

Counselling with People Who Have an Intellectual Disability:

Issues and Challenges

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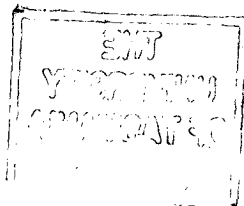
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This thesis contains no material which has been accepted for the award of any other higher degree or graduate diploma in any university and, to the best of my knowledge and belief, no material previously published or written by another person, except where due reference is made.

Miranda Stephens
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*Throughout this project I have appreciated the support of my colleagues
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Table of Contents

	page
Abstract	1
Overview	2
The principles of counselling	2
A rationale for counselling with people who have an intellectual disability	5
Challenges in counselling people with an intellectual disability	14
Augmentative communication and counselling	18
References	22
A Journal Article:	
Augmentative counselling with people who have an intellectual disability:	
An evaluation of a resource kit	29
Appendices (A - G)	61

Abstract

Historically, people with an intellectual disability have not had the same opportunities to engage in counselling as have people without an intellectual disability. The difficulties apparent when using traditional counselling methods with a person with an intellectual disability have resulted in counselling being viewed as an ineffective process. A review of the literature was conducted which aimed to identify effective counselling processes for counsellors working with people with an intellectual disability. The results suggest that elements of person-centred, behavioural and problem-solving approaches may be useful in assisting people with an intellectual disability to manage more effectively their difficulties with daily living. Recent evidence of visual stimuli such as pictures aiding comprehension suggests that the use of pictures may further enhance counselling processes. The effectiveness of a combined person-centred, behavioural, and problem-solving counselling process utilising communication supports such as pictures, merits investigation.

Overview

This review is a consideration of the counselling needs of people with an intellectual disability. In considering the appropriateness of counselling experiences for people with an intellectual disability it is first necessary to establish the principles of general counselling. These are explored and then discussed in relation to counselling with people who have an intellectual disability, as well as approaches which are effective for use with this population. Specific challenges that an intellectual disability presents for counsellors and counselees, are discussed in relation to the various techniques for managing these challenges. Augmentative communication, or the use of visual aids such as pictures to support interaction with people who have an intellectual disability is a specific technique that can enhance the effectiveness of counselling for this population. The review describes this technique and implications of the use of such supports for counselling processes are examined. Directions for future research in this area are proposed.

The Principles of Counselling

Counselling is a term used to refer to many different techniques, processes, principles, and situations. For some theorists, counselling means social exchange (Rosen, Clark, & Kivitz, 1977). For others, counselling occurs when two people work together to

solve problems using specific techniques (Burnard, 1989). On a basic level, counselling may be defined as a dialogue or interview where one person helps another with an important personal difficulty. Counselling may involve being purely supportive with the primary role of the counsellor as the listener. Counselling may also involve giving information in terms of facts, educating, supporting people in crisis, or working with people to alleviate emotional distress or to develop meaning in life (Burnard, 1989).

The range of situations which may be defined as counselling is great, and the principles and theories underlying the counselling process are numerous. However, there are some common elements within the various theories which seem crucial to the process of counselling. These may be identified as the core elements of counselling. The first of these is the principle of counselling as a process of problem solving and of change. The essence of many models is the goal of assisting clients to manage difficulties more effectively. To achieve this goal, a structure of defining the problem or issue, generating options and choosing the appropriate solution is often employed. This method may be termed problem solving (Egan, 1994). In its attempt to solve problems, the method also aims to increase the client's response capacity and encourage the creation of new thoughts, behaviours, and decision-making abilities (Thomas & Parker, 1992). A second common element within many counselling approaches is that of being person-centred. This means that the counsellor focuses upon the specific needs and characteristics of the client (Nelson-Jones, 1983; Pfadt,

1991; Egan, 1994). More effective problem solving, positive self-regard, and a sense of self-control over behaviour are outcomes of the person-centred approach (Rogers, 1961). The relationship and interaction between client and counsellor is central to the development of a person-centred approach.

A number of communication skills involved in building and maintaining a person-centred relationship can also be identified as common core elements of counselling. The most crucial communication skills and principles include active listening, confrontation, and the display of empathy, respect, genuineness and warmth (Burnard, 1989; Egan, 1994; Berliner, 1986). Active listening refers to the actual skills of observing and reading nonverbal behaviour in the client as well as listening to and understanding the client's verbal messages. Empathy is the ability to identify a client's feelings accurately and to convey this awareness to them. Respect means appreciating the dignity and worth of the client and their right to make their own decisions. Respect also involves a belief in the other's capacity to make something of their life. Counselling which respects the individual also takes into account the client's strengths, accomplishments and resources. The counsellor's ability to be genuine and non-defensive is a further crucial characteristic, as is warmth. Warmth is defined as the ability to express caring and concern, both verbally and behaviourally, rather than being detached and aloof (Egan, 1994). Some authors argue that confrontation is critical in facilitating client change. This process involves compelling a client to deal with their discrepant behaviours such as the contradiction between what they are

saying and what they are subjectively experiencing, or what they are saying and currently doing. These skills are specific and essential in both developing a person-centred relationship and in facilitating change and problem solving (Nelson-Jones, 1983).

In conclusion, while counselling may mean many different things to different people, it is ultimately a process whereby change, learning, and problem solving occur within a supportive and communicative relationship between client and counsellor. Difficulty arises when the core elements of counselling are applied with clients whose inherent problems or characteristics challenge these very approaches.

A Rationale for Counselling With People Who Have An Intellectual Disability

It has been argued in the literature and witnessed in the daily interactions of counsellors, that person-centred and problem-solving counselling assists people who have problems in their lives (Egan, 1994). However, counselling has not always been regarded as essential or even helpful for people who have an intellectual disability.

Historically it was presumed that counselling such clients was an inefficient and useless process (Pfadt, 1991). The arguments against counselling included the notion that people with an intellectual disability were incapable of using language to regulate their behaviour or to recognise the cause and effects of their behaviour. It was also believed that disabilities were due to brain damage and therefore psychotherapy would

be ineffective (Pfadt, 1991). Therapists such as Rogers (1961) claimed that clients must have at least average intelligence and a good ability to communicate in order to benefit from “talking therapy”. These conditions of therapy meant that people with an intellectual disability were largely excluded from counselling. As a result, counselling has not historically been utilised to the same extent with this population as with people without intellectual disabilities.

Whereas concerns have been raised in previous years over the usefulness of counselling, contemporary literature argues to the contrary. Research has shown that people with an intellectual disability are capable not only of change but of change through counselling. In a search of the literature, Rosen, Clark, and Kivitz (1977), could find no evidence that people with an intellectual disability are incapable of improvement and change through psychotherapeutic efforts. Many studies since have demonstrated the use of counselling approaches in the facilitation of change in the lives of people with an intellectual disability (Matson, 1984; Walker, 1987; DesNoyers Hurley, 1989; Booth & Booth, 1996). Recent research has examined how specific therapies can be adapted and then applied within counselling settings in order to suit the needs of individuals with disabilities. For example, traditional muscle relaxation procedures have been adapted using concrete behavioural instructions for people with an intellectual disability (Lindsay & Baty, 1986). The use of the narrative counselling approach has also been recently modified for use with people with an intellectual disability. Modifications include the incorporation of pictures and drama and an

increase in the number of direct and specific questions used (Booth & Booth, 1996; Clare & Grant, 1994). It seems that in the past misconceptions about working with people who have an intellectual disability led to a dearth of counselling research and therapeutic applications, a trend which is not apparent in the current literature.

With more recent beliefs that people with an intellectual disability can manage or change problem situations, have emerged arguments citing actual need for counselling and therapeutic intervention. It can be argued that an intellectual disability results in an increased rather than decreased need for support. By definition, an individual with an intellectual disability experiences significant difficulties with the demands of daily living. Counselling provides a means of addressing such difficulties and facilitating change and problem solving. Counselling then, may assist people with an intellectual disability to live more independently (Etherington, 1990).

The move over the last two decades towards deinstitutionalisation and community integration has meant that people with an intellectual disability are experiencing new situations which have the potential to create stress. Sometimes inadequate supports are set up to facilitate these changes, and the need for counselling in order to assist with adaptation has increased. In light of this situation, Matson (1984) argues that emotional problems for people with an intellectual disability are more likely to occur compared with the nondisabled population. He claims that while community integration is beneficial for people with an intellectual disability, it can create new

stresses from such factors as opposition from the local community. According to Matson, we therefore need to assist people in dealing with those situations. Bramston and Bostock (1994) also assert that many people with an intellectual disability face an extensive range of stressors as models of service delivery change. These stressors include adapting to open employment opportunities and new independent living schemes. These authors claim that such changes could be stressful for individuals who feel unsure of their ability to cope with change. However, Bramston and Bostock neglect to report that for some people, the eventual move from a restricted living environment to a more independent situation may eventually produce positive emotional reactions, thus facilitating coping responses (Tully, 1986; Belcher, 1994).

