True story, 1:
I'd been working as an SLP in an elementary school for some time – I think it was my third year in. I had a little guy with me, super sweet, very cute; presented with many characteristics consistent with an autism spectrum diagnosis. I put two cards in front of him and spoke the question, "Who has a hat?"

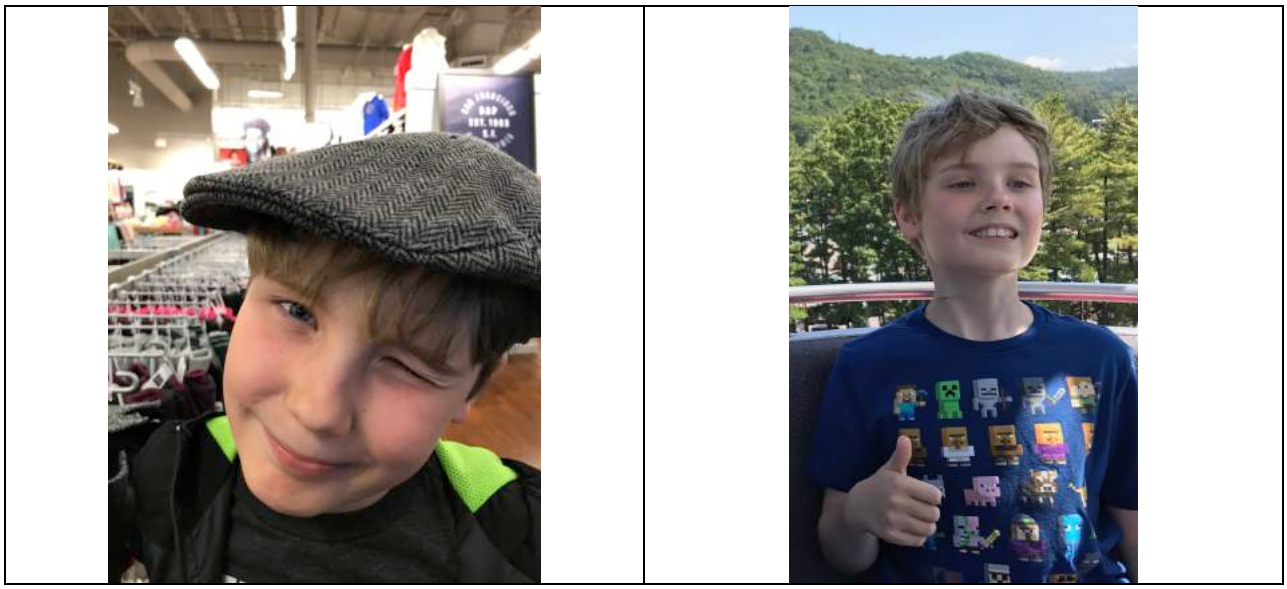


Photo illustrations of how I might've contrasted, "Who has a hat?"

My learner did nothing. So I asked again, this time with a more animated tone: "WHO has a hat?" And he did nothing.

It came to me: what did I *imagine* he was going to do? I knew he didn't comprehend WH-questions, that was one of the reasons he qualified to see me. What was *I* doing? I hadn't taught him how to understand. I hadn't taught him the task we were engaging in. I hadn't taught him how to respond.

Someone asking him questions he had no reckoning with was what he experienced all of the time with everyone everywhere. He came to me because I supposedly could be different, and I wanted very much for that to matter.

True story, 2:
Some time later, I had taken a new position, working in part as an instructor of practicum experiences overseeing the assessments for Augmentative and Alternative Communication (AAC) in a University clinic. I was made aware (probably by email) that I needed to start taking on cases for AAC intervention. I was provided a grad student's name, a client name and contact, the schedule, and the supervision rule for how to construct my time weekly: 30 minutes for review of paperwork/feedback, 30 minutes to meet with student and discuss, 25% observation of sessions in the clinic or 100% if we were at another location.

Let's say it was my third semester there, so I had a copy of the clinic manual. I would've done grading for at least 2 assessment teams, so I knew that there was a quantitative feedback process. No one had ever observed/reviewed my supervision approach, my assessment plans, reports, grading, or discussions, nor asked about either the student or client satisfaction.

One night after my own kids' were in bed, I was going through the grad student's paperwork and I couldn't follow her therapy lesson plan. I emailed and asked if we could talk, and by phone from my home I asked her to share with me her thinking: according to her data, the learner was not showing progress, but I didn't see any connection to that in her lesson plan.

