

ISSUE III-B – For Clinic Directors: Remediating Poorly Performing Students in Our Clinical Programs.

Judith Brasseur, Ph.D. Professor – California State University, Chico

Lisa Lucks Mendel, Ph.D. Associate Professor– University of Memphis

Elizabeth McCrea, Ph.D. Associate Clinical Professor – Indiana University

Abstract: This panel presented ways to address and improve the less-than-expected performance of students in a clinical education program. Relevant issues included how to identify and address problems encountered by graduate students with special needs, including students with disabilities and graduate students for whom multicultural issues (e.g., clinical expectations of L2 students in terms of American English language and cultural proficiency) present difficulties.

The panel presented “success stories” and highlighted practical descriptions of approaches that have worked. The panel also debated the degree of responsibility that graduate programs have to insure that students who are admitted to the program successfully complete the program.

Panel members represented different levels of graduate programs: a comprehensive university offering bachelors and masters degrees, a research university offering bachelors, masters, and doctoral degrees, and a research university offering masters and doctoral degrees only (i.e., no undergraduate “feeder” program). Further, panel members included both audiology and speech-language pathology clinic directors.

PROGRAM PHILOSOPHY

A major factor that influences how remediation is approached is an individual program's philosophy. It is essential that you examine your program's mission and goals. Subsequently, it is critical to examine your program's philosophy regarding its commitment to the marginal student. For example, when a student is accepted into your program, do you feel that you are obliged to see him/her successfully complete the program? When you have a student with special needs, what is the usual routine for helping him/her? For example, does one faculty member advise and mentor or is there a group or elected committee that collaborates to plan appropriate assistance or remediation?

Dowling (2001) defined the *marginal clinician* as one who cannot work independently, is not able to formulate appropriate clinical goals and procedures, has basic gaps in conceptual understanding, and cannot follow through with suggestions (p.162). She also pointed out that these kinds of supervisees are typically identified relatively soon after they begin practicum because they have problems during initial testing or early in the process of planning and implementing treatment. Further, they lack the ability to accurately evaluate their own performance and have inflated perceptions of their competence. In contrast, some students may be performing poorly because of language issues, or because of gender, cultural or generational differences. Program philosophy will likely be contingent on the root of poor performance, a student's perceived level of motivation and effort, and the individual's interpersonal demeanor.

Program philosophy, in part, may be a function of type of university – doctoral granting/research institution versus a comprehensive/master's level institution. Admission standards and who is

involved in the selection process are likely to influence this philosophy. Admission deadlines, whether or not an institution offers early admissions, the time(s) when students are admitted (e.g., once a year or each semester), and the precise admission requirements (e.g., GPA, GRE, resume, letters of recommendation, personal statement) vary across institutions. Obviously, careful selection is the ideal procedure for preventing the occurrence of a marginal student. Nonetheless, despite such careful selection, marginal students periodically emerge in a class. While there is much written in our professions, in education and in counseling about predicting success in post-baccalaureate programs, most of it is theoretical and perceptual. There is a paucity of research that identifies, observable, measurable, reliable, valid predictors of success (Brasseur, 1996).

Retention and Remediation. When a student is considered marginal, active steps need to be taken in order to assist the student in enhancing his/her clinical skills to the expected level. ASHA standards mandate formative and summative assessments. Further, the standards specifically state that the amount of supervision “must be appropriate to the student’s level of knowledge, experience, and competence.” We have stressed that several issues need to be resolved in making this determination:

- The supervisee’s ability to problem solve
- The degree of dependency/independency of the student as clinician and supervisee
- The ability of the supervisee to self-observe and self-analyze
- The supervisor’s flexibility in adapting his or her style to supervisee levels of development (McCrea & Brasseur, 2003).

Regular performance reviews of a student’s clinical and academic performance and interpersonal skills are important, particularly for identifying areas that need to be remediated. If a student is

considered marginal, a remediation plan must be developed with specific actions that need to be completed and satisfied before the student will be considered competent in his/her weak areas.

After a remediation plan is developed, supervisors must be diligent in documenting the supervisee's performance. Dowling (2001) recommends several forms: (1) an ongoing written log or journal of observations and interactions, (2) evaluative rating scales, (3) collected data, (4) copies of supervisor notes on lesson plans or other types of communication to the supervisee, (5) drafts of written materials, and (6) records of conferences and other interactions. Supervisee's signatures on feedback documents and midterm and final evaluations are an important record keeping function.

