concrete and the ‘safe’:

> Try to extend discussion beyond the concrete to deeper and more abstract themes. An objective of counselling is supporting clients to achieve deeper levels of self-exploration and self-understanding than those in which they habitually engage, and it also rings true when clinicians are working with people with complex communication needs. However, this objective may be difficult to achieve for clients who have access to limited message sets. As discussed above, a useful strategy to overcome this problem is providing additional relevant vocabulary items.

Another useful strategy is taking full advantage of clients’ capacities to provide Yes/No responses and utilising a graduated-levels approach. A graduated-levels approach is one in which clinicians ask an initial closed question that is designed to tap a thought or feeling, and proceed to ask further closed questions that tap progressively deeper levels of meaning. For example: “Do you feel depressed? Is your mood worse than what it was two weeks ago? Has something happened recently to make you feel this way? Is this something to do with a friend or family member?”

A risk to be aware of when using this strategy is that it may encourage clients to become locked in to responding either Yes or No. Clinicians can delicately check the reliability of client responses by asking reverse questions, and seeking reverse responses. For example: “Is your mood better now than what it was two weeks ago?”

> Clinicians may need to explore their attitudes to disability, as a preliminary strategy for working with this group, and address any beliefs or values that may act as a barrier to fostering self-exploration and self-understanding in this group. For example, one attitudinal barrier that may exist is based on the faulty belief that people with disabilities are not capable of personal
insight, or need to be protected from discussion of sensitive topics because such discussion may prove emotionally overwhelming. This attitude may be reflected quite subtly in the context of the therapeutic relationship. For example, there may be a natural tendency for clinicians to ask ‘safe questions’, that is, those unlikely to tap any deeper emotional issues. Though safe questions certainly have a role in counselling, for example, developing therapeutic rapport, a reliance on these rarely challenges clients sufficiently to achieve the required depth of awareness.

Support clients to extend their range of action strategies. Clients may feel compelled to restrict themselves to only a limited set of options in their decision-making. This may reflect a lack of self-confidence in exploring other choices, a lack of information about choices or a restricted response repertoire. Although clients’ preferences for a previously successful adaptive strategy is certainly valid; there may also be some value in exploring alternative adaptive strategies that may be available to the individuals concerned that have not been tested in the past. Such exploration will require that clinicians be creative in problem-solving and examining non-conventional strategies. Also involved is the exploration of the consequences of these newly-arrived at options on themselves and others, for example, asking the question: “What would happen if you did …?”

Summary of specific strategies for making the counselling process more accessible to the person with complex communication needs.

Table 1 provides a summary of strategies for counselling people with complex communication needs. This information is arranged in terms of: (1) the specific technique or micro-skill utilised in counselling; (2) identified barriers in achieving these techniques; (3) the hallmarks of counselling that are impeded most directly; and (4) strategies for contending with and overcoming these barriers.
Clinicians may need to explore their attitudes to disability, as a preliminary strategy for working with this group.

Table 1: Summary of strategies for counselling people with complex communication needs.

