

CHANGING OUR APPROACH: SUPERVISING THROUGH APPRENTICESHIP

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Helping student clinicians become self-supervising professionals is a challenging but necessary process for colleges and universities across the country. As we discuss methods used to teach student clinicians, it is important to point out that we make no assumptions about existing approaches to clinical training. It is clearly not our intention to suggest that existing supervisory programs are not effective or valuable within the broad landscape of methods used to supervise student clinicians. To suggest this would discount the fine contributions made by many of our colleagues who diligently address clinical supervision with the respect and vigor it demands (Anderson, 1998a, 1998b; Dowling, 1992a, 1992b; Farmer, 1987; Farmer & Farmer 1989; Gillam, Strike-Roussos, & Anderson, 1990; Shapiro, 1989; Shapiro & Anderson, 1988; Smith et al., 1989). With this in mind, our goals are: (a) to discuss the philosophical underpinnings and procedural components of an apprenticeship (Vygotskian) model of clinical supervision, (b) to describe a process used to develop and implement an apprenticeship approach to clinical supervision, (c) to describe briefly an evaluation tool designed to collect critical information about students' clinical competency, and (d) to examine video illustrations of apprenticeship procedures used in a college clinic setting.

In an effort to provide students, supervisors, and support staff with an easy way to view the various dimensions of student evaluation, we offer a graphic representation of the evaluation process (see Appendix A). In our estimation, this graphic captures a variety of aspects of apprenticeship supervision and allows for student evaluation to be viewed at a glance. There are four dimensions of evaluation displayed, all containing interrelated evaluation continua. They include (a) the student's experience (i.e., the amount of clinical experience the student has had to date), (b) the student's performance during clinical placement, (c) the amount of support provided by the

supervising clinician to ensure success in a clinical placement, and (d) the complexity of the client receiving services (e.g., an adult with a complex motor speech disorder compared to a child with a slight articulation disorder). There also is an orbiting layer of this graphic that directly impacts all of the dimensions described above. This layer, entitled “Critical Clinical Attributes and Behaviors” was developed by Ylvisaker (1991) and is made up of characteristics such as accountability, flexibility, respect, initiative, maturity, interactive competence, and independence (see Appendix B). We find these attributes particularly relevant to the supervisory process and have included terms commensurate with these attributes within our clinical evaluation tool, known as the Clinical Apprenticeship Record.

Philosophy of Clinical Supervision

The faculty and staff of the Communication Disorders Department believe strongly that providing graduate and undergraduate students with high quality clinical supervision is central to the mission of the program. The process of supervising students in our program is also based on the concepts, values, and roles identified in the department’s clinical philosophy. It is our goal to help students develop and use critical clinical competencies through the use of a clinical supervision framework based on the provision and subsequent fading of intellectual, procedural, and self-determination support systems.

Intellectual Support

The term *intellectual support* encompasses a vast array of concepts and procedures associated with helping students learn how to think. In fact, the notion of imparting clinical, theoretical, and personal knowledge through interaction pervades much of the literature related to cognitive development (Hendrix, 2001; Hockly, 2000; Lave & Wenger, 1991; Mezirow, 1990; Rogoff, 1990; Stice, 1987; Vygotsky, 1978, 1981, 1987) and has direct relevance to clinical supervision. For this reason, our

comments will be more elaborative in this domain compared to those related to other domains of support.

In our judgment, the contributions made by Vygotsky (1978, 1981, 1987) and Rogoff (1990) are particularly applicable to the process of clinical supervision. First, Vygotsky offers the notion of internalization. This concept involves the idea that learning takes place through regular external exposure to a target behavior (e.g., a language concept or a method of problem solving). Over time, the learner develops an ability to understand and use the target behavior independently. In the case of clinical supervision, target behaviors might consist of a wide variety of clinical problem solving skills, critical thinking, planning, goal setting and many other processes. Logically, these processes are modeled by the supervisor and gradually learned, or internalized, by the student clinician. Second, Vygotsky offers the concept of the zone of proximal development. While this concept is offered in the context of cognitive and linguistic development in children, it certainly has relevance to clinical supervision. Rogoff (1990) describes the zone of proximal development as “a dynamic region of sensitivity to learning the skills of culture, in which children develop through participation in problem solving with more experienced members of the culture” (p. 14). In the case of clinical supervision, the student develops the ability to think and act at a level just beyond his or her current level through guided instruction and participation in meaningful clinical activities.