Potential Legal Issues. Dowling (2001) notes that the marginal student has "more potential for legal implications than any other group of trainees" (p.166). Therefore, documentation is essential. Programs may want to describe precise policies and the procedures that will be implemented for students identified as "at risk" in a handbook or clinic manual. For example, procedures may include observation of the clinician by other supervisors, completion of weekly videotapes, and delineation of tasks and performance objectives with deadlines for completion. Dowling further advises that one supervisor should not be solely responsible for the clinical education of supervisees with significant problems – "every effort should be made to split those person's assignments so that they simultaneously have more than one supervisor" (p.167).

In a discussion of *vicarious liability*, Newman (2001) advises that supervision in excess of defined guidelines may be problematic. In cases where a supervisor could have reasonably predicted the poor performance of the supervisee (i.e., documentation for the marginal student) and where the supervisor is deemed to have the power to control the actions, adverse legal

outcomes may result. Specifically, in litigation, higher amounts of supervision may be viewed as an indication that a supervisee's performance was considered questionable and required increased involvement of the supervisor.

While there is no specific legislation or laws that speak directly to the issue of marginal students, there are **legal concepts** that need to be considered in regard to the management of students who are having difficulty. The most important of these is *due process*. This begins with explicitly identifying the essential functions that are necessary for a student to exhibit or perform. Training programs need to specify for students exactly what its expectations are for students, beyond maintaining a certain GPA and accruing a certain number of credit and practicum hours.

Specific outcomes in regard to clinical skill(s) and academic knowledge need to be identified, so that students know exactly what the expectations of the program are of them. The knowledge and skills assessments required in ASHA standards can help students understand the program's expectations of them.

As students consider the program's expectations for essential functions or competencies, they can begin to reflect on their ability to meet them. If they find that they need help to be successful in the program, it is their responsibility to seek out these resources. These kinds of resources can range from consulting with a writing center to strengthen written communication and writing skills or registering with the Disabled Student Services Office to obtain the services of a note taker. Additionally, a training program's identification of its expectations through specification of its essential functions can help students begin to self-select, i.e., to help them begin to actively

consider the appropriateness of the profession for them, given the nature of the skills that are necessary and that they will need to demonstrate.

Lastly, training programs need to have a process in place that specifies the remediation procedure and timeline that will be followed when a student has difficulty. This procedure needs to be made available to all students and while the framework of the procedure will be the same for all students, the content within it will be student specific. This procedure also needs to identify the consequences for the student if they unable to meet the requirements of the remediation plan.

These three components (notice, student participation, and opportunity for remediation) will help training programs meet the challenges of providing students due process.

ASSESSMENTS

Anderson's Continuum Model of Supervision.