In terms of the emotional needs people with an intellectual disability may have in relation to counselling, Benson and Laman (1985) suggested that people with mild to borderline intellectual disabilities may be at a particular risk of suicide and therefore have a great need for counselling. In a retrospective study of the suicidal tendencies of adults with a mild or borderline intellectual disability, it was concluded that such people have particular difficulties. They may be at a high risk of suicide because of their awareness of their limitations and restrictions and because of a lack of cognitive and communication skills to solve or cope with such difficulties (Benson & Laman, 1985). The problems this sample consistently reported as stressful were work and school difficulties, including disciplinary action, losing a job, and interpersonal disputes with friends, staff, and peers. Such a study demonstrates the similarity in

difficulties people with and without an intellectual disability may experience in everyday living. Conclusions by these authors that emotional problems were in part a result of coping deficits also fits the commonly-accepted model of stress resulting from poor coping responses that is used for non disabled populations (Cormier & Cormier, 1991).

People with an intellectual disability have significantly fewer opportunities to make decisions about what to eat, wear, how to spend free time, and with whom to live than people without an intellectual disability (Kishi, Teelucksingh, Zollers, Park-Lee, & Meyer, 1988). These deficits in choice-making opportunities have the potential to decrease the quality of life of people with an intellectual disability and may possibly lead to an increase in emotional difficulties. Counselling in such situations may assist choice-making abilities and opportunities.

People with an intellectual disability commonly experience problems of communication. For people who are unable to speak or to adequately verbalise their needs, wants, likes, and dislikes, non-verbal communication often becomes the alternative mode for these expressions. In many instances, people who have limited opportunities for decision-making and limited abilities to communicate basic needs and preferences, resort to problem behaviours in order to achieve these needs or express their preferences. In essence, there appears to be a strong correlation between communication difficulties and the presence of problem behaviour (Durand, 1990).

Even a person with a mild intellectual disability typically lacks abstract reasoning skills and therefore in situations of debate or negotiation, the person without an intellectual disability usually has the upper hand. Such a situation can lead to a rapid increase in frustration for the person with the disability and the subsequent use of maladaptive behaviour as a means of communication (Durand, 1990). Current behaviour management techniques utilise a problem-solving process and counselling skills to reduce the frequency of such behaviour and to assist others in managing it effectively (Meyer & Evans, 1989).

When considering the difficulties encountered and needs of people with an intellectual disability, recognition of the strengths and resources that individuals already possess is important (Egan, 1994). It may be argued that people who have an intellectual disability have the right to manage problems without counselling and without a somewhat paternalistic assumption that high stress automatically results in a need for counselling. Lenny (1993), follows this reasoning to the extreme, arguing that people with disabilities do not require counselling and that counselling perpetuates a view of the person with the disability having the problem. She maintains that in actual fact it is society which creates the disability in others. "If this is the case, and I shall argue that it is, then the answer is that while disabled people may need political action, self-help groups, community work, social programmes and the like, *they unequivocally do not need counselling*" (p. 233). Lenny's argument may have merit in challenging many service providers' assumptions of the dependence and helplessness of people with an

intellectual disability. The view also reflects elements of Wolfensberger's (1972) normalisation philosophy, but it seems to be taken to an extreme by Lenny. It should not be assumed that because a person has an intellectual disability he or she automatically requires counselling. However access to the process and techniques of counselling should be as available to people with an intellectual disability as they are to other members of the community.

When counselling becomes an appropriate option for people with an intellectual disability, a combination of elements within person-centred, behavioural, and problem-solving approaches may best suit the needs of such people. Whereas limited research has been conducted about the impact of counselling approaches on people who have an intellectual disability, the literature suggests that the central elements of a person-centred relationship are crucial (Berliner, 1986). Person-centred counselling assists people to take control over their lives, enables people to explore their own situations and meanings, and can address issues the way the person themselves wishes to have them addressed (Rogers, 1961; Egan, 1994). Such an approach is in line with normalisation philosophy which is the concept that people who have a disability should have the same opportunities and control over their life that people without disabilities enjoy (Wolfensberger, 1972). The specific skills and principles within the person-centred approach, such as empathy, are also important for counselling outcomes with people who have an intellectual disability. Walker (1986) asserts that person-centred therapy is an effective method of providing services to people with an

intellectual disability who have psychological and emotional problems. He claims that it is important to respect clients and achieve rapport in order to counter the extensive rejection the person may have experienced throughout his or her life. The utilisation of basic counselling skills such as warmth, empathy, genuineness, and respect are ultimately essential in fostering independence, improving self-esteem, and establishing behavioural change (Walker, 1987; Nelson-Jones, 1983). Behavioural approaches involve the application of learning theories and have particular relevance for counselling with people who have an intellectual disability. Behavioural approaches enable abstract features within counselling to become concrete, practical, and meaningful through the use of such techniques as role plays and demonstrations (Robertson & Brown, 1992). The problem-solving process of counselling involves clarifying issues, identifying options, and pursuing solutions (Egan, 1994). The application of this decision-making process in counselling with people who have an intellectual disability allows specific issues to be addressed and resolved and enables client involvement in decision making.

Specific techniques in counselling, which add to generic counselling skills, may be successfully used with people who have an intellectual disability. One of these techniques is the use of facilitated humour. Facilitated humour occurs when the counsellor's humour is deeply appreciated by the client, the client responds spontaneously and the interview becomes noticeably more relaxed (Davidson & Brown, 1989). In studies of the use of facilitated humour in counselling people with

an intellectual disability, Davidson and Brown found that it related to higher overall ratings of counsellor effectiveness by mildly intellectually disabled clients. The researchers argued that the positive effects of facilitated humour may occur because people with an intellectual disability are unlikely to have as many opportunities to share humour with others and therefore, when it does happen, it is of greater significance. Unfortunately, this study did not allow for or control acquiescent-like effects. It is possible that participants laughed when they perceived non-verbal or voice tone cues from the counsellor and may not in fact have understood the actual content of the counsellor's speech.

Some practical counselling techniques have been investigated that may provide additional assistance for counsellors of people with an intellectual disability. Brooks (1994) claims that counsellors can assist the counselling process by speaking less in a session. High verbal content can create overload and trigger mental withdrawal in counselees with intellectual disabilities. Giving clients time to think and to talk is important, because generally slower information processing is characteristic of an intellectual disability (Kail, 1992).

DesNoyers Hurley (1989) provides six guidelines involving the adaptation of therapeutic procedures for people with an intellectual disability. Matching counselling techniques to the cognitive and developmental levels of the counsellee by modifying language and using nonverbal and appropriate child therapy techniques are essential

for counselling success. A directive approach, using structure and setting limits to focus the therapy on relevant issues is also important. Flexibility through changing the task when necessary and being flexible with time spent in single sessions assists people with attention difficulties. Involving the family and staff when necessary in order to gather information, assist with change and to provide support for these carers is a further recommendation. DesNoyers Hurley includes the management of transference or countertransference issues and issues associated with disabilities as final points of consideration for effective counselling with people who have an intellectual disability.

A large number of techniques, skills and processes have been identified in recent years which can assist the counselling process for people with an intellectual disability. Such techniques mean that counselling opportunities historically denied are now more available. Despite these recent changes, the characteristics of an intellectual disability still present a number of challenges for effective counselling.

Challenges In Counselling People With An Intellectual Disability

An intellectual disability is defined as deficits in adaptive behaviour (independent living skills) and in general intellectual functioning which arise during the developmental years (Grossman, 1983). An individual may have varying strengths and weaknesses, but overall cognitive functioning and daily living skills are lower than would be expected of someone of a similar age. Historically the counselling debate

has identified the cognitive elements of an intellectual disability and the difficulties they present in counselling to argue against the use of counselling. Counselling with people who have problems attending, remembering, problem solving, reasoning, and understanding abstract concepts can be very difficult for both interactional partners. People with an intellectual disability often find it difficult to understand verbal information such as instructions, requests, and conversation due to such impairments.

Brooks (1994) maintains that people with communication disorders due to developmental disabilities such as an intellectual disability, have difficulties processing and producing words and sentences. Comprehension difficulties may include an inability to understand lengthy descriptions or to follow stories, problems appreciating nonliteral language, or difficulties understanding meanings, humour, or indirect requests. Further, individuals who have an intellectual disability may fail to integrate the context of a situation with the verbal content (for example, to understand the purpose of a meeting). Expressive difficulties include inappropriate word choices, vague or confusing speech, difficulty producing words, difficulty putting words into sentences, an inappropriate manner in initiating interactions or introducing inappropriate topics. Competent language use requires cognitive and social skills in addition to linguistic proficiency.

Booth and Booth (1996) identified four characteristics of an intellectual disability which present significant challenges for counselling situations. These characteristics

include the inability to communicate fluently in words (inarticulateness); unresponsiveness to particular types of questioning; maintaining a concrete frame of reference and difficulty thinking in abstract terms; and problems with understanding time sequences and settings. Such characteristics produce significant challenges for traditional counselling based on abstract concepts, complex questions, with an expectation of the counsellee volunteering much information and requiring verbal processes to produce change.