Like Vygotsky (1978), Rogoff (1990) also offers a number of concepts that have particular relevance to clinical supervision. As the title of our presentation suggests, we consider the notion of apprenticeship as central to our approach to supervision. In her comprehensive book on cognitive apprenticeship, Rogoff (1990) eloquently applies an apprenticeship analogy to Vygotskian theory:

Vygotsky’s model for the mechanism through which social interaction facilitates cognitive development resembles apprenticeship, in which a novice works closely with an expert in joint problem solving in the zone of proximal

development. The novice is thereby able to participate in skills beyond those that he or she is independently capable of handling. Development builds on the internalization by the novice of the shared cognitive processes, appropriating what was carried out in collaboration to extend existing knowledge and skills. (p. 141)

This quote not only highlights the relationship between the supervisor and the student clinician; it also emphasizes the importance of meaningful interaction as paramount to the learning process and perhaps more specifically, to the provision of intellectual support.

While the theoretical underpinnings of intellectual support provide a strong conceptual framework for supervision, it is also important to consider how these supports are provided in real world supervisory contexts. For example, in order to help students bridge the gap between academic work and clinical interactions, supervisors may supply the student with theoretical information, recent publications, and/or stimulating discussion about an area of interest that directly impacts the clinical decision making process. This type of support may also include a supervisory model in which collaboration with others (e.g., colleagues or administrators) occurs to increase the supervisor's and/or students' overall understanding of a specific area of interest. Furthermore, students may be supplied with various supports related to the creation and use of documentation to review, plan, and organize information related to intervention programs (e.g., collaborative writing experiences, samples of reports or lesson plans).

Procedural Support

The term *procedural support* is used to capture a wide variety of clinical behaviors that may be used to help service recipients learn target behaviors. In behavioral terms, procedures may include, but are not limited to modeling, cueing, imitating, shaping, fading, role-playing, modifying the task, and creating interactive routines. For students to fully understand and use intervention procedures, it is critical that supervisors model clinical procedures in order to promote success. Modeling may

also include in-context coaching, pre-session or post-session role-plays, or other opportunities to directly observe the supervisor making use of procedures to reach a desired therapeutic outcome.

Supports for Professional Growth and Self-Determination

The use of specific supervisory procedures designed to promote students' accurate self-evaluation is central to the supervisory process. This includes the use of a variety of informal and formal methods that may be applied before, during, or after therapeutic intervention to evaluate the student's performance and to promote success. Within this domain, supervisors make use of methods designed to help students engage in self-evaluation and self-monitoring activities in the context of an intervention activity. In turn, students are expected to develop an increased sense of intrinsic motivation and independence in planning and implementing meaningful intervention programs. Not surprisingly, support in this domain is tailored to meet the individual needs of students within specific service delivery contexts.

Apprenticeship Model of Supervision

The following excerpt was taken directly from the clinical evaluation tool used at The College of Saint Rose (i.e., the Clinical Apprenticeship Record; Feeney et al., 2001). It provides a description of apprenticeship as it applies to clinical supervision and is included in the introductory portion of the tool.

An apprenticeship approach to clinical supervision involves ongoing collaboration between the supervisor and the clinician in training. The approach is based on the repeatedly validated model of teaching used for centuries in the crafts and trades, as well as many other professions. For example, the teaching relationship between a master furniture maker and an apprentice furniture maker is identical to the relationship between an academic neurosurgeon and a resident neurosurgeon, between a master mechanic and an apprentice mechanic, between Socrates and his philosophy students, and many others. The use of a clinical apprenticeship model creates an opportunity for students to develop their

clinical skills in the context of a positive working relationship with the supervisor, ongoing supervisory instruction, and consistently high quality services for the client.