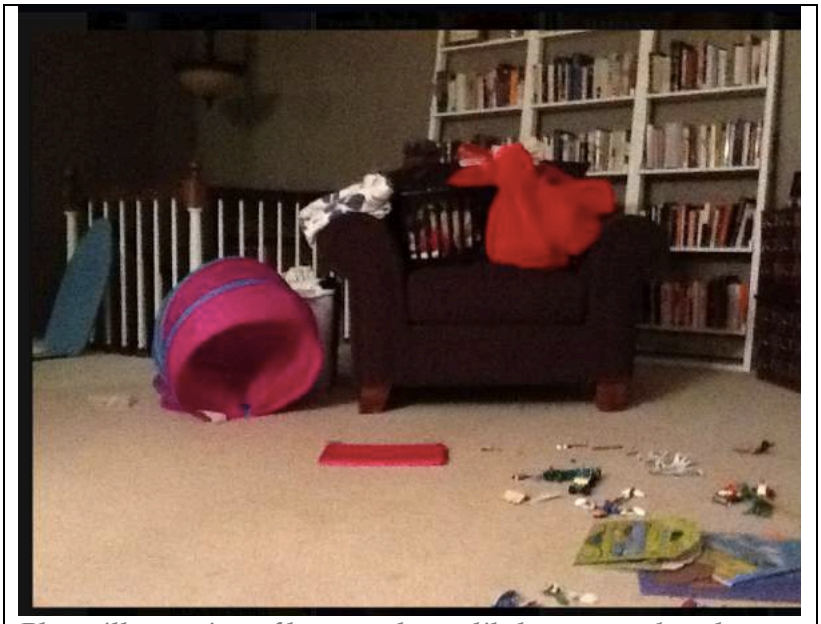


Photo illustration of how my home likely appeared at the time of my phone call.

I said that her objective data should inform what she did next in her plan: they should be clearly related.

Pause. Then she asked, "What do you mean?"

I realized it, again: it's the teaching. If I could supposedly be different to this grad student, and, through her to the learner she served, if that was going to matter, I had to teach it as if it mattered.

Photo illustration of me.

My name is Jessica Currall. I have an MS and I have worked as fully certified Speech-language Pathologist (SLP) since 2003. I was in the public school system primarily in an elementary school setting for about 8 years. That time included my year of clinical fellowship, and I lead a couple of presentations within my district. I was never asked to mentor or supervise in any capacity. I left that position to work in a University setting with a dual role of research assistant and clinical supervision, which I did for about 8 years. I absolutely claim no expertise.

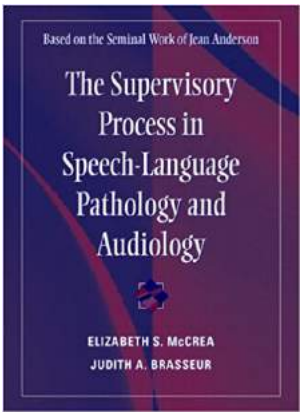
I have nothing to financial to disclose.

Beyond financial disclosure, I extend that my bias as an SLP has developed to be strongly anchored around multimodal communication for everyone. I believe that with very few exceptions everyone benefits from and intuitively incorporates a range of sounds with mouthparts, gestures with face and body parts, visual media (print and images), and increasingly nowadays, technology.

I aim for this to be in keeping with first-person accounts such that it will include:

- discussion about the relationships in clinical practicum instruction in a University setting that came to be meaningful to me, and
- sharing resources about the ways I experienced the conversations with graduate student clinicians about intervention for serving persons with complex communication profiles. Specifically, I rallied around:
  - staged teaching,
  - materials of instruction and reference about being a clinician, and
  - examples and role play towards explicitly *teaching* the teaching.

Although I read a lot and sought continuing education, I would not characterize what I did as exhaustive review of literature/evidence. Although I intentionally tried to keep careful notes and be consistent within myself, I cannot even estimate a sense of validity or reliability. To be clear: my story is not a review of a clinical practice (relative to supervision), that was "designed" or meets an evidence-based criteria.