Research into how people with an intellectual disability respond to questioning has revealed tendencies to produce response errors in typical patterns. Further studies have identified factors influencing the likelihood of errors. Common errors include acquiescence or a tendency to answer yes to questions, and defensive avoidance answering, where the client attempts to put off decision making or attempts to have someone else make the decision (Jenkinson & Nelms, 1994; March, 1992; Cummins, 1993). The crucial factors identified as contributing to these errors are reduced cognitive competency including degree of intellectual disability, restricted vocabulary, and verbal fluency as well as a lack of experience in decision making and general questioning interactions (Zetlin, Herriot, & Turner, 1985; March, 1992; Cummins, 1993; Jenkinson & Nelms, 1994; Brinton & Fujiki, 1994). Thus questions which require a yes or no answer, that seek self-disclosure, are controversial, or difficult to understand are likely to produce response errors (Cummins, 1993; Sigelman, Budd, Spanhel, & Schoenrock, 1981). The tendency of people with an intellectual disability

to produce errors in responding to questions has significant implications for the counselling process. Problem solving, person-centred counselling often utilises questioning not only to elicit information but to produce attitudinal and behavioural change (Egan, 1994). Current research has sought to address these issues and identified a number of ways that interactions with people who have an intellectual disability can be altered to reduce response error. These techniques include requiring either-or responses rather than yes-no answers to questions, simplifying the language used in questions, allowing people time to process and respond, reducing the abstract concepts used within conversation, and using sensory cues such as pictures (Sigelman et al., 1981; Kail, 1992; Bacon, Potter, & Seikel, 1992; McCandlish & Webb, 1995).

In conclusion, the characteristics of an intellectual disability have a significant impact on the style and outcomes of interactions, including counselling interactions.

However, techniques have been identified to enhance the counselling process for a person with an intellectual disability. The utilisation of such techniques as specific question types and simplifying language largely depends upon the degree of disability or cognitive impairment of the counsellee (Brooks, 1994). For many people with a mild to moderate intellectual disability, such techniques vastly improve the quality and effectiveness of interactions. However, for people with severe or profound cognitive impairments or who lack verbal expression skills, these questioning techniques may not be enough support. The use of additional supports such as augmentative aids may be required.

Augmentative Communication and Counselling

People who have an intellectual disability also have a communication disability (Brooks, 1994). Communication disability refers to difficulties understanding the gestures and spoken words used by others, or difficulties in expressing needs, thoughts, and preferences. In general, the greater the degree of cognitive impairment, the greater is the person's difficulty with language comprehension and expression. Individuals with a moderate to severe intellectual disability are less likely to understand abstract concepts or complex sentences and are more likely to have difficulties expressing basic needs and wants than people with a mild or borderline intellectual disability. The ability to communicate effectively with others is important for learning skills, achieving tasks, and gratifying social needs. Communication difficulties may result in isolation and possibly emotional problems. Communication, according to Brooks (1994) "...is a means of showing my concern and affection for others. It allows the wonder, doubt, hurt, joy and all the other emotions I feel inside to be expressed and shared...I learn, inform, persuade, request, beg indulgence, gain compliance, and win cooperation from others through the communication that takes place via my words and actions" (p. 109).

One of the more recent developments in the field of intellectual disability is the increasing use of augmentative communication techniques. Augmentative communication involves supports to supplement speech and thus enhance comprehension and expression. Supports may include objects (for example, holding a

cup when talking about a drink), graphics (including drawings, magazine pictures, or computer generated pictures which represent objects or concepts), sign language (non-verbal symbols), or electronic devices. Such supports are used in conjunction with speech, and provide additional perceptual input which may serve to enhance attention, facilitate recall, and aid the storage and retrieval of information (Dohrmann, 1994). The visual aspect of objects and pictures also increases interest and motivation, provides a specific reference point or stimulus, and contributes to the context and overall meaning of a message (Heller, Alberto & Ronski, 1995; Wright, 1989; Kaiser & Goetz, 1993). These aspects of augmentative aids increase the ability of a person with an intellectual disability to comprehend and express information and thus enhances the effectiveness of interactions.

Whilst augmentative communication may assist any person with an intellectual disability, such aids become increasingly useful for people who have significant communication disabilities, typically associated with severe intellectual disability. Turnell and Carter (1994) argue that augmentative communication offers the tools for people with a severe intellectual disability to express preferences, interact, make choices, and gain control over daily activities and events. "Speech alone may not represent a viable mode of communication for many students with severe and multiple disabilities" (p. 193). Thus, augmentative aids are chosen according to an individual's cognitive, social, expressive, and receptive communication abilities. For example, pictures are more abstract than real objects, so a person with a severe disability may

require objects rather than pictures to assist communication. On the other hand photographs or drawings may be used with people who have less severe disabilities.

Various studies have systematically supported the effectiveness of augmentative communication with children and adults with varying degrees of disability. For example, Heller et al. (1995) identified that augmentative systems such as using objects, increased the comprehension of children with an intellectual disability and enabled them to understand spoken instructions. March (1992) also found that using pictures when questioning adults with intellectual disabilities decreased the verbal loading of the question's meaning. Further, pictures produced a reduction in the need for interviewees to make a verbal response since they needed only point to a picture. The pictures also reduced the systematic response bias often associated with responses to verbal questions, and increased responsiveness, including the frequency of comments, gestures, and signs made by participants. The use of augmentative aids can produce effective changes within the everyday interaction of people with an intellectual disability.

The usefulness and validity of augmentative aids in counselling people with an intellectual disability can only be assumed at this stage. Research has clearly established the effectiveness of communication supports within everyday interactions, but not specifically within the counselling process. It is highly likely however, that this effectiveness will translate to counselling because counselling is in its essence,

interaction. If augmentative aids assist in the comprehension of concepts and expression of thoughts and feelings in everyday interaction, they may well do so in a counselling interaction. For example, the types of concepts discussed in counselling scenarios such as emotions may be made more concrete by using pictures such as faces displaying emotions. Augmentative aids then, theoretically allow for an increase in the number of situations in which counselling becomes viable. More abstract issues can be made meaningful with aids and people with severe communication disabilities can access counselling opportunities not previously available.

The positive effect of augmentative aids in aspects of everyday interactions with people who have an intellectual disability has been validated, as has the benefit of counselling techniques such as empathy and question types. However, the impact of using augmentative aids in counselling situations with people with disabilities merits investigation. The additional benefits of utilising augmentative communication in counselling scenarios, over and above counselling techniques, needs to be systematically explored through empirical studies.

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Augmentative Counselling with People who have an Intellectual Disability:

An evaluation of a resource kit

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Abstract

In recent years, augmentative communication techniques, such as the use of photographs and pictures along with speech, have been utilised by clinicians to increase the effectiveness of certain therapies. The present study investigated the effectiveness of augmentative techniques and a problem-solving process in counselling interactions compared to basic counselling skills. It was hypothesised that the training of support workers in the use of augmentative aids in the context of a problem-solving counselling approach would increase both counsellee and counsellor satisfaction with communication, and problem definition and resolution compared with basic counselling skills training that included non-verbal skills, active listening, empathy, and probing. Expected interactions did not occur, however expected trends in data were noted. Ratings on satisfaction of interactions for both counsellors and counsellees increased following supervisor training, as did supervisors' knowledge of augmentative communication and problem solving. Directions for future research are noted, including a larger sample size, increased training time, and a more sensitive measure of knowledge gained.

In the past, counselling has not been regarded as effective or indeed appropriate for people with an intellectual disability. It was argued that people with an intellectual disability were unable to use language to regulate their behaviour or to recognise the cause and effects of their behaviour (Pfadt, 1991). It was also believed that disabilities were due to brain damage and therefore psychotherapy would be ineffective (Pfadt, 1991). It has been only relatively recently that clinicians have begun to meet this challenge and to use counselling to assist people with an intellectual disability to resolve problems in living or to assist them to develop personal resources (Etherington, 1990). Furthermore, research has only recently suggested that this population may benefit from counselling in adjusting to stress and coping with changes, increasing independence, and managing complex emotional problems (Matson, 1984; Bramston & Bostock, 1994; Benson & Laman, 1985; Kishi, Teelucksingh, Zollers, Park-Lee, & Meyer, 1988).

Core counselling skills such as empathic responses are useful tools for beginning to support effectively people with an intellectual disability. The application of principles such as respect for the individual and skills such as active listening are crucial for developing an atmosphere where the client is comfortable discussing issues and where motivation for change can be enhanced (Egan, 1994). Professional counsellors are not the only individuals able to apply these skills. Carers or support workers can also learn such techniques in order to enhance communication with clients. Empathic responses, active listening, the use of non-verbal behaviour, and conveying warmth, are all skills that can be identified and systematically taught. For people who care for

or work with individuals who have an intellectual disability, such counselling skills can assist in the development of a relationship and in the effective provision of support (Walker, 1986; Berliner, 1986; McLennan, 1994; Robertson & Brown, 1992). Robertson and Brown (1992) argue that "...training in counselling techniques should be part of the education of all those who work directly with persons who have disabilities...(who) wish to communicate and provide support as effectively as possible" (p. 3).

As well as counselling skills, it can be argued that people who support individuals with an intellectual disability, also require processes to follow when counselling. Egan (1994) presents the view that counselling skills training without a process, leads to people knowing how to communicate, but not how to help. He suggests a problem-solving process as an effective procedure for assisting clients who have difficulties with daily living. This process involves specifically identifying the issue or problem, considering resolution options, choosing the most suitable option, and planning implementation. Such a process enables specific issues to be addressed and allows the client to direct solutions. Further, this process can increase the client's general problem-solving abilities (Egan, 1994). Elements of behavioural approaches may also suit the counselling needs of people with an intellectual disability. Behavioural approaches focus on changing overt behaviour rather than cognitions or feelings directly, and therefore may utilise role plays, demonstrations and other concrete observable techniques. Whereas counselling skills develop a therapeutic relationship and support change, behavioural techniques allow for "talking therapy" to become

“doing therapy”, thereby reducing the need for cognitive competence in consumers (Robertson & Brown, 1992).