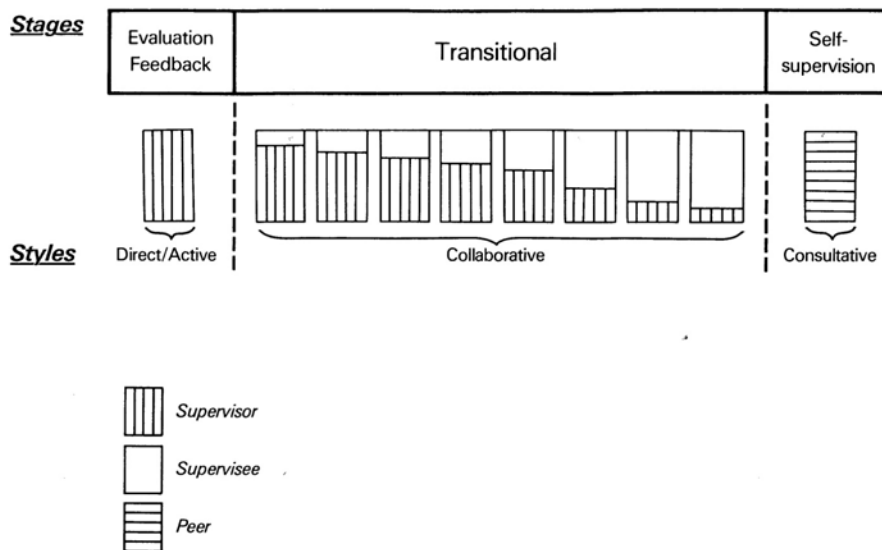


Figure 2.4

Anderson's continuum model of supervision (Anderson, 1988) is a perfect framework for the current ASHA standards in which the goal is to provide the amount of supervision that is appropriate to the "students' level of knowledge, experience, and competence" and that will help develop a professional "who is able to think critically, make decisions, and solve problems." The model is predicated on the belief that supervision exists on a continuum which spans a professional career and that there are differences in strategy and style of interaction which are appropriate at different points in time and which are determined by the variables inherent in the process, i.e. needs, competencies, expectations, and philosophies of both supervisor and supervisee as well as variables associated with the setting (task, client, organizational structure etc). The model offers a structure for supervisors and supervisees to examine their own philosophies about supervision, identify their own behaviors, and determine what changes they wish to make, if any (Brasseur, 1989; Casey, Smith & Ulrich, 1988). As a result, it suggests an approach to continuous improvement which spans a career from preprofessional training and the CF or a fourth year AuD student as a supervisee through experienced supervisory and clinical practice.

While the 13 tasks and 81 associated competencies contained in the 1985 ASHA Position Paper on Clinical Supervision provide a thorough description of *what* supervisors need to do, the *how* (i.e. their degree and amount of involvement) is likely to depend on eight factors:

1. Supervisee's clinical competence
2. Supervisee's psychological maturity and commitment
3. Supervisee's perceptions of the supervisor's expertise
4. Supervisee's expectations of the supervisor
5. The styles and expectations of supervisor's superiors
6. The supervisor's colleagues

7. Organizational goals, policy, philosophy and expectations
8. Time

Anderson (1988) therefore advocated a continuum perspective that enables supervisors to vary the amount and degree of involvement – i.e. to adjust their style in order to facilitate the *ultimate goal* - **Self-Supervision**. Anderson's approach does not place supervisors exclusively in the expert role. - Her focus is on the *supervisory process*. She stated that

“Supervision exists on a continuum which spans a professional career and there are styles of interaction which are appropriate to each stage of the continuum” (Anderson, 1988, p.49).

It's important to emphasize:

- ❑ None of the stages are time bound - a supervisee may be at any point on the continuum during her/his career.
- ❑ A supervisee's progression on the continuum is **not** linear - supervisees may enter the continuum at any point, or move back and forth on it, depending on a number of variables.
- ❑ It is important to assess and reassess the appropriate point on the continuum at which a supervisee is able to function.

The stage on the continuum where the supervisee is functioning dictates the supervisor's style. Thus, it is essential to assess a supervisee's appropriate place on the continuum, which is analogous to completing baseline measures for clients. The ultimate goal of the process is self-supervision - the Consultative Style.

There are five stages of the supervisory process which facilitate the development of supervisees across the continuum. These stages are cyclical, and over time, permit the increasing independence of students and their abilities to become self-analytical and to think critically.

- Understanding: Prepares both the supervisor and supervisee to communicate accurately and participate meaningfully together in the supervisory process.
- Planning: Requires the construction of professional development goals for supervisee and supervisor to ensure that clinical education does not proceed haphazardly.
- Observation: Requires the collection of objective data in such a way that events can be reconstructed validly enough to be analyzed. Moves supervision from a subjective process to an objective one.

- Analysis: Distills and organizes observational data so that it can be used to draw conclusions about what happened in the teaching-learning process between supervisee and client (as well as supervisor-supervisee).
- Integration/Renewed Planning: Purposeful communication between supervisor and supervisee which uses data to understand the outcomes associated with the targeted goals. Stage in which ongoing planning for additional goals and outcomes is initiated. (Typically occurs during regular, planned conferences.)

Baseline Assessments

The following outline is a brief overview, certainly not exhaustive, of information needed *before* the point on the continuum can be determined.

Clinician Information

- a. General clinical experience
- b. Experience with clients with the disorder
- c. Academic background in disorder area
- d. Other experiences relevant to the client, the disorder, or the diagnostic or therapeutic clinical situation
- e. Clinician's perception of strengths and needs in terms of the client
- f. Anxieties about this client or disorder
- g. Understanding the needs of the client

Supervisee Information

- a. Type(s) of supervisory interaction experienced previously
- b. Perception of self in terms of dependence/independence in general and with clients
- c. Prior responsibility in data collection and analysis of client behavior
- d. Experience in data collection and analysis of own clinical behavior prior to

conferences

- e. Perceptions of responsibility for bringing data and questions to the conference, assisting in problem solving, and decision making
- f. Expectations for learning or modification of clinical skills from the current situation.
- g. Perception of need for feedback (amount and type)