The critical features of apprenticeship teaching are the following:

1. The product is always an excellent product. In surgery, this means that the surgery is correctly done; in philosophy, the argument is sound; in cabinet making, the cabinet is an excellent cabinet; in speech-language pathology, the client is served as effectively as possible, the plans are sound plans, the reports are excellent reports, and the like.
2. In apprenticeship teaching, the process used to achieve an excellent product is not one in which there is extensive trial and error learning by the student. For example, a neurosurgeon cannot allow the resident in neurosurgery to fail. The learner's (i.e., apprentice's) performance is always competent because the teacher (i.e., master craftsman) ensures competent performance with adequate antecedent support. Therefore, evaluation of the learner is based more on the amount of supervisory support needed to do a competent job and less on the competence demonstrated in the actual performance (performance should always be competent).
3. Supports for successful performance (see above) are used liberally at the outset of the clinical training, and then systematically withdrawn as it becomes possible to do so. The student's (apprentice's) job is to work very hard at mastering the skills of the supervisor (master craftsman) so that supports can be withdrawn as quickly as possible. Type, amount, and duration of supports are directly related to the student's experience, the complexity of the individual receiving services, and the student's ability to flexibly demonstrate clinical competence in context.
4. Throughout the clinical practicum, the supervisor's job is not only to teach specific clinical skills, but also to teach the clinician in training to think like a competent clinician. Teaching another person to think effectively involves thinking (out loud) with that person, thinking with that person a lot, thinking with that person about issues that are important for that person to think clearly about, making the clinical thought processes and clinical decision-making processes as salient as possible, and using whatever concrete supports the learner might need to understand the thinking process. (p. 4)

Possible Dangers in Using and Apprenticeship Approach

While there are likely a number of challenges related to the implementation of the apprenticeship approach to supervision, there are two primary dangers that seem to

stand out among all of the possibilities. These include (a) an increased likelihood of learned helplessness on the part of the student clinician and (b) the possibility that students will put forth minimal effort during the initial period of clinical work. In our experience, a useful method to avoid these dangers has been to meet with supervisors during the first week of the semester to discuss ways to identify students who exhibit these behaviors. We have also found it helpful to discuss these issues with students during an orientation meeting on the first day of the semester. Clearly, no single method to avoid these issues exists.

Developing and Implementing an Apprenticeship Approach to Supervision

It seems that one of the most pervasive questions among clinical administrators and staff revolves around the implementation process. In our program, we began the process of developing a new approach to student evaluation and supervision in the mid-nineties. During this phase of development, we implemented the use of a formal evaluation grid designed to capture students' performance within a variety of clinical domains. We then added critical clinical attributes and behaviors (Ylvisaker, 1991) to the grading system as well as other methods/procedures (e.g., transition videos, demonstration therapy, staggered starts for clients seen under one supervisor) to help student clinicians in our on-campus clinic. The Appendix C provides a timeline of events related to the development and implementation of the apprenticeship approach to supervision in our on-campus clinic and external placement.

The Clinical Apprenticeship Record

In an effort to evaluate students using a system that fosters the development of critical clinical attributes in the context of an apprenticeship model of learning, we developed an evaluation system that allows for the assessment of student performance

in a variety of clinical domains. These domains include assessment, preparation for and management of treatment, responsibility, supervisory interactions, interactive competence, professional behavior, accountability, and clinical processes. While formal evaluation typically occurs twice a semester (i.e., at mid-semester and at the end of the semester), an apprenticeship approach to clinical supervision makes use of ongoing supervision (e.g., in-context coaching, written supervisory feedback) and self-evaluation systems (e.g., retrospective self-evaluation using video). The purpose of ongoing evaluation is to help students establish and maintain an awareness of their own strengths and weaknesses as well as to increase the likelihood of positive student growth over the semester.