Despite the now recognised need to apply counselling skills with people who have an intellectual disability, it can be a challenging process for the counsellor. Traditional counselling typically involves a situation where the counsellee identifies thoughts, behaviours, and emotions, recounts past events, expresses ideas, analyses meaning, and considers options. This process is undertaken using the spoken word and usually takes a significant period of time. For a person with an intellectual disability, such a process may be confusing and overwhelming. This is due to problems understanding language, particularly abstract concepts, recalling information, expressing thoughts, feelings and needs fluently, and understanding time sequences and settings (Brooks, 1994; Booth & Booth, 1996). Typically, difficulties solving problems, paying attention, and generally processing information also exist (Kail, 1992). Such problems result in a number of response error patterns including acquiescence which occurs when the client answers “yes” almost indiscriminately to questions (Sigelman, Budd, Spanhel, & Schoenrock, 1981; Jenkinson & Nelms, 1994). Such characteristics may render traditional counselling ineffective and unsatisfying for both counsellors and counsellees. Counsellors find it difficult to gather information and produce change in clients who are unable to problem solve and grasp abstract concepts effectively, or who respond affirmatively to most questions. Counsellees on the other hand, may find talking to someone who does not understand their communication needs and whom they cannot fully understand, overwhelming or pointless. The current challenge for

counsellors who provide services for people with an intellectual disability is to adapt traditional counselling techniques. Counsellors may also create viable alternatives that in fact meet the needs of individuals with varying abilities and disabilities and that thereby become effective and efficient means of assisting people with daily living issues.

Researchers and clinicians have identified specific techniques for enhancing the effectiveness of counselling for people with an intellectual disability. Such techniques include allowing time between questions and information giving for consumers to adequately process the verbal material, and allowing counselees to describe problems in their own words in order to aid comprehension and memory (Brown & Hughson, 1993; Kail, 1992). Altering language to simplify concepts can reduce client difficulties in comprehending abstract ideas and may eliminate the response biases that are often present (Brown & Hughson, 1993; Kail, 1992). Flexibility in the length of sessions as well as the setting for counselling are further beneficial considerations (DesNoyers Hurley, 1989).

DesNoyers Hurley (1989) argues that counselling must be tailored to the individual's cognitive and developmental level. This is not an argument many therapists would disagree with. However, the difficulty comes when a consumer presents with significantly reduced cognitive competence and it becomes clear that even the "simplest" verbal approach will not be effective. For counselees with moderate to severe intellectual disabilities, non-verbal techniques are essential (DesNoyers Hurley,

1989). Such techniques may include modified versions of appropriate play therapy, sign language, or the use of pictures or objects. Visual supports such as pictures increase the ability of a person who has an intellectual disability to comprehend and express information by providing a specific reference point or stimulus and by contributing to context and overall meaning (Heller, Alberto, & Ronski, 1995; Wright, 1989). Using such visual aids to support verbal interactions is termed “augmentative communication”. The type of augmentative aid utilised within interactions is dependent on the severity of the person’s communication disability. Real objects are more meaningful than pictures that are in turn of a more concrete nature than sign language. For example, when making a request to a person who has significant difficulties understanding everyday concepts such as brushing their hair, holding a hairbrush when speaking will increase the likelihood of the person comprehending the request. A person with a less severe disability may require only a picture of a hairbrush in order to understand the request.

In response to the increasing use of augmentative communication, an Australian company has developed computer generated line drawings or pictographs named COMPIC’s (COMPIC Development Association, 1992). Such pictures represent objects (for example, a bed), actions (such as kicking), emotions (as in a sad face), and processes (such as talking or running a meeting). For people who have the ability to understand pictures, COMPICs provide an easy to generate and simple option. Symbol systems such as COMPICs are both meaningful and easy to learn for people who have an intellectual disability (Kiernan, 1983). Because pictures assist people to

understand concepts in everyday interactions, it is likely that pictures will also assist counselling processes which are a special type of human interaction. If augmentative aids such as pictures assist people who have an intellectual disability to comprehend and express thoughts and feelings in everyday interaction, they may well do so in a counselling encounter. COMPICs can be used in conjunction with questions or statements from the counsellor in order to assist comprehension. For example, presenting COMPICs of “work”, “home”, “bus stop”, and “somewhere else” (a picture of a house with a question mark), whilst asking “Where were you when you lost your purse ?” may assist in question comprehension. The COMPICs also support the counsellee’s expressive difficulties by enabling a pointing response rather than a verbal answer. COMPICs then, theoretically allow for an increase in the number of situations in which counselling becomes viable, and allow for people with severe communication disabilities to benefit from counselling encounters.

The use of augmentative communication is a new area in the fields of both disability and counselling, compared with some older techniques. Research (e.g., Berliner, 1986) over the last two decades has led to an increase in the number of effective techniques available for counsellors working with people who have an intellectual disability. Such research (e.g., Walker, 1986; Brown et. al., 1993) has identified elements of person-centred and behavioural approaches to counselling as being effective. The utilisation of a problem-solving process and counselling skills such as empathy and active listening add to the proficiency of counsellors. Interactional techniques such as asking either-or questions and speaking less in counselling

sessions are further tools. However, the use of augmentative aids in counselling situations has not yet been systematically investigated. Photographs and drawings have been employed by clinicians in recent years in an attempt to increase the effectiveness of certain therapies such as the narrative approach (e.g., Clare & Grant, 1994), but the value of the aids themselves in the counselling context has not been the subject of research. This study therefore aimed to examine the effect of augmentative communication in combination with counselling techniques on problem-solving encounters between clients with intellectual disabilities and their support workers in vocational settings. It was hypothesised that the training of support workers in the use of augmentative aids in the context of a problem-solving counselling approach, would increase both counsellor and counsellor satisfaction with communication, and problem definition and resolution compared with basic counselling skills training that included non-verbal skills, active listening, empathy, and probing.

Method

Participants

Participants were 20 adults with an intellectual disability who worked in supported or open employment settings, and their 10 non-disabled supervisors. The 10 males and 10 females with intellectual disabilities were aged between 28 and 46, were capable of understanding computer pictographs (COMPICs) and were rated as having mild to moderate disabilities by their supervisors. The supervisors (2 females and 8 males) were aged between 29 and 52 years, and had worked in employment settings with

people who have an intellectual disability for between 1 and 11 years. Over 60% of supervisors had not had any specialist training in disability but had trade qualifications.

The settings for the study were supported and open employment organisations in the Hobart area where the majority of employees had an intellectual disability. Managers of seven such settings were approached regarding their employees' and supervisors' participation in the study. Consent was obtained from management in four of these settings (three supported and one open employment organisation). Employees of the organisations were then approached. Consent and information forms for employees were written and incorporated COMPICs to assist with comprehension. The study was verbally explained to all participants and then explained using a COMPIC information sheet. All participants were given the option of having an advocate assist them with the decision to participate. Thirteen of the 20 participants requested that a supervisor from work or home assist as an advocate. Two people who were approached declined to participate. Three other people were excluded from the study on the basis of not being able to understand COMPICs. Immediate supervisors of the employees were then approached for consent, with only one supervisor declining to participate. Between two and three supervisors participated in each organisational setting. The four employment settings were randomly assigned to either the augmentative counselling or comparison conditions. Employees with a disability were the counselees and supervisors acted as counsellors.

A pilot study was conducted prior to the evaluation in order to assess the validity of questionnaires for counselees. Ten employees from a separate supported employment organisation were approached for the pilot study. All ten consented and participated. A representative from an advocacy organisation assisted with consents from this group.

Materials

Questionnaires were designed to assess communication satisfaction and ease and satisfaction of problem definition and resolution. A five point Likert scale was used and participants with an intellectual disability were provided with questionnaires using COMPIC (see Appendix A). These questionnaires were validated using a video of a satisfying counselling session and an unsatisfying session. The 10 pilot study participants rated the segments using the questionnaire. Mean ratings of the two video segments adequately differentiated them as effective and ineffective counselling sessions in terms of client satisfaction with communication and ease and satisfaction of problem definition and resolution (see Appendix B).

A parallel form of the employee questionnaire was designed for supervisors, using a printed rather than COMPIC Likert rating scale, and employing slightly different question wording (Appendix C). The questions supervisors were asked to rate included: "It was difficult to understand what the client was telling me"; "The client found it easy to understand what I was saying"; "The issue was easy to identify"; "It was difficult to find a resolution to the issue", and "I am satisfied that the whole

problem has been identified and will be resolved". The questionnaires formed the primary data collection tool.

A training package was designed for supervisors. The training was carried out in two sessions within a week of each other, totalling five and a half to six hours. The package consisted of four sections: the characteristics of an intellectual disability; four counselling skills (non-verbal skills, active listening, empathy, and probing); augmentative communication, and use of a problem solving process and COMPICs in a kit form. Training included written notes, demonstrations of skills, and set role plays. A questionnaire was delivered pre-and post training in order to measure prior knowledge and knowledge gained from training for each of the training package sections (Appendix D).

Training for the augmentative counselling group involved instruction and practice in the use of a Counselling Resource Kit (CRK). This kit involved a problem solving process - a framework for counsellors to apply in counselling situations. The process involved a series of questions which could be used to assist in the identification of issues and solutions (Appendix E). The kit also included a set of COMPIC cards which represented questions and potential responses. For example, the section on feelings had a question "How do you feel ?" printed in COMPIC and then a series of cards with faces displaying varying emotions. The comparison group did not receive a copy of or instruction in use of this kit.