Supervisor Information

- a. General clinical and supervisory experience
- b. Experience with type of client and disorder
- c. Theoretical and practical approach to the disorder as compared to that of supervisee
- d. Preferred or customary supervisory style
- e. Expectations for the supervisee as a clinician and as a supervisee
- f. Self-perception of role (McCrea & Brasseur, 2003)

Determining Dependence/Independence. Shriberg and colleagues (1974, 1975) were the first to operationalize the construct of evaluating the amount and degree of supervisory support that is needed for a supervisee to be able to demonstrate clinical competencies. In the Wisconsin Procedure for Appraisal of Clinical Competence (W-PACC), a 10-point scale is used to identify the supervisee's level of independence. The scale consists of the following levels of scoring: Score 1 - Specific direction from supervisor does not alter unsatisfactory performance and inability to make changes; Scores 2-3-4 - Needs specific direction and/or demonstration from supervisor to perform effectively; Scores 5-6-7 - Needs general direction from supervisor to perform effectively; and Scores 8-9-10 - Demonstrates independence by taking initiative, making changes when appropriate and is effective.

In addition to the maturity and demonstrated independence of student's technical skills, Whalen (2001) identified 10 "generic abilities" and 4 levels of behavioral criteria (beginning level, developing level, entry level, post-entry level) that define them. While demonstrated independence is not specifically identified as part of the levels of these behavioral criteria, it is implied by them. Generic abilities are behaviors, attributes, or characteristics that are not explicitly part of a profession's core of knowledge and technical skill but nevertheless are required for success in the profession. These abilities include:

- Commitment to learning. The ability to self-assess, self-correct, and self-direct; to identify needs and sources of learning and to continually seek new knowledge and understanding.
- Interpersonal skills. The ability to interact effectively with patients, families, colleagues, other health care professionals, and the community and to deal effectively with cultural and clinic diversity issues.
- Communication skills. The ability to communicate effectively (i.e. speaking, body language, reading, writing, listening) for varied audiences and purposes.
- Effective Use of Time and Resources. The ability to obtain the maximum benefit from a minimum investment of time and resources.
- Use of Constructive Feedback. The ability to identify sources of and seek out feedback and to effectively use and provide feedback for improving personal interaction.
- Problem-Solving. The ability to recognize and define problems, analyze data, develop and implement solutions and evaluate outcomes.
- Professionalism. The ability to exhibit appropriate professional conduct and to represent the profession effectively.

- Responsibility. The ability to fulfill commitments and to be accountable for actions and outcomes.
- Critical Thinking. The ability to question logically; to identify, generate and evaluate elements of logical argument; to recognize and differentiate facts, illusions, assumptions, and hidden assumptions; and to distinguish relevant from irrelevant.
- Stress Management. The ability to identify sources of stress and to develop effective coping behaviors (May et. al, 1995).

According to Whalen, mastery of this repertoire of generic abilities facilitates the entry level, i.e. beginning graduate practicum, professional's ability to:

- Generalize from one context to another
- Integrate information from different sources
- Successfully apply knowledge and skills in practice settings
- Synthesize cognitive, affective, and psychomotor behaviors
- Interact effectively with clients, families, the community and other professionals

Whalen (2001) describes a process in the University of Cincinnati Physical Therapy (PT) Training Program in which each PT student assesses her/himself according to the 10 generic abilities along with a simultaneous assessment by a member of the faculty. If the student is found to demonstrate skills that are not the Developing Level, an action plan which contains goals, timelines, benchmarks, and consequences is implemented by the student in collaboration and consultation with their supervisor(s) to address the deficiencies, often before the student can begin practicum. These abilities continue to be monitored for sustained growth by both the student and their supervisor(s) throughout the student's training. If at any time they are found to

be deficient, an action plan is again implemented that requires active involvement of both student and supervisor(s) in engaging these behaviors in the context of their profession training experiences.

Dowling (2001) states that it is helpful to identify the basic skills that supervisees are expected to be able to demonstrate prior to the initiation of a practicum. For example, skills might include how to write objectives and lesson plans, demonstrating X number of behavior management strategies, being able to administer certain tests, demonstrating data collection skills, administering and interpreting basic diagnostic tests, etc. Perhaps it might even be advisable to devise a proficiency test for each identified skill. If trainees fail to demonstrate baseline proficiency, practicum will be postponed until they possess the skills. This procedure will highlight fundamental skills and require trainees to assume responsibility for acquiring them prior to clinic enrollment.

Formative Assessments. Formative assessment occurs when a supervisee's skills, values, reflective and analytical abilities are a focus of development by both supervisor and supervisee. The challenge is to develop a process and correlate skills that support formative assessment.