The Continuum of Support

Within each clinical domain, students are evaluated using a continuum of support. While there are specific criteria given to define the extreme ends of continua within each domain (i.e., maximum support versus minimum support), it is important to note that the amount and type of support a student needs may vary depending on his or her experience and the complexity of the person receiving services. For example, a student with no clinical experience who is working with a person who has a highly complex motor speech disorder is more likely to need supervisory support throughout the semester than a graduate student in his or her final semester working with a child who has a slight articulation disorder.

Completing the Form

Each domain of student evaluation contains a scale on which the supervisor (and possibly the student) can mark the level of support that represents the student's support needs within the specified area. In the example below, an advanced student clinician is evaluated within the area of diagnostics. Notice the line (drawn by the supervisor)

indicating that the student's performance is judged to be toward the "minimum support" end of the continuum. This judgment, coupled with the supervisor's comments, suggests that the student is performing well in the area of interpreting and integrating information, but some supervisory assistance is needed to accurately make use of the information in the diagnostic process.

Evaluates the information learned during the assessment session:

- a. Interprets and integrates the results of testing

Maximum Support

Student requires significant supervisory support to interpret and integrate assessment information.

Minimum Support

Student independently and accurately interprets results of assessment procedures and integrates information to determine the nature and extent of the communication disorder.

Comments:

Tasha often initiates conversations with me regarding the diagnostic process. In nearly all of our diagnostic experiences together, she accurately identified the type of communication disorder being exhibited. Tasha also benefited from supervisory discussions that allowed her to make accurate judgments about the impact (or potential impact) of specific communication disorders on the everyday life

interactive competence, professional behavior, accountability, and clinical processes), supervisors make a judgment about the student's overall performance. Students are then evaluated at the middle and end of the semester and will receive a PASS, FAIL, or

INCOMPLETE as described below:

Superior (PASS). The student independently demonstrates the critical clinical attributes. The student performs in clinical situations as a mature, professional, and responsible individual. The student's behavior in relation to the client, his/her family and/or client's professional support personnel is respectful. The student is sensitive to the client's needs and plans appropriately. The student follows procedures independently, develops and maintains accurate record keeping, and is prompt in submitting information. The student demonstrates superior written language skills. The student engages in clinical interactions with his/her supervisor in a mature and professional manner.

Excellent (PASS). The student demonstrates some independence but minimal support is needed from the clinical supervisor for some aspects of the critical clinical attributes. The student performs in clinical situations as a mature, professional and responsible individual with minimal input from the clinical supervisor. The student's behavior in relation to the client, his/her family, and/or client's professional support personnel is respectful. The student is sensitive to the client's needs and plans appropriately with minimal guidance. The student with minimal support follows procedures, develops and maintains accurate record keeping, and is prompt in submitting information. Minor changes in the student's writing style in needed.

The student engages in clinical interactions with his/her supervisor in a mature and professional manner.

Very Good (PASS). The student demonstrates the critical clinical attributes with support from the clinical supervisor. With guidance, the student performs in clinical situations in a mature manner. The student recognizes the need for planning and designing appropriate activities for the client but continues to need guidance to follow through independently. The student requires some correction in written content and

style of reports. The student engages in clinical interactions with his/her supervisor in a non-defensive and appropriate manner.

Competent (PASS). The student demonstrates aspects of some of the critical clinical attributes with support from the clinical supervisor. The student requires reminders and guidance to analyze data and report findings appropriately. Subsequently, the student follows up on suggestions. Support is required by the clinical supervisor regarding written language. Supervisory interactions may be difficult for the student and issues may not be resolved in a professional manner.

Incomplete. The student is unable to demonstrate clinical competence in the placement and is recommended for continuation of this practicum.

Fail. The student is unable to demonstrate clinical competence and will be dismissed from the program.