Procedure

Prior to random allocation to augmentative counselling or comparison groups, a meeting was held with supervisors on each work site. The target issues for filling out questionnaires were agreed upon. They were issues commonly encountered in the workplace where joint problem solving between employee and supervisor was required. For example, it was decided with Mary from organisation A that every time she arrived at work crying and wanting to talk to her supervisor (which occurred approximately three times a week), a questionnaire would be completed after the interaction.

Participants with an intellectual disability were then introduced to a research assistant (qualified clinical psychologist) who was unaware of group allocation. Following each identified interaction, the supervisor completed a questionnaire and notified the research assistant. The assistant then supported the employee to complete the questionnaire rating their satisfaction with communication and outcomes in the recent interaction with their supervisor. The counsellee was not asked specific questions about the issue or problem discussed, merely satisfaction with communication and outcomes. The questionnaire was completed in a private room and the assistant read the questions to the counsellees who looked at the question concurrently in COMPIC. A verbal answer was obtained from the participant and then matched with the appropriate rating. For example, if counsellees acquiesced, for example answered “yes” to the question “How well did you understand Bill?”, or answered inappropriately for ratings, they were asked to fine tune the response to either “well” or “very well”. Immediately prior to each questionnaire completion, a series of

questions in a similar format were asked of the participant. These questions were designed to produce a variety of responses allowing the counsellee practice in using both extremes of the rating scale. These practice questions were thus designed to counteract any acquiescence effect. Pre-training data collection was conducted for a period of 3 to 7 weeks.

A training phase followed with each group of supervisors receiving six hours of training from the author over two sessions within a week. Comparison group and augmentative counselling group training occupied the same amount of time despite the different content. The augmentative counselling group received instruction in the characteristics of an intellectual disability and the potential impact of such a disability on an individual's life. Four counselling skills were presented: use of non-verbals, active listening, empathy, and probing. A session examining augmentative supports followed. Training in the use of such aids in counselling situations as well as a problem-solving process using the Counselling Resource Kit concluded sessions. Supervisors received written information and each aspect of training involved demonstrations of skills and set role plays for the group to practice the new skills. The comparison group received identical written information, demonstrations and training role plays but only pertaining to the characteristics and impact of an intellectual disability and the four counselling skills. The augmentative counselling training was offered to comparison group participants at the conclusion of the evaluation.

Knowledge gained in training was evaluated using questionnaires with sections pertaining to each aspect of the training. All four of the sections of the knowledge questionnaire were administered pre-and post training to the augmentative counselling group. The first two sections were administered to the comparison group, because they related directly to the information given in training. The final two sections were administered post-training only to this group in order to measure knowledge of augmentative communication and problem solving despite training not given in these areas. A post-training data collection period of three to five weeks followed with questionnaires again being completed after problem-solving encounters between staff and clients. The issues for which questionnaires were completed were then rated by two naive counsellors, experienced in counselling adults with an intellectual disability. The issues were rated on a five point Likert scale for both severity of problem and the difficulty such an issue would present for counselling.

Results

Data were collated from the counsellee and counsellor questionnaires by allocating a number from one to five for each rating option. Higher numbers indicated increased satisfaction with communication and problem solving. Means were calculated for each question as well as a grand mean from the total of 5 questions completed per participant. The knowledge questionnaire administered pre-and post training to counsellors was comprised of four sections: operational knowledge of an intellectual disability; counselling skills; augmentative communication; and the Counselling

Resource Kit. For each of the four sections, participants received a score out of five. This score was determined by evaluating responses against the written training information presented. Each question was awarded a score of 1 or 0.

Data were analysed using the computer package, CSS Statistica. Two-way Analysis of Variance (ANOVAs) were performed on each of the five questions within the questionnaires, as well as for the overall means of counsellor and counsellee ratings. Thus the augmentative counselling and comparison groups were contrasted on pre-training and post-training measures. Table 1 shows the means for counsellee question responses for both augmentative counselling and comparison groups, pre-and post training.

Table 1
Means and Standard Deviations of Pre-and Post-Training Ratings of Satisfaction with Communication and Ease and Satisfaction with Problem Solving for Augmentative Counselling (n=10) and Comparison Group Counselees (n=10)

Augmentative Counselling Group					Comparison Group		
		Pre Training	Post Training		Pre Training	Post Training	
*Question							
1	<i>M</i>	4.40	4.20	<i>ns</i>	4.65	5.00	<i>ns</i>
	<i>SD</i>	.55	1.3		.44	.00	
2	<i>M</i>	3.84	4.00	<i>ns</i>	4.59	4.63	<i>ns</i>
	<i>SD</i>	1.31	1.00		.49	.52	
3	<i>M</i>	4.36	4.40	<i>ns</i>	4.45	4.47	<i>ns</i>
	<i>SD</i>	1.32	.55		.43	.71	
4	<i>M</i>	4.42	4.40	<i>ns</i>	4.34	4.75	<i>ns</i>
	<i>SD</i>	.62	.54		.47	.46	
5	<i>M</i>	4.56	4.72	<i>ns</i>	4.43	4.50	<i>ns</i>
	<i>SD</i>	.72	.55		.47	.62	
Q 1-5	<i>M</i>	4.46	4.48	<i>ns</i>	4.40	4.73	<i>ns</i>
	<i>SD</i>	.90	.79		.46	.46	

Note. *Q1 = “How well did the (staff) understand your worry?” Q2 = “How well did you understand (staff)?” Q3 = “Was it easy to tell (staff) your worry?” Q4 = “ How well did you understand how to fix the worry?” Q5 = “How do you feel about the worry now?”
ns = $p > .05$

Analysis revealed no significant main effects or interactions ($p > .05$) for any of the five questions answered by counselees, or for the mean rating over all five questions. See Table 2 (also see Appendix F for details).

Table 2

Summary Analysis of Variance Results for Pre and Post Training Ratings of

Satisfaction with Communication and Ease and Satisfaction with Problem-Solving for

Augmentative Counselling (n = 10) and Comparison Group Counselees (n = 10) for

Questions 1 - 5

	Group			Time			Group x Time		
*Question	<i>F</i>	<i>df</i>	<i>p</i>	<i>F</i>	<i>df</i>	<i>p</i>	<i>F</i>	<i>df</i>	<i>p</i>
1	2.97	1,11	.11	.12	1,11	.73	1.66	1,11	.22
2	2.82	1,11	.12	.21	1,11	.66	.08	1,11	.78
3	.46	1,11	.51	.33	1,11	.57	.19	1,11	.67
4	.43	1,11	.53	.88	1,11	.37	1.07	1,11	.32
5	.62	1,11	.45	1.88	1,11	.20	.90	1,11	.36
1-5	.19	1,11	.67	2.23	1,11	.16	1.75	1,11	.21

Note. *Q1 = “How well did the (staff) understand your worry?” Q2 = “How well did you understand (staff)?” Q3 = “Was it easy to tell (staff) your worry?” Q4 = “ How well did you understand how to fix the worry?” Q5 = “How do you feel about the worry now?”

The ratings reveal a ceiling effect both before and after training, with means that are very close to the maximum Likert value of five on each scale. Thus, the pre-training ratings allow little room for any post-training increases. Table 3 shows corresponding data for counsellors.

Table 3

Means and Standard Deviations of Pre-and Post-Training Question Ratings of Satisfaction with Communication and Problem-Solving for Augmentative Counselling and Comparison Group Counsellors (n=10)

		Augmentative Counselling Group		Comparison Group	
		Pre Training	Post Training	Pre Training	Post Training
Question					
1*	<i>M</i>	2.63	3.50 <i>ns</i>	3.22	3.74 <i>ns</i>
	<i>SD</i>	.48	.58	.91	1.41
2*	<i>M</i>	3.93	4.13 <i>ns</i>	3.40	3.96 <i>ns</i>
	<i>SD</i>	.43	.25	.43	.29
3*	<i>M</i>	3.50	3.63 <i>ns</i>	3.76	3.94 <i>ns</i>
	<i>SD</i>	.91	.48	.75	.72
4*	<i>M</i>	3.00	3.25 <i>ns</i>	3.06	4.20 <i>ns</i>
	<i>SD</i>	1.15	.96	.49	.84
5*	<i>M</i>	3.68	3.50 <i>ns</i>	3.14	4.00 <i>ns</i>
	<i>SD</i>	.62	.41	.96	.71
Q 1-5	<i>M</i>	3.48	3.60 <i>ns</i>	3.32	3.96 <i>ns</i>
	<i>SD</i>	.26	.41	.51	.67

Note. *Q1= "It was difficult to understand what the client was telling me" *Q2 = "The client found it easy to understand what I was saying" *Q3 = "The issue was easy to identify" *Q4= " It was difficult to find a resolution to the issue" *Q5 = "I am satisfied that the whole problem has been identified and will be resolved"

ns = $p > .05$

Here analysis again revealed no significant interactions for any of the five questions or for the mean ratings on all five questions. There was a main effect $F(1,7) = 5.64$, $p < .05$, for time in the case of Question 2 "The client found it easy to understand what I was saying". Here, both augmentative counselling and comparison groups

showed an increased perception that they were better understood after ($M = 3.66$) than before ($M = 4.04$) training. See Table 4 (also see Appendix G for details).