Evaluation instruments like the W-PACC, as well as assessment of the 10 generic abilities can serve as diagnostic tools to determine the level of supervisee dependence. They can be used by supervisees at any level of training or professional practice as a self-appraisal of their perception of their own independence and professional maturity as well as a means to define their own goals. They can be used jointly, in total or in part, for the same purpose. Furthermore, if all supervisors in an organization used them, and could maintain agreement, appraisals from

previous semesters or work periods could provide a ready basis for determining the stage of dependence/independence, and therefore the need for an action plan to address areas of need. These notions – longitudinal tracking along with independent and competent skill documented through formative assessment strategies – are at the heart of ASHA standards for accreditation and certification. In addition, written responses from the supervisor to the clinician can be incorporated on a daily, weekly, and/or semester basis to provide constant and consistent feedback to the student clinician.

The process of establishing specific clinical development goals and goals for the refinement of professional behavior of supervisees can be especially productive for them. It is also consistent with the notion of formative assessment and is predicated on the five stages of Anderson's continuum. The targeting of specific skill development goals is initially the result of collaboration between the supervisee and supervisor and can be accomplished during the Planning stage of the supervisory process. As a supervisee matures, this process of goal development can move to the consultative stage of the continuum when the supervisee assumes most of the responsibility for his or her own professional behavior.

Sample clinical development and professional behavior goals early in a supervisee's development might include:

- I will increase my wait time between stimuli presentation and provision of additional cues to 15 seconds by the end of the next session.
- I will provide accurate reinforcement and concrete feedback, according to schedule, in every TX session.
- I will provide a rationale for pre-selection of diagnostic procedures based upon case history information.

- Each week, I will use data-based analysis of my clinical performance to determine my effectiveness in achieving my clinical development goal(s).
- I will construct and follow a daily agenda to ensure that I accomplish all activities for both class and clinic in a timely manner.

Once goals are established in this manner, supervisees and supervisors will have points of discussion that are specific to each student. These discussions will be data-based and can support profitable conversations with supervisees that can lead to a greater understanding of their strengths and needs as developing professionals. It will also model a process for them that will support their continued and increasingly independent self-supervision.

Tools. A student who is performing poorly will be functioning at the evaluation-feedback end of the supervisory continuum. This means that a supervisor will be using a highly directive style of supervision. Dowling (2001) states that the following strategies are likely to be helpful: jointly planning sessions, role-playing specific skills or procedures, preplanned demonstration therapy, structured observations, videotaping/audiotaping and providing selected verbatim transcripts. In completing structured observations, Dowling suggests that the student chart target behaviors but keep data collection procedures simple. Focusing on a limited amount of data will make patterns more distinct. Selected verbatim transcripts may be derived from tapes to describe behaviors such as giving directions or providing models. Verbatim recordings are particularly helpful for making problem behaviors salient. For example, if a supervisee is having difficulty with accurate auditory discrimination of /r/ phonemes, the supervisor can complete a verbatim transcript, using narrow transcription. The power of seeing antecedent events; the kinds of stimuli that evoke correct, incorrect and close approximations of the desired behavior; and the exact verbalizations and events used to consequate client responses enables a clinician to

carefully analyze the clinical interaction and figure out what needs to be done differently (McCrea & Brasseur, 2003). Such techniques can be equally useful for the audiology student (e.g., preplanning questions to be asked in the case history and tests to be administered, role-playing counseling techniques, and determining appropriate recommendations ahead of time).

There are a number of tools that can be used to collect data and supervisors are encouraged to use a variety of procedures (ASHA, 1985). Verbatim or selected verbatim transcripts, tallies of behaviors (e.g., Mawdsley's 1985 KISS), and the used of interaction analysis systems (e.g., Boone & Prescott's 1972 system or Schubert, Miner & Till's 1973 ABC) are among the objective data collection techniques. These tools are detailed in Anderson (1988), Casey, Smith and Ulrich (1988) and McCrea and Brasseur (2003). In addition, Simon and Boyer's (1974) anthology contains a number of interaction analysis systems that were developed for education but are adaptable for use in classroom based service delivery settings. Further, Dowling (2001) has also devised a number of practical, useful data collection systems. Objective data collection, followed by careful analysis, provides the foundation for subsequent evaluation. ASHA's Position Statement (1985) makes it clear that observation and analysis (Task 6) are distinctly different tasks than evaluation (Task 9). Rating scales and checklists are evaluative and subjective but can be useful if ratings are preceded by and based on observations and analyses.