Illustrations of Apprenticeship Supervision

In an effort to provide specific examples of apprenticeship procedures and to bring to life many of the interactive competencies previously discussed, we have collected a variety of video illustrations of faculty and staff interacting with students. These illustrations offer a range of pre-session, within-session, and post-session interactions designed to foster independence and clinical growth through apprenticeship. While a complete description of each of the apprenticeship procedures displayed in the video samples is beyond the scope of this paper, it is important to highlight a few important supervisory competencies that represent an apprenticeship model of supervision. First, in each sample the supervisor is thinking out loud with the clinician. While this may seem like a natural process for many supervisors, in our estimation, it is central to the students' internalization of critical thinking skills related to clinical problem solving and planning. It is also directly tied to the underlying

Vygotskian theory related to teaching and learning. Second, the supervisors in each illustration are invariably well organized in their discussions with students. Again, this may seem like a natural supervisory interaction procedure to many, but it is also a manifestation of an underlying theoretical orientation that drives the teaching process. Third, many of the interactions between supervisors and students are built on the premise of supplying support when support is needed. In other words, the supervisor is working within the student's zone of proximal development. Fourth, the interaction between the supervisors and the students in the video illustrations is collaborative in nature rather than overtly pedagogical. That is, the student is learning by interacting with the supervisor in a non-didactic and respectful manner.

Issues Impacting Apprenticeship Supervision

Since we began using an apprenticeship approach to supervision in our on campus clinic, we have found a number of issues that have impacted its implementation. It is important to note, however, that these issues are likely idiosyncratic and may exist in various forms depending on any number of environmental, administrative, or other variables. In our experience, it seems that supervisory interaction often occurs as a manifestation of how the supervisor was supervised during clinical training. This notion has been discussed directly and indirectly in educational literature (Dowling & Larkey, 2000; Pannbacker, Middleton, & Lass, 1990; Wagner, 1996; Wagner & Hess, 1997) and has obvious implications for understanding the nature of the supervisory process. We have also noticed that the apprenticeship approach, like any supervisory method, can become extremely challenging when working with a struggling student. The primary challenge in this area seems to exist in the form of spending excessive amounts of time with students who require significant amounts of support to deliver high quality service.

Another issue that may impact implementation of apprenticeship supervision, or any approach to supervision for that matter, is the supervisor's ability to understand and

use the interactive procedures associated with apprenticeship supervision. Logically, difficulties in this area have the potential to impact the implementation process. Apprenticeship supervision frequently calls for increased communication with students, either through verbal interaction (e.g., thinking out loud as often as possible), electronic dialogue (e.g., e-mail), or other modalities. This increase in communication, however, is often challenging for supervisors who must manage other students and individuals on their caseload.

What's Next?

It is our strong sense that there is much to learn about the supervisory process and methods designed to teach students how to become self-supervising. As we look to the future, it seems clear that many questions exist around the effectiveness of specific supervisory practices, not excluding apprenticeship supervision. It has never been our intention to suggest that apprenticeship supervision is a panacea for colleges and universities providing clinical training to student clinicians. Further research designed to examine supervisory methods is clearly warranted. It also seems that there are insufficient educational opportunities for working supervisors interested in helping students learn critical clinical skills. With this in mind, there is much room for further development of continuing education experiences for working professionals. We share the sentiments that many important contributors to this field have suggested (Anderson, 1980; ASHA, 1985, 1994, 2000; Brassler, 1989; Bruce, 1994; Casey, Smith & Ulrich, 1998; Dowling 1992a, 1992b; Farmer & Farmer, 1989; Shapiro, 1989): the provision of high quality clinical supervision in college, university, and professional settings is paramount in shaping the landscape of our profession.