Table 4

Summary Analysis of Variance Results for Pre and Post Training Ratings of Satisfaction with Communication and Ease and Satisfaction with Problem-Solving for Augmentative Counselling and Comparison Group Counsellors (n = 10) for Questions 1 - 5

*Question	Group			Time			Group x Time		
	<i>F</i>	<i>df</i>	<i>p</i>	<i>F</i>	<i>df</i>	<i>p</i>	<i>F</i>	<i>df</i>	<i>p</i>
1	.911	1,7	.37	2.17	1,7	.18	.14	1,7	.72
2	3.59	1,7	.10	5.64	1,7	.04	1.27	1,7	.30
3	.85	1,7	.39	.16	1,7	.70	.01	1,7	.94
4	1.13	1,7	.32	4.27	1,7	.08	1.75	1,7	.23
5	.00	1,7	.95	.72	1,7	.42	1.64	1,7	.24
1-5	.43	1,7	.53	1.65	1,7	.24	.75	1,7	.42

Note: *Q1= “It was difficult to understand what the client was telling me” *Q2 = “The client found it easy to understand what I was saying” * Q3 = “The issue was easy to identify” * Q4= “ It was difficult to find a resolution to the issue” *Q5 = “I am satisfied that the whole problem has been identified and will be resolved”

An ANOVA and *t*-tests for unrelated samples were carried out to investigate the effects of training on supervisors' knowledge of counselling and augmentative communication issues. An ANOVA for the first two sections of the training knowledge pre-and post-training for both groups was performed. No significant main effects for group $F(1,8) = 2.69, p > .05$ or time $F(1,8) = .10, p > .05$ were found. Furthermore, there were no significant interactions $F(1,8) = 1.00, p > .05$ (See Appendix H for details). Additionally, *t* values for related samples were calculated to compare pre-and post-training knowledge for the augmentative counselling group on the final two sections of the questionnaire, $t(1,5) = 2.63$. Further, to compare post-training responses on these two final questionnaire sections across the groups, *t*-tests for unrelated samples were carried out, $t(2,5) = 1.13$. The means for these analyses appear in Table 5. No significant differences ($p > .05$) were found for any of the comparisons.

Table 5
Means and Standard Deviations for Scores Obtained on the Knowledge
Questionnaire Administered to Counsellors

		Augmentative Counselling Group		Comparison Group	
		Pre Training	Post Training	Pre Training	Post Training
<hr/>					
*Questionnaire					
1 & 2	<i>M</i>	7.80	8.40 <i>ns</i>	9.20	9.20 <i>ns</i>
	<i>SD</i>	1.48	1.51	.45	.84
3 & 4	<i>M</i>	5.00	8.00 <i>ns</i>	-	7.20
	<i>SD</i>	2.24	1.22	-	1.30

Note. *Sections 1 & 2 = knowledge of definition of intellectual disability and counselling skills
 Sections 3 & 4 = knowledge of augmentative communication and counselling resource kit
ns = $p > .05$

A number of trends can be noted from the data. Post-training scores are consistently higher than pre-training scores, despite a lack of significant difference between the means.

Pearsons r was calculated to investigate possible gender and age effects on counsellor and counsellor ratings. Years of work and level of training were also correlated with counsellor ratings. Correlations examining the possible effects of gender and age on both counsellor and counsellor ratings, revealed data trends but no significant ($p > .05$) r values. However, coefficients suggest that older counsellors and counsellors tended to rate counselling encounters more favourably and female counsellors rated the encounters more favourably than did males. Correlations of years worked and

specialist disability training for counsellors with ratings revealed significance ($p > .05$) for years of work and training indicating that new workers have received more specialist training than more experienced workers. These data are displayed in Tables 6 and 7.

Table 6
Correlation of Counsellor Characteristics, and Counsellor Pre-Training Ratings of Ease and Satisfaction with Counselling Encounters for (n=10) male and female counsellors

	Pre-training mean of all question ratings	*Gender	*Age	*Specialist Training	Years Worked
Pre-Training mean of all question ratings	1				
Gender	-.06	1			
Age	.40	-.08	1		
Specialist Training	.50	-.61	-.05	1	
Years Worked	.16	-.43	.46	.64*	1

Note. * = $p < .05$
*Gender = females coded as 1, males as 2
*Age = age in years
*Specialist training = = < 2 weeks, 2 = >2 weeks

Table 7
Correlation of Counsellee Characteristics, and Counsellee Pre- and Post-Training Ratings of Ease and Satisfaction with Counselling Encounters for male (n = 10) and female (n = 10) counsellors

	*Gender	*Age	Pre-training mean of all question ratings	Post-training mean of all question ratings
Gender	1			
Age	.27	1		
Pre-Training mean of all question ratings	-.20		.49	1
Post-Training mean of all question ratings	-.42		.45	.50

Note. *Gender = females coded as 1, males as 2
*Age = age in years

Discussion

This study hypothesised that the training of support workers in the use of augmentative aids in the context of a problem-solving counselling approach, would increase both counsellee and counsellor satisfaction with communication, and problem definition and resolution, compared with basic counselling skills training. This expected interaction between temporal and group effects was not found, with non-significant ANOVA results. A number of explanations may be considered in accounting for this result. It is possible that training counsellors in counselling

techniques does not actually increase the satisfaction of counsellors and counselees with problem-solving and communication. This however, does not fit with prior research on the effects of counselling (Egan, 1994; Robertson & Brown, 1992). An alternative explanation for the non-significant result focuses on the sensitivity of the satisfaction rating scales. A pilot study confirmed the validity of the counsellor questionnaire for counselling scenarios at the extremes of satisfaction. However, it is possible that questionnaires for both counselees and counsellors were not sensitive to measuring less extreme counselling encounters. Alternatively, the questionnaires may have indicated a ceiling effect, whereby satisfaction was so high pre-training that the training did not provide any additional benefits. It is also possible that counsellors did not actually implement the techniques covered in the training sessions and therefore no change in satisfaction levels could be noted. The finding by interview that the comparison group knew just as much about augmentative communication as the augmentative counselling group, despite the topic not being covered in training, may further account for the lack of significant results.

Despite non-significant interactions for ratings, a consistent trend in both counsellor and counsellor data towards higher post-training ratings on all questions, was revealed. Although statistically non-significant, trends are in the expected direction: it was expected that there would be some improvement across all measures of satisfaction with communication, problem definition, and resolution following training for counsellors. The small number of participants may well have contributed to the effect being a trend rather than a significant effect and with a larger number of

participants, this trend may have reached significance. However a ceiling effect in the data was noted at pre-training, with ratings in the upper range of the scale of one to five for both counsellors and counselees. This effect indicates that employees and supervisors were either relatively satisfied with communication and problem solving prior to intervention, or that the questionnaire was not sufficiently detailed or sensitive to gauge more subtle post-training attitudes. The high pre-training ratings for counselees may also be partly explained by an acquiescence effect. Despite an independent assistant and practice questions aimed at decreasing acquiescence effects, the tendency of people with an intellectual disability to answer affirmatively, or positively rather than negatively may have been too strong (Cummins, 1993; Jenkinson & Nelms, 1994; Sigelman et al., 1981).

A main effect for Question 2 “The client found it easy to understand what I was saying” in the counsellor data indicates that both augmentative counselling and comparison groups perceived an increase in counsellee’s comprehension following training. This indicates that both groups were positively affected by the training and believed that changes had occurred in their interactions with counselees, leading counselees to comprehend information more readily. The lack of confirmation of this result in counsellee ratings, suggests that either this perceived change did not actually translate to counselees, or that the rating scale for counselees was not sensitive enough to measure these subtle effects.

In order to further investigate the non-significant interaction from ratings, ANOVA and *t*-test analysis of questionnaires aimed at measuring knowledge gained through training were performed. These also failed to show significant results. A trend is however noted for the augmentative counselling groups for the second sections of the questionnaire pre-and post training. This group scored higher on the post training measure, indicating that knowledge was apparently gained but that the effect did not reach significance, again possibly as a consequence of a small number of participants. The comparison group was also assessed for knowledge of augmentative communication and problem-solving process as a post training measure. The results suggest that by the end of the training period, both groups had a similar knowledge of this area, despite the comparison group not receiving any training in the techniques. An informal interview confirmed this finding, revealing that both comparison groups had received interventions from speech pathologists and psychologists emphasising the use of augmentative aids and a problem solving process, within the last eighteen months. An additional explanation for such results may be that like the rating questionnaire, the questionnaire developed for assessing such knowledge lacked sufficient sensitivity and depth.

In the analysis of factors that may have moderated the results, non-significant differences in the mean ratings for severity of issues and difficulty for counselling indicates that neither group differed, either pre or post-training, in regard to the problematic nature of the counselling encounter for counsellors and counselees. Therefore these factors have not influenced outcomes.

Correlations for age showed that older counsellors and counselees tended to rate counselling sessions more favourably than their younger counterparts. The possibility of age and experience contributing to communication and problem solving may be worthy of further study. Further correlations revealed that counsellors who had access to more specialist training in disability tended to rate counselling situations less favourably than did counsellors with less training. It is possible that an increase in knowledge about disability leads to an increased awareness of the difficulties in communication with people who have an intellectual disability and thus a more pessimistic (or realistic) perception of client comprehension. Future communication or counselling training should consider the impact prior training in disability may have on perceptions of client understanding.