I don't precisely recall the timeline on when I came into some of the resources that shaped my thinking, but The Supervisory Process in Speech-Language Pathology and Audiology (2003) by Elizabeth S. McCrea and Judith A. Brasseur was soon after that late night phone call with my student. It has been defining and revelatory. Even the "Preface to the Original Edition" struck me – most notably:

(1) that being in a supervision or mentorship role is a statistically likely situation for most SLPs at some point in their career, but one that we were not likely to have been prepared for explicitly or supported with during, and
(2) the challenge, "Is there something in this teaching aspect of supervision that makes the difference between clinicians who become clones of their supervisors and clinicians who are able to go beyond their supervisors and become independent, autonomous clinicians…?" (xviii)

I found Jean Anderson's Continuum Model of Supervision (1988) to be elegant in its ambition, and the gradual release of responsibility premise aligned well with my beliefs about teaching generally.

Copyright respectful photo scene illustration of Anderson's Continuum Model of Supervision (1988)

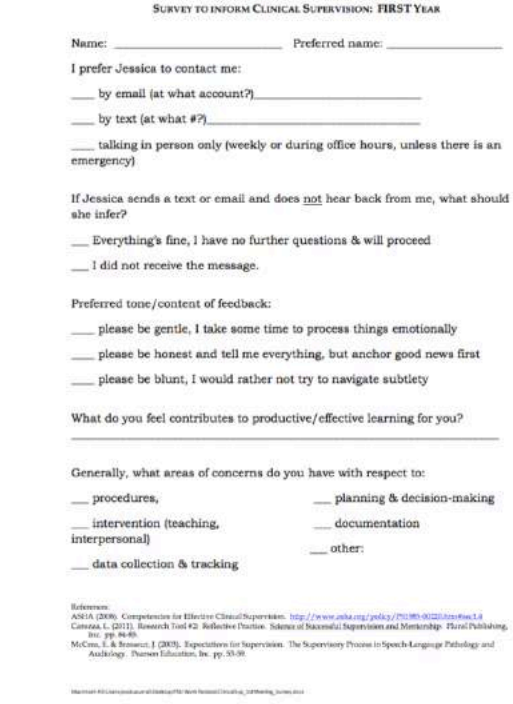
That said, I struggled for a practical translation of identifying where a student clinician was at their starting point in the relationship with me, recognizing the benchmarks of their readiness to transition, and how these fit into the timelines I had no control over: the math for how much time I had to confer with students did not change, the semester shifts did not change. Trying to ensure that students got broad experience with a variety of case profiles limited how much they could rely on previous learning to demonstrate autonomy. The population of persons who had complex communication needs at our university clinic was sufficiently diverse that it was unlikely that a graduate student would be able to build confident familiarity around primary diagnosis characteristics within the two semesters I had opportunity to work with them. Compared to settings which have specific expertise and protocols with aphasia, for example, I might be directing a student to readings for early intervention with a toddler diagnosed with Down Syndrome in the Spring semester of their first year, and preparing for end of life means of communication for an adult with ALS in the Fall.

Certainly they would also have opportunities to work with other supervisors and settings, building an overall skill set, but I was never quite sure how to assess and characterize Anderson's "Transitional/Collaborative" phases where my role would be less direct.

The pattern which had resulted was an unstable combination of:
(1) how much energy I had,
(2) how 'strong' versus 'stressed' the student presented in conversations and documentation, and
(3) what data they shared with me on their learners progress (contingent on the first point). If their learners were showing positive trends, I hoped that was an indicator that the graduate student clinician knew what they were doing.

So I put together/revised a series of own lesson plans (and related materials) staged according to a need-based timeline consistent with the required components of the academic semester. That helped me feel I was consistent with a structure student-to-student and semester-to-semester, modeled my belief that incorporating multimodal communication benefits everyone, and maximized my time/energy.

Before I met with a student, I asked that they provide me with information from the following 1-page surveys (depending on what year they were in the grad program).



SURVEY TO INFORM CLINICAL SUPERVISION: FIRST YEAR

Name: _____ Preferred name: _____

I prefer Jessica to contact me:

___ by email (at what account?)_____

___ by text (at what #?)_____

___ talking in person only (weekly or during office hours, unless there is an emergency)

If Jessica sends a text or email and does not hear back from me, what should she infer?

___ Everything's fine, I have no further questions & will proceed

___ I did not receive the message.

Preferred tone/content of feedback:

___ please be gentle, I take some time to process things emotionally

___ please be honest and tell me everything, but anchor good news first

___ please be blunt, I would rather not try to navigate subtlety

What do you feel contributes to productive/effective learning for you?