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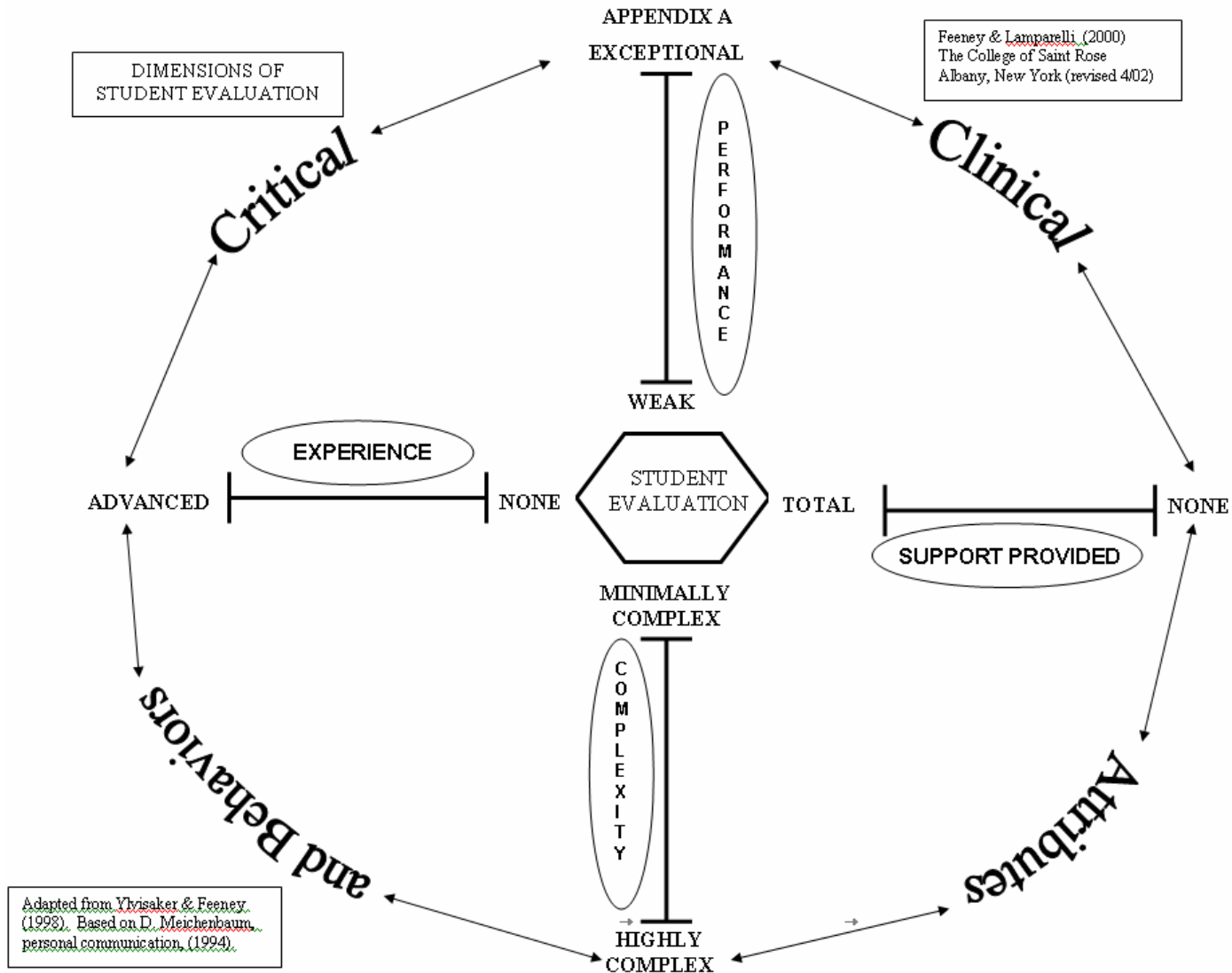
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APPENDIX B

BEING A PROFESSIONAL MOST CRITICAL CLINICAL ATTRIBUTES AND BEHAVIORS

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In my judgment, the following attributes and behaviors comprise the core of an effective and successful clinician. They are critical to success in clinical training and in professional life. Therefore, student clinicians should pay particular attention to the development of these behaviors and attributes.