A further explanation for the non-significant difference between pre-and post-training results between groups relates to the training itself. Despite utilising techniques such as role plays which are effective methods for learning new skills, the length of training was perhaps insufficient considering the amount of material that had to be covered.

For many of the counsellors who had been trained as tradesmen and who had no formal training in disability, the topics covered were novel and challenging.

McLennan (1994) claims that counselling training should be conducted in a minimum of 10 hours and that there should be a sufficient spread between training sessions in order to allow for generalisation and skills internalisation.

This study aimed to investigate the additional effects of augmentative communication in counselling scenarios by comparing augmentative counselling and comparison groups. The direct impact of supervisor training on people with an intellectual disability was measured and a combination of knowledge and attitudinal factors were investigated. Whilst consistent trends in the direction of hypothesis were noted in the question responses of both counselees and counsellors, further research is required to confirm such trends. Future investigations may involve a larger group of participants, a more sensitive measure of knowledge gained in training, plus an increase in training time. Clearly defining the effects of counselling itself, by including a true control group who do not receive training of any sort would also provide a realistic baseline for comparison purposes. This was not possible in the present study due to the small population of Hobart and the difficulty in finding sufficient numbers of participants for a three group design. Multiple methods for assessing training outcomes as well as self-report or observation procedures for determining what techniques counsellors actually implement following training may also shed further light on the value of augmentative counselling with people who have an intellectual disability.

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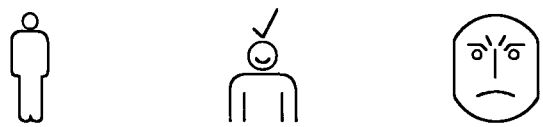
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Appendix A

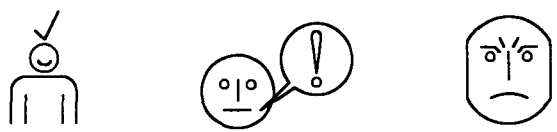
**Counselee Questionnaire Measuring Communication Satisfaction and Ease and
Satisfaction of Problem Definition and Resolution.**



1. How well did (supervisor) understand your worry ?



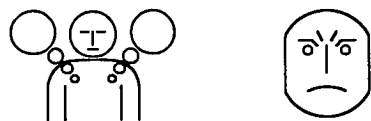
2. How well did you understand (supervisor) ?



3. Was it easy to tell (supervisor) your worry ?



4. How well did you understand how to fix the worry ?



5. How do you feel about the worry now ?

Appendix B

Mean Scores on Counsellee Questionnaires Following Video Viewing of Satisfying and
Unsatisfying Counselling Sessions (n=9)

		Satisfying session	Unsatisfying session
*Question			
1	<i>M</i>	4.44	1.56
2	<i>M</i>	4.22	1.44
3	<i>M</i>	4.56	2.11
4	<i>M</i>	4.78	1.44
5	<i>M</i>	3.56	1.22
Q 1-5	<i>M</i>	4.31	1.55

Note: *Q1 = How well did the staff understand the girl's worry ? Q2 = How well did the girl understand the staff ? Q3 = Was it easy for the girl to tell the staff her worry ? Q4 = Did the girl know how to fix her worry ? Q5 = How did the girl feel about the worry in the end ?

Higher numbers denote more favourable ratings

Appendix C

Counsellor Questionnaire Measuring Communication Satisfaction and Ease and Satisfaction of Problem Definition and Resolution

1) It was difficult to understand what the client was telling me

strongly agree agree unsure disagree strongly disagree

2) The client found it easy to understand what I was saying

strongly agree agree unsure disagree strongly disagree

3) The issue was easy to identify

strongly agree agree unsure disagree strongly disagree

4) It was difficult to find a resolution to the issue

strongly agree agree unsure disagree strongly disagree

5) I am satisfied that the whole problem has been identified and will be resolved

strongly agree agree unsure disagree strongly disagree

Appendix D

Pre-and Post-Training Knowledge Questionnaire Administered with Counsellors

PART A

1. THE MOST IMPORTANT ELEMENT IN COUNSELLING IS:

(CHOOSE ONE)

- A) TALKING TO PEOPLE ☐
- B) SUPPORTING CLIENTS TO SOLVE THEIR PROBLEMS MORE EFFECTIVELY ☐
- C) TELLING CLIENTS HOW TO DO THINGS ☐

2. THE DEFINITION OF AN INTELLECTUAL DISABILITY IS:

(CHOOSE ONE)

- A) BEING UNABLE TO DRIVE A CAR. ☐
- B) BEING AGGRESSIVE ☐
- C) HAVING A SIGNIFICANTLY LOW LEVEL OF INTELLECTUAL FUNCTIONING, PLUS DIFFICULTIES LIVING INDEPENDENTLY, ALL OF WHICH OCCURRED WHILST GROWING UP ☐

3. HAVING AN INTELLECTUAL DISABILITY MEANS HAVING PARTICULAR DIFFICULTIES. NAME 2 THINGS A PERSON WITH AN INTELLECTUAL DISABILITY MAY FIND DIFFICULT (E.G. REMEMBERING THINGS):

1. _____

2. _____

4. JUST BECAUSE SOMEONE HAS AN INTELLECTUAL DISABILITY DOESN'T NECESSARILY MEAN THEY NEED COUNSELLING. HOWEVER, SOMETIMES COUNSELLING CAN ASSIST PEOPLE WITH AN INTELLECTUAL DISABILITY TO: (FILL IN THE BLANK E.G. *EXPRESS THEMSELF BETTER*)

5. NAME 3 DIFFICULTIES THAT A PERSON MAY HAVE THAT MAY BE SOLVED THROUGH COUNSELLING: (E.G. *EXPERIENCING PAIN, FEELING WORRIED ABOUT NEW STAFF MEMBER AT HOME.*)

1. _____
2. _____
3. _____

PART B.

1. PEOPLE USUALLY HAVE TO FEEL COMFORTABLE WITH SOMEONE BEFORE THEY CAN DISCUSS THEIR PROBLEMS. (TRUE OR FALSE)

TRUE ☐

FALSE ☐

2. RESPECT MEANS: (CHOOSE ONE)

A) BEING NICE ☐

B) VALUING SOMEONE FOR WHO THEY ARE ☐

3. COUNSELLING CAN ASSIST PEOPLE TO SOLVE PROBLEMS BY:

(CHOOSE APPROPRIATE ANSWER)

A) SUPPORTING THE CLIENT TO SOLVE THE ISSUE ☐

B) FIXING THE PROBLEM FOR THE PERSON ☐

4. EMPATHY MEANS UNDERSTANDING THE PERSON'S POINT OF VIEW.

(TRUE OR FALSE)

TRUE ☐

FALSE ☐

5. YOU SHOULD ATTEMPT TO GAIN A CLEAR AND SPECIFIC PICTURE OF WHAT THE PERSON'S CONCERN IS ABOUT. VAGUE PROBLEMS LEAD TO VAGUE AND INEFFECTIVE SOLUTIONS. (TRUE OR FALSE)

TRUE ☐

FALSE ☐

PART C

1. NAME THREE WAYS WE COMMUNICATE, NOT INCLUDING SPEECH (E.G. SIGNING).

1. _____

2. _____

3. _____

2. PEOPLE WHO HAVE AN INTELLECTUAL DISABILITY USUALLY:

A) CAN UNDERSTAND EVERYTHING YOU SAY TO THEM

☐

B) HAVE GREAT DIFFICULTY UNDERSTANDING WHAT YOU SAY TO THEM

☐

C) HAVE A LITTLE DIFFICULTY UNDERSTANDING WHAT YOU SAY TO THEM

☐

3. WHEN PEOPLE ARE STRESSED, THEIR ABILITY TO COMMUNICATE:

- A) STAYS THE SAME
- B) IMPROVES
- C) IS REDUCED

4. FILL IN THE BLANK. “IT IS MUCH EASIER TO UNDERSTAND SOMEONE IF THEY USE A LOT OF _____ COMMUNICATION AS WELL AS SPEECH”.

5. NAME 2 DIFFERENT WAYS OF ASKING PEOPLE QUESTIONS. (E.G. OFFER THEM A CHOICE “WAS IT _____ OR _____ ?”)

1. _____
2. _____

PART D.

1. WHAT IS A PROBLEM SOLVING APPROACH ?

2. IT IS USEFUL TO INVESTIGATE WHAT THE PERSON WANTS TO DO ABOUT THEIR PROBLEM WHEN COUNSELLING.

(TRUE OR FALSE):

TRUE ☐

FALSE ☐

3. PEOPLE WHO CAN SPEAK MAY STILL BENEFIT FROM USING PICTURES IN COUNSELLING SITUATIONS.

(TRUE OR FALSE):

TRUE ☐

FALSE ☐

4. ASKING A CLIENT TO TALK ABOUT THE ISSUE WITH SOMEONE ELSE IS A FORM OF RESOLVING THE IMMEDIATE CONCERN.

(TRUE OR FALSE):

TRUE ☐

FALSE ☐

5. "COUNSELLING" DOESN'T NECESSARILY HAVE TO TAKE PLACE IN PRIVATE ROOM.