Students must at some point learn to use these procedures to observe and analyze their own behaviors and interactions. If they have had some training and experience in using objective techniques to collect data during observations of others and to analyze those data, the transition to self should be easier. The key to success is in the timing – that is, poorly performing

supervisees are not likely to be emotionally or psychologically ready to engage in data collection at the beginning of a practicum. The supervisor will initially collect data and identify discrepancies between what the supervisee assumes and what actually exists – that is, the difference between perceptions and reality. In time, the supervisor and supervisee can work together to complete joint data collection and analyses.

Analysis of Supervisors

Supervisors must recognize the complexity of the supervisory process. They must determine if they see it as teaching, modeling, evaluation or collaboration, or all of these models, depending upon the dynamics and needs of a given situation. They must analyze their own philosophical foundation for the practices which they evidence. In addition, supervisors must think analytically about their ability to perform the tasks and competencies identified in the ASHA Position Statement on Clinical Supervision. Self study, as well as feedback from students, can inform supervisors' understanding of the nature of their work and their ability to meet the challenges posed by the variety of students in contemporary clinical education settings.

It may be helpful for supervisors to think about their behavior within the supervisory process in two domains: technical skills and process skills. This dichotomy will help in analyzing what they do and then, how they behaviorally mediate their technical plan with the supervisees with whom they work. Consideration of the “what” followed by the “how” in this way will permit supervisors to understand a bit more precisely where they might need to make changes in their work with a particular student. *In this regard it might be important for supervisors to develop professional development goals for themselves, much as supervisees do, in order to facilitate*

change in their process or behavior to meet the needs of a supervisee(s). Sample goals for a supervisor might be something like:

- I will share responsibility with the supervisee for developing the agenda for clinical education conferences.
- I will use data to support my observational feedback to supervisee.
- I will use self analysis as a tool to understand my question asking behavior during conferences with supervisee

Employing a strategy like this can permit supervisors to continue to enhance their own professional growth across supervisees as well as support their ability to meet the challenge of the 13 Tasks of Supervision (ASHA, 1985).

Documentation.

As stated earlier, after a remediation plan is developed, supervisors must be diligent in documenting the supervisee's performance. In addition, documentation should be comparable across supervisees. Further, a supervisor needs to be able to document specific supervisory practices and activities that have been implemented in support of supervisees. When specific behaviors and skills are identified that need immediate improvement, it is advisable to develop a written follow-up contract that includes observable, measurable objectives, an action plan and time frame, and a follow-up date to document if proficiency was achieved within the expected time, as suggested by Shapiro's research on commitments (Shapiro & Anderson, 1988).

INNOVATIVE EXPERIENCES TO ENHANCE COMMUNICATION INTERACTION

At the University of Memphis, the students, clinical faculty, and academic faculty participate in several communicative interaction exercises designed to enhance communication between and

among faculty and students. In the Fall Semester, students and faculty participate in a Personal Preferences Exploration exercise where questions are posed regarding how each individual tends to behave in different situations and scenarios. Participants are given a handout that asks several questions in pairs regarding personal preferences (Wark, 2005). For example,

A. “Are you friendly, talkative and easy to get to know?”

B. “Are you seen as one who is reserved, quiet and sometimes hard to get to know.”

Once a decision has been made, all of those who chose “A” stand on one side of the room and all of those who chose “B” stand on the other side of the room. This physical orientation allows students and faculty to see which individuals are on which side providing input regarding each individual’s approach to his/her work. Another example of question pairs is

C. “Would you prefer to be the one to carry out the project?”

D. “Would you prefer to create the ideas/plan rather than carry out the project?”

Again, the “C’s” and “D’s” migrate to separate sides of the room. These types of questions challenge the individuals to consider how they approach the work they do and the communicative interactions in which they participate. Learning on the front end such differences among the students and faculty can be helpful when those individuals have to work together. For example, if a clinical supervisor is one who likes to handle plans and deadlines in advance and he/she is working with a student whose personal preference is to meet deadlines at the last minute, some communication will be necessary in order for the interactions between those two individuals to be successful (Wark, 2005).