RESPECT

- Fundamental commitment to, concern for, and respect for the client (student, patient) and his or her family.

To Do:

- Communicate concern and respect directly -- to the client and family.
- Empower individuals and their families; create a working alliance (vs. clinician taking responsibility for all decision making).
- Follow-up on discharged clients.
- Go the extra mile.
- Respect confidentiality.

To receive a passing grade, the student clinician's behavior in relation to the client and his or her family must be uniformly respectful.

INITIATIVE/RESPONSIBILITY

- High level of energy, interest, curiosity, willingness to learn, and

acceptance of responsibility.

To Do:

- Work hard, go beyond minimal requirements.
- Ask questions; take responsibility for dealing with your confusion, lack of information, or other needs.
- Seek out extra learning opportunities: e.g., reading, talking to other clinicians.
- Explore alternative procedures, activities, etc.
- Never think of yourself as a victim!

To receive a passing grade, the student clinician must give some evidence of initiative (effort toward successful clinical performance that is not explicitly required by the supervisor) and must take responsibility for his or her performance by communicating openly and freely with the supervisor about possible needs for assistance.

INTERACTIVE SKILL

- Well developed communication skills, ability to interact effectively and positively with a variety of people.

To Do:

- Interact positively, sensitive to the needs of your partner.
- Encourage clients, family members, and coworkers.
- Use interactive skills effectively to control behavior, motivate, calm, excite, etc., as needed.

To receive a passing grade, the student clinician must interact with the client and his or her family in a way that is positive and customized to meet their needs.

MATURITY

- Controlled, nondefensive posture in relation to others.

To Do:

- Accept suggestions and criticism positively.

- Actively seek suggestions for improvement.
- Interact with other professionals in a collegial, nonterritorial manner.
- Refrain from blaming others when problems inevitably arise.
- Maintain professional behavior despite personal or professional challenges.

FLEXIBILITY

- Willingness to do whatever needs to be done to serve the client.

To Do:

- Change plans as frequently and quickly as necessary.
- Try new approaches.

PROBLEM-SOLVING SKILL

- Ability to identify problems, understand the problem, consider alternative solutions, select intelligent solutions, and learn from experience.

To Do:

- Always look for a better understanding of the issues at hand.
- Approach problems as a detective -- as a creative hypothesis tester, not as a person looking for "the answer".
- Rejoice when you face difficult problems, knowing that this is how you learn.

ACCOUNTABILITY

- Ability to identify, track, and summarize behaviors that indicate progress or lack of progress in relation to therapy goals and objectives.

To Do:

- Understand goals and objectives sufficiently that appropriate behaviors are selected as indicators of progress. Progress can be tracked.
- Carefully document progress in relation to goals and objectives. Progress can be tracked as (a) percentage correct; (b) number of instances; (c) amount or type of support needed for success; (d) individual behaviors

- observed or reported; (e) other.
- Periodically summarize progress in relation to objectives and use that summary to evaluate the effectiveness of intervention.
 - Write well.

To receive a passing grade, the student clinician must demonstrate the ability to operationalize goals and objectives, and maintain a record keeping system that makes it possible to objectively measure progress or lack of progress in relation to goals and objectives, and summarize progress in reports that are well written.