(TRUE OR FALSE):

FALSE ☐

TRUE ☐

Appendix E

Problem Solving Process for Identifying and Resolving Everyday Issues

IDENTIFY THE PROBLEM**CLARIFY THE SITUATION**

- WHO
- WHAT
- WHERE
- WHEN
- HOW
- WHY (UNDERSTANDINGS, MOTIVATIONS)

**INDIVIDUAL'S RESPONSE**

- HOW THEY FEEL
- THEIR EXPLANATIONS, THOUGHTS
- WHAT THEY WANT TO DO ABOUT IT -
SEE CHANGED

**BRAINSTORM POSSIBLE SOLUTIONS****CHOOSE THE BEST ONE****PUT INTO ACTION**

Appendix F

Sums of Squares and Mean Square Values for Analyses of Variance of Pre and Post
Training Ratings of Satisfaction with Communication and Ease and Satisfaction with
Problem-Solving for Counselees for Questions 1 - 5

Table 1
Analysis of Variance of Counsellee Ratings of Counsellor Comprehension (Q1)

Source of Variation	<i>df</i>	Sum of Squares	Mean Square	<i>F</i>	<i>p</i>	Sig
Groups (G)	1	1.70	1.70	2.97	.11	<i>ns</i>
Error	11	6.28	.57			
Time (T)	1	.03	.03	.12	.73	<i>ns</i>
Error	11	3.08	.28			
G x T	1	.47	.47	1.66	.22	<i>ns</i>
Error	11	3.08	.28			

Note: Group (G) = augmentative counselling and comparison groups. Time (T) = pre-training and post-training.

Table 2
Analysis of Variance of Counsellee Ratings of Own Understanding (Q2)

Source of Variation	<i>df</i>	Sum of Squares	Mean Square	<i>F</i>	<i>p</i>	Sig
Groups (G)	1	2.90	2.90	2.82	.12	<i>ns</i>
Error	11	11.30	1.03			
Time (T)	1	.06	.06	.21	.66	<i>ns</i>
Error	11	3.18	.29			
G x T	1	.02	.02	.08	.78	<i>ns</i>
Error	11	3.18	.29			

Note: Group (G) = augmentative counselling and comparison groups. Time (T) = pre-training and post-training.

Table 3
Analysis of Variance of Counsellee Ratings of Ease of Communication (Q3)

Source of Variation	<i>df</i>	Sum of Squares	Mean Square	<i>F</i>	<i>p</i>	Sig
Groups (G)	1	.30	.30	.46	.51	<i>ns</i>
Error	11	7.07	.64			
Time (T)	1	.18	.18	33	.58	<i>ns</i>
Error	11	5.91	.54			
G x T	1	.10	.10	.19	.67	<i>ns</i>
Error	11	5.91	.54			

Note: Group (G) = augmentative counselling and comparison groups. Time (T) = pre-training and post-training.

Table 4
Analysis of Variance of Counsellee Ratings of Ease of Problem Solving (Q4)

Source of Variation	<i>df</i>	Sum of Squares	Mean Square	<i>F</i>	<i>p</i>	Sig
Groups (G)	1	.11	.11	.43	.53	<i>ns</i>
Error	11	2.83	.26			
Time (T)	1	.24	.24	.88	.37	<i>ns</i>
Error	11	2.96	.27			
G x T	1	.29	.29	1.07	.32	<i>ns</i>
Error	11	2.96	.27			

Note: Group (G) = augmentative counselling and comparison groups. Time (T) = pre-training and post-training.

Table 5
Analysis of Variance of Counsellor Ratings of Satisfaction with Problem Solving (Q5)

Source of Variation	<i>df</i>	Sum of Squares	Mean Square	<i>F</i>	<i>p</i>	Sig
Groups (G)	1	.48	.48	.63	.45	<i>ns</i>
Error	11	8.39	.76			
Time (T)	1	.41	.41	1.88	.20	<i>ns</i>
Error	11	2.41	.22			
G x T	1	.20	.20	.90	.36	<i>ns</i>
Error	11	2.41	.22			

Note: Group (G) = augmentative counselling and comparison groups. Time (T) = pre-training and post-training.

Table 6
Analysis of Variance of Counsellor Ratings on all Measures of Satisfaction with Communication and Ease and Satisfaction with Problem Solving (Q1 - 5)

Source of Variation	<i>df</i>	Sum of Squares	Mean Square	<i>F</i>	<i>p</i>	Sig
Groups (G)	1	.05	.05	.19	.67	<i>ns</i>
Error	11	3.05	.28			
Time (T)	1	.18	.18	2.23	.16	<i>ns</i>
Error	11	.90	.08			
G x T	1	.14	.14	1.75	.21	<i>ns</i>
Error	11	.90	.08			

Note: Group (G) = augmentative counselling and comparison groups. Time (T) = pre-training and post-training.

Appendix G

**Sums of Squares and Mean Square Values for Analyses of Variance of Pre and Post
Training Ratings of Satisfaction with Communication and Ease and Satisfaction with
Problem Solving for Counsellors for Questions 1 - 5**

Table 1
Analysis of Variance of Counsellor Ratings of Own Comprehension (Q1)

Source of Variation	<i>df</i>	Sum of Squares	Mean Square	<i>F</i>	<i>p</i>	Sig
Groups (G)	1	.77	.77	.91	.37	<i>ns</i>
Error	7	5.95	.85			
Time (T)	1	2.16	2.16	2.17	.18	<i>ns</i>
Error	7	6.98	.99			
G x T	1	.14	.14	.14	.72	<i>ns</i>
Error	7	6.98	1.00			

Note: Group (G) = augmentative counselling and comparison groups. Time (T) = pre-training and post-training.

Table 2
Analysis of Variance of Counsellor Ratings of Counsellee Comprehension (Q2)

Source of Variation	<i>df</i>	Sum of Squares	Mean Square	<i>F</i>	<i>p</i>	Sig
Groups (G)	1	.53	.53	3.59	.10	<i>ns</i>
Error	7	1.03	.15			
Time (T)	1	.64	.64	5.64	.04	
Error	7	.80	.11			
G x T	1	.14	.14	1.27	.30	<i>ns</i>
Error	7	.80	.11			

Note: Group (G) = augmentative counselling and comparison groups. Time (T) = pre-training and post-training.

Table 3
Analysis of Variance of Counsellor Ratings of Counsellee Comprehension (Q3)

Source of Variation	<i>df</i>	Sum of Squares	Mean Square	<i>F</i>	<i>p</i>	Sig
Groups (G)	1	.37	.37	.85	.39	<i>ns</i>
Error	7	3.03	.43			
Time (T)	1	.10	.10	.16	.70	<i>ns</i>
Error	7	4.48	.64			
G x T	1	.00	.00	.01	.94	<i>ns</i>
Error	7	4.48	.64			

Note: Group (G) = augmentative counselling and comparison groups. Time (T) = pre-training and post-training.

Table 4
Analysis of Variance of Counsellor Ratings of Ease of Problem Solving (Q4)

Source of Variation	<i>df</i>	Sum of Squares	Mean Square	<i>F</i>	<i>p</i>	Sig
Groups (G)	1	1.13	1.13	1.13	.32	<i>ns</i>
Error	7	7.00	1.00			
Time (T)	1	2.15	2.15	4.27	.08	<i>ns</i>
Error	7	3.52	.50			
G x T	1	.88	.88	1.75	.23	<i>ns</i>
Error	7	3.52	.50			

Note: Group (G) = augmentative counselling and comparison groups. Time (T) = pre-training and post-training.

Table 5
Analysis of Variance of Counsellor Ratings of Satisfaction with Problem Solving (Q5)

Source of Variation	<i>df</i>	Sum of Squares	Mean Square	<i>F</i>	<i>p</i>	Sig
Groups (G)	1	.00	.00	.00	.95	<i>ns</i>
Error	7	2.30	.33			
Time (T)	1	.52	.52	.72	.42	<i>ns</i>
Error	7	5.08	.76			
G x T	1	1.19	1.19	1.64	.24	<i>ns</i>
Error	7	5.08	.73			

Note: Group (G) = augmentative counselling and comparison groups. Time (T) = pre-training and post-training.

Table 6
Analysis of Variance of Counsellor Ratings on all Measures of Satisfaction with Communication and Ease and Satisfaction with Problem Solving (Q 1 - 5)

Source of Variation	<i>df</i>	Sum of Squares	Mean Square	<i>F</i>	<i>p</i>	Sig
Groups (G)	1	.05	.05	.43	.53	<i>ns</i>
Error	7	.77	.11			
Time (T)	1	.65	.65	1.65	.24	<i>ns</i>
Error	7	2.76	.39			
G x T	1	.29	.29	.75	.42	<i>ns</i>
Error	7	2.76	.39			

Note: Group (G) = augmentative counselling and comparison groups. Time (T) = pre-training and post-training.

Appendix H

Sums of Squares and Mean Square Vaules for Analysis of Variance of Sections 1 & 2 of
Knowledge Questionnaire

Source of Variation	<i>df</i>	Sum of Squares	Mean Square	<i>F</i>	<i>p</i>	Sig
Groups (G)	1	6.05	6.05	2.69	.14	<i>ns</i>
Error	8	18.00	2.25			
Time (T)	1	.45	.45	1.00	.35	<i>ns</i>
Error	8	3.60	.45			
G x T	1	.45	.45	1.00	.35	<i>ns</i>
Error	8	3.60	.45			

Note: Group (G) = augmentative counselling and comparison groups. Time (T) = pre-training and post-training.