_____

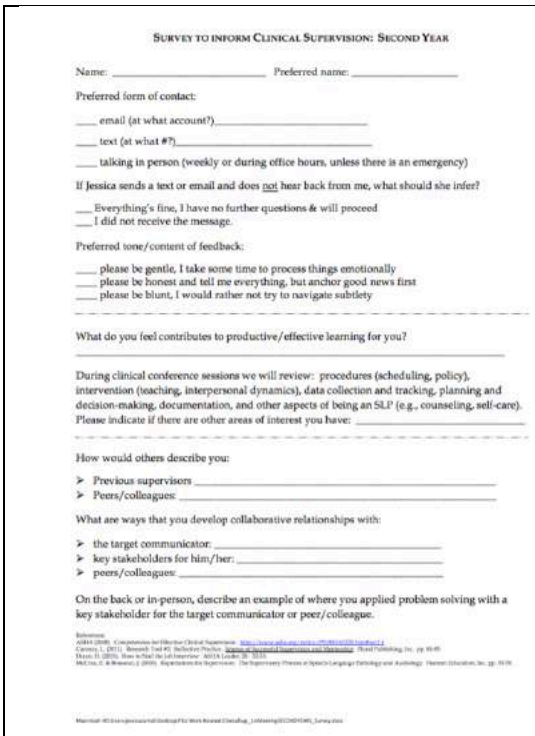
Generally, what areas of concerns do you have with respect to:

___ procedures,
___ planning & decision-making
___ intervention (teaching, interpersonal)
___ documentation
___ other:
___ data collection & tracking

References:
ASHA (2008). Competencies for Effective Clinical Supervision. http://www.asha.org/policy/PS2005-00220.htm#sec3.0
Carozza, L. (2011). Research Tool #2: Reflective Practice. Science of Successful Supervision and Mentorship. Plural Publishing, Inc. pp. 84-85.
McCrea, L. & Brossart, J. (2003). Expectations for Supervision. The Supervisory Process in Speech-Language Pathology and Audiology. Pearson Education, Inc. pp. 53-59.

For students at the very beginning of their experience, I wanted to get to know their personality, preferences, and awareness of themselves and how they relate to others.

Specifically:
- I didn't assume that the name I was given is what they wish to be called,
- what our agreed-on sense of electronic etiquette would be,
- I introduced the idea of different kinds of feedback and learning, including ways of getting familiar with someone else,
- I gave an overview of topics I consider to be pivotal to clinical practice as an SLP,
- I modeled that references matter, and
- I demonstrated one organizational strategy (using filename paths in the footnote to track digital storage).



SURVEY TO INFORM CLINICAL SUPERVISION: SECOND YEAR

Name: _____ Preferred name: _____

Preferred form of contact:

___ email (at what account?)_____

___ text (at what #?)_____

___ talking in person (weekly or during office hours, unless there is an emergency)

If Jessica sends a text or email and does not hear back from me, what should she infer?

___ Everything's fine, I have no further questions & will proceed
___ I did not receive the message.

Preferred tone/content of feedback:

___ please be gentle, I take some time to process things emotionally
___ please be honest and tell me everything, but anchor good news first
___ please be blunt, I would rather not try to navigate subtlety

What do you feel contributes to productive/effective learning for you?

During clinical conference sessions we will review: procedures (scheduling, policy), intervention (teaching, interpersonal dynamics), data collection and tracking, planning and decision-making, documentation, and other aspects of being an SLP (e.g., counseling, self-care). Please indicate if there are other areas of interest you have: _____

How would others describe you:

- Previous supervisors _____
- Peers/colleagues: _____

What are ways that you develop collaborative relationships with:

- the target communicator: _____
- key stakeholders for him/her: _____
- peers/colleagues: _____

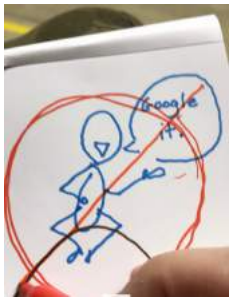
On the back or in-person, describe an example of where you applied problem solving with a key stakeholder for the target communicator or peer/colleague.

References

	With the graduate students coming back after their summer off-site placement, I had a *slightly* different approach. Some of the key elements remained, but I also want to encourage an increased sense of that semester as a last stepping-stone. Specifically: - I included questions that have commonly been asked when providing references for students at CFY/job placements, - In addition to the overview of topics featured, I established collaboration and problem-solving as critical skills