<table>
<thead>
<tr>
<th>Technique</th>
<th>Barriers and Risks</th>
<th>Hallmark</th>
<th>Strategy</th>
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| Open questioning  | • Only Yes/No response  
                    • Access to limited messages  
                    • Slow communication exchange  
                    • Disrupted flow of communication  
                    • Difficulties comprehending  
                    • Difficulties with reasoning  
                    • Difficulties with information retention  
                    • Reliance on closed questions | Self-directedness, Shared goals, Confidentiality and Rapport | • Become familiar with the person’s communication method.  
• Support the person to use the system that is familiar to him or her.  
• Involve a communication assistant.  
• Be aware of and address any comprehension issues; for example, visual strategies, concrete aids, short statements, Talking Mats.  
• Start from the more general and become more specific, having the client lead.  
• Allow sufficient time.  
• Extend beyond the concrete.  
• Use “closed question openers”; for example, “Is there anything else that’s worrying you?”  
• Have access to vocabulary resources relevant to the discussion topic.  
• Be lead by the client’s values.  
• Be aware of your own values and beliefs.  
• Be aware of the impact of other people’s values and interpretations and how they may lead the client.  
• Be aware of confidentiality issues; share only what must be shared.  
• Be aware of the range of action strategies available to client. |
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<thead>
<tr>
<th>Technique</th>
<th>Barriers and Risks</th>
<th>Hallmark</th>
<th>Strategy</th>
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<tbody>
<tr>
<td>Attending &amp; Listening</td>
<td>• Problems in understanding the client because of poor speech intelligibility</td>
<td>Empathy and Rapport</td>
<td>• Be aware of factors that impact on the client’s functioning and behaviour.</td>
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<td></td>
<td>• Client’s possible feelings of frustration when not understood</td>
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<td>• Ensure optimal body posture and eye contact.</td>
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<td></td>
<td>• Difficulties reading the client’s body language</td>
<td></td>
<td>• Become familiar with the person’s body language and AAC system.</td>
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<td></td>
<td>• Lack of familiarity with the client’s AAC system</td>
<td></td>
<td>• Be aware of session scheduling; for example, choose a time of day when the client is rested.</td>
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<td></td>
<td>• Maintaining attention for the time it takes the client to express a message</td>
<td></td>
<td>• Be open and honest about the difficulties of understanding communication.</td>
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<td></td>
<td>• The client’s poor posture and/or eye contact</td>
<td></td>
<td>• Employ communication repair strategies.</td>
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<td></td>
<td>• The client’s potential to fatigue easily</td>
<td></td>
<td>• Use writing and note taking to track sequence of communications.</td>
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<tr>
<td>Summarising and</td>
<td>• Limited information to base paraphrasing upon</td>
<td>Self-directedness, Shared goals, and Rapport</td>
<td>• Check regularly that you understood the client.</td>
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<tr>
<td>Paraphrasing</td>
<td>• In attempting to ‘fill in the gaps’, risking putting words into the client’s mouth</td>
<td></td>
<td>• Undertake paraphrasing and summarising more regularly and check their accuracy.</td>
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<td></td>
<td>• Directing the client down a particular path</td>
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<td>• Provide opportunities for the client to correct the clinician.</td>
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<td></td>
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<td></td>
<td>• Use visual aids for summarising and paraphrasing.</td>
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<td></td>
<td>• Use a client’s own words when summarising and paraphrasing.</td>
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<td></td>
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<td></td>
<td>• When filling in the gaps, employ general and/or intuitive knowledge.</td>
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<td></td>
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<td></td>
<td>• Be aware of your own values and beliefs.</td>
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<tr>
<td>Use of silence</td>
<td>• Frequent and long silences</td>
<td>Rapport</td>
<td>• Be comfortable with silence.</td>
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<td></td>
<td>• Feelings of discomfort associated with silences</td>
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<td>• Acknowledge the role of silence as a therapeutic tool.</td>
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<tr>
<td>Eliciting &amp; Probing</td>
<td>• Difficulties achieving deeper levels of insight (particularly for clients with comprehension difficulties)</td>
<td>Shared goals, Self-directedness, Confidentiality and Rapport</td>
<td>• Extend beyond the concrete by exploring creative options and their consequences for the client and others; for example, “What would happen if you did X?”</td>
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<td></td>
<td>• Communication systems that lack the words needed for exploration of an issue</td>
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<td>• Offer a range of therapeutic interpretations.</td>
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<td></td>
<td>• Reasoning blocks for someone with cognitive limitations</td>
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<tr>
<td>Technique</td>
<td>Barriers and Risks</td>
<td>Hallmark</td>
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<tr>
<td>Eliciting &amp; Probing (cont.)</td>
<td>• Probing in a tangential or circuitous way</td>
<td>Shared goals, Self-directedness, Confidentiality</td>
<td>• Develop visual templates to explore issues at progressively deeper levels.</td>
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<td></td>
<td></td>
<td>and Rapport</td>
<td>• Employ flexible communication approaches lead by counselling themes rather than vice versa.</td>
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<td></td>
<td>• Allow time for confronting ‘reasoning blocks’.</td>
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<td></td>
<td>• Work from where the client is in his or her reasoning; adopt an educative approach; use concrete examples to gently challenge reasoning blocks.</td>
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<td></td>
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<td></td>
<td>• Be aware of a client’s responses as possible indicators of emotional state; for example, teariness or changes in physical state.</td>
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<tr>
<td>Challenging (incorporating congruence)</td>
<td>• Tendency to ask ‘safe questions’</td>
<td>Confidentiality and Rapport</td>
<td>• Be aware of the therapeutic role of safe questions.</td>
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<td></td>
<td>• Lack of contextual information about the client’s situation</td>
<td></td>
<td>• Avoid using safe questions as the basis of counselling; ask questions that directly address the issue.</td>
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<td></td>
<td>• Greater potential for incongruence between what the client says and what the client does</td>
<td></td>
<td>• Gather as much information about the client to give you the ‘best available context’; for example, “is there anybody else that can tell us more about this?”, “do you want me to talk to this person about this?”</td>
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<td></td>
<td>• Difficulties in determining sources of incongruencies</td>
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<td>• Collect additional information from other sources to resolve incongruencies.</td>
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<td></td>
<td>• The client’s difficulties in recognising and identifying faulty thinking</td>
<td></td>
<td>• Employ sensitivity and openness in discussing issues of incongruence.</td>
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<td></td>
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<td>• Develop visual templates that reflect common irrational thoughts.</td>
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<td>• Where appropriate, involve others in supporting clients with homework activities.</td>
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<tr>
<td>Clarifying</td>
<td>• A greater need for clarification</td>
<td>Empathy, Shared goals, Self-directedness and Rapport</td>
<td>• Check-in with the client; for example, “Am I heading down the right track?”, “Am I missing anything”, “Feel free to tell me if I’ve got it right”.</td>
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<td></td>
<td>• Putting an incorrect slant on the clarification</td>
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<td>• Encourage client to indicate if he or she does not confer with the clinician.</td>
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<td></td>
<td>• Client acquiescence</td>
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<td>• Echo key-words when clarifying to facilitate meaningfulness, relevance and confirmation.</td>
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</table>
REFERENCES


Murphy, J., & Cameron, L. (2001). *Talking mats and learning disability*. University of Stirling, AAC Research Unit.


Practitioners who provide counselling services are increasingly likely to consult with people with complex communication needs as part of their clinical practice. The guidelines have been developed to support these practitioners in their inclusion of people with complex communication needs. The guidelines provide suggestions and strategies for making counselling as maximally accessible to people with complex communication needs, whilst maintaining the integrity of counselling principles.