In the second exercise, students and faculty meet as a group to discuss the issue of defensiveness as it relates to communicative interactions. Gibbs (1961) discussed different “communication

climates” that can be perceived as being either defensive or supportive. For example, some behaviors that appear to be evaluative may increase one’s reaction of defensiveness. If the content, manner, or tone of voice of the sender of the message appears to be evaluating or judging the listener, then the receiver may put up some defenses. In contrast, if the listener thought that the speaker considered him/her as an equal and was being open and spontaneous, the evaluativeness of the message might be neutralized. Thus, the two opposing communicative climates in this example are *Evaluation* versus *Description*. An *Evaluation climate* sets up defenses by passing judgment and blaming. In contrast, a *Description climate* tends to arouse a minimum of uneasiness and supports the individual by asking for information, presenting feelings and perceptions, and participating in a process without implying that the receiver must change behavior. The six defensive and supportive climates discussed by Gibbs (1961) are:

Defensive Climates	Supportive Climates
Evaluation	Description
Control	Problem Solving
Strategy	Spontaneity
Neutrality	Empathy
Superiority	Equality
Certainty	Provisionalism

These contrasting climates are presented to students and faculty, and their application to the process of clinical education of our students is discussed. Students and faculty are encouraged to role play each contrasting climate in order to demonstrate positive and negative examples of communicative interaction.

Finally, Satir (1976) encouraged individuals to pay attention to the specific words used during communication. Some words that should be used with caution include “**I**,” “**You**,” and “**They**.” Using “**I**” clearly means that you are taking responsibility for what you say, even if what you are saying is your perception. Using “**You**” can be felt as an accusation when only reporting or sharing is intended (e.g., “You are making things worse.”). The use of “**They**” is often an indirect way of talking about “**You**.” It is important to be clear as to who “**They**” are so that the message is concrete and understood. Other words to be used with caution include “**It**” (if used too generally, the meaning/reference can be misperceived); “**But**” (implies using “yes” and “no” in the same sentence; try substituting “and” for “but” and make two like statements instead of contradicting ones); “**Yes**” and “**No**” (a lack of clarity for these terms leaves room for misunderstanding); “**Never**” and “**Always**” (these terms have the potential for guilt and feelings of inadequacy); “**Should**” and “**Ought**” (these are trap words that imply that there is something wrong with you and you have failed).

Each of these communicative interaction exercises increases awareness among faculty (clinical and academic) and students about ways to achieve successful communication. We all must be aware of the different personalities that may be involved in our interactions, the climates in which we communicate, and the words we use to express our thoughts and perceptions.

Increased awareness about these issues will enhance the successful communication that is necessary in the clinical education of our students.

KNOWLEDGE AND SKILLS NEEDED TO PROVIDE CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

The ASHA document, *Knowledge and Skills Needed to Provide Culturally and Linguistically Appropriate Services (2004)*, emphasizes that the ethnic, cultural and linguistic makeup of the United States has been changing steadily during the past few decades. “Cultural diversity can result from many factors and influences including ethnicity, religious beliefs, sexual orientation, socioeconomic levels, regionalisms, age based peer groups, educational background, and mental/physical disability”(ASHA, 2004, p.1). As professionals, we must be prepared to provide services to clients and students that are responsive to this diversity. Recent ASHA demographics demonstrate that less than 8% of ASHA members are from ethnic minority backgrounds, and the same holds true for members who are bilingual or multilingual. Thus, it is imperative that professionals develop appropriate skills. Although the document focuses on the clinical process, we think it is applicable to the supervisory process as well. Supervisors who supervise culturally and linguistically different supervisees need to develop competencies to insure culturally and linguistically appropriate clinical education practices. In addition, they need to be able to guide non-minority supervisees in attaining competencies. Supervisors and supervisees must identify their strengths and weaknesses and develop a plan to address deficiencies. The document identifies the following categories and roles:

Cultural Competence

1. Sensitivity to cultural and linguistic differences that affect the identification, assessment, treatment and management of communication disorders/differences in persons.
2. Advocate for and empower consumers, families and communities at risk for or with communication/swallowing/balance disorders.

Language Competencies of the Clinician

3. Ability to identify the appropriate service provider for clients/patients.
4. Obtain knowledge base needed to distinguish typical and disordered language of clients/patients.
5. Identification/Assessment of typical and disordered language.
6. Treatment/Management of disordered language.

Articulation and Phonology

7. Identification/Assessment of individuals at risk for articulation/phonological disorders.
8. Treatment/Management of individuals with articulation or phonological disorders.

Resonance/Voice/Fluency

9. Identification/Assessment and Treatment/Management of individuals at risk for resonance, voice, and/or fluency disorders.