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APPENDIX C

Figure 1

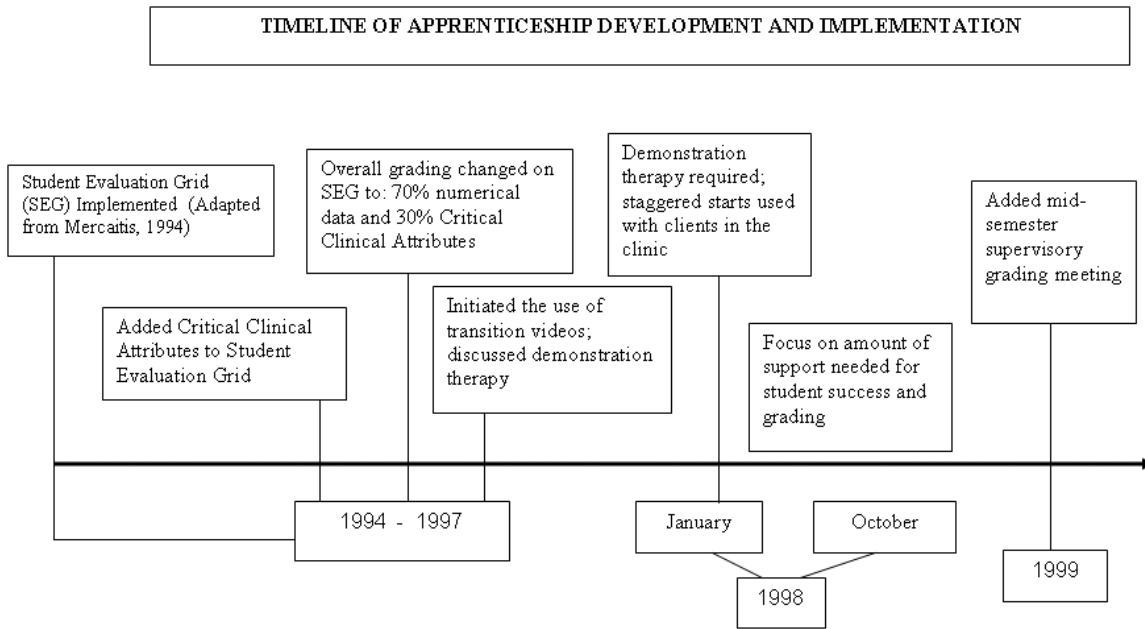


Figure 2

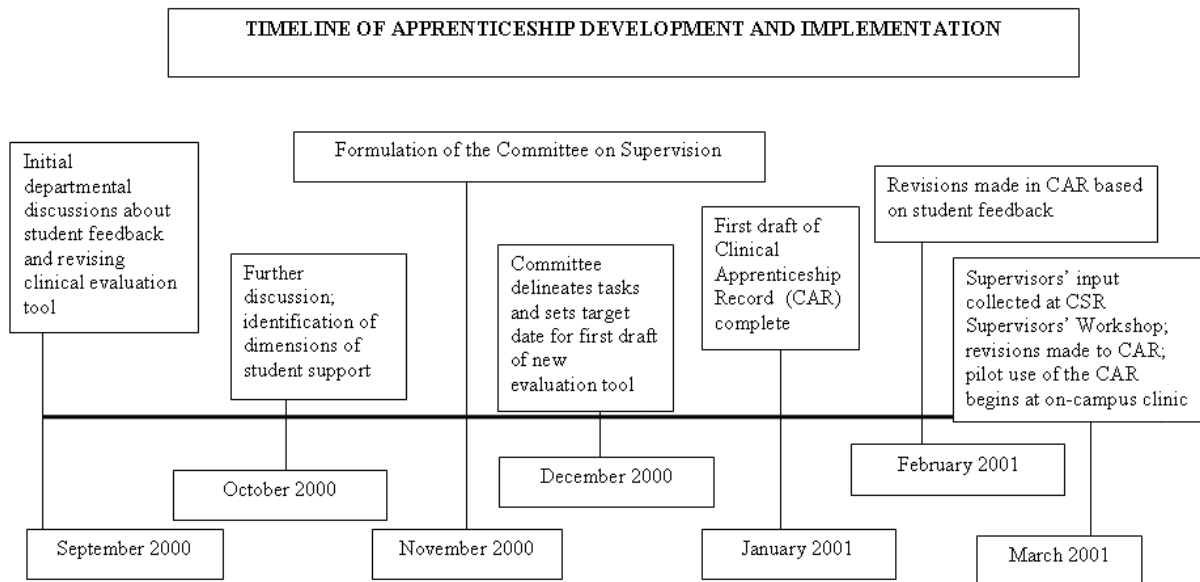


Figure 3