Swallowing

10. Identification/Assessment and Treatment/Management of individuals at risk for swallowing/feeding disorders.

Hearing/Balance

11. Identification/Assessment of clients/patients with or at risk for hearing/balance disorders.
12. Treatment/Management of individuals at risk for hearing/balance disorders.

The seven-page document details a set of knowledge and skills relative to each category, which provide a focus – the “what “ we need to be able to do. Another strategy to identify learning goals is available on the ASHA website. In response to one of ASHA’s current focused

initiatives, a cultural competence awareness assessment was developed:

<http://www.asha.org/about/leadership-projects/multicultural/self.htm>

Supervisors and supervisees will likely find this assessment valuable for identifying areas of strength and weakness (ASHA 1998, 2005). In addition, publications by Goldstein (2000), Langdon and Cheng (2002) and Roseberry-McKibben (1995, 2002) are helpful resources.

CONCLUSION

The current ASHA standards, which require formative and summative assessments of supervisees across the breadth of their clinical training, implies clinical education processes that are consistent with Anderson's continuum model of supervision. Specifically:

- The amount of supervision must be appropriate to the student's level of knowledge, experience and competence.
- The process of assessing students' *developing* knowledge and skill must be completed *throughout* the applicant's program of study.
- Such assessments must evaluate *critical thinking, decision making, and problem solving*.

Poor clinical performance may be the result of inadequate academic preparation; an individual's level of maturity and motivation; sensory or physical problems; and/or gender, cultural and/or age related issues. Our challenge as clinical educators is to identify issues as early as possible so that we can minimize frustration and facilitate successful outcomes for everyone involved.

REMEDIATION EXAMPLE

During this session, a few cases were presented for application and discussion. Following is one case. It was developed by Renee Miler, Chief Speech-Language Pathologist and Coordinator of the Speech and Hearing Clinic at California State University, Fullerton. This particular case was one of four cases presented in a session at the 2004 ASHA convention and is used with permission of the author.

Case Study #1 – Supervisee from Vietnam Proficiency in the articulation management of the American /r/

The supervisee, originally from Vietnam, was enrolled in Child Practicum, a graduate level clinic, for the semester. This supervisee had two semesters to complete in order to receive her M.A. with about 100 ASHA clock hours yet to earn. There had been concerns throughout the supervisee's graduate career, most recently from an off-campus site supervisor, about her accent and her ability to be clearly understood. The supervisee had been enrolled in several accent modification programs prior to and during her graduate school career. In this semester's Child Practicum, she had been assigned a six year old with an articulation disorder and another pre-school child with a language delay. Following the supervisee's contact to set up the initial diagnostic session with the mother of the child with the articulation disorder, the child's mother called the clinic coordinator and voiced her concerns about the supervisee working with her son and being able to model /r/ successfully because of the supervisee's accent. Following this discussion with the parent, the coordinator discussed the situation with the supervisee's immediate supervisor as well as a faculty member who was heading the Speech Instrumentation Clinic at the university. The group discussed the possibility of adding instrumentation to the treatment regimen as well as bringing a native English speaking clinician into each therapy

session to model /r/. The supervisor discussed the plan with the supervisee, letting her know that the program was fully supporting her in the practicum and hoping that the accommodations that we would be making would allow her to increase her improve her skills in working with children with articulation disorders. The supervisee would be in charge of doing initial and final semester assessments, writing lesson plans and all other written documentation, providing feedback regarding the child's performance in the therapy session as well as any parental conferencing responsibilities. The native English speaking clinician would be brought in to be a model for correct /r/ production as well as implement the use of instrumentation. The supervisee discussed her anxiety in working with this particular child because of the mother's concerns about her "competence" because of her accent. The supervisee was assured that the program was committed to assisting her in the process of working with this child and she was in agreement with the solution that had been formulated. The coordinator contacted the child's family and spoke with the mother about the solution to working with her son's articulation issues and the child's mother expressed her opinions about trying a new approach. We conveyed to the mother that we were a training program committed to working with a diverse student body while at the same time balancing her interest in having her son receive the best possible therapy. The supervisee and supervisor met regularly to discuss the progression of therapy while the English-speaking model was brought into some of the meetings. The supervisor met with the supervisee throughout the semester and assisted the supervisee in a number of different areas such tracking data, discriminating correct vs. incorrect responses, test interpretation, report writing, therapy planning and record keeping. The semester had a successful conclusion as was evidenced by the child's progress with the production of /r/. The improved confidence and skills that the supervisee had gained in the area of articulation was also very apparent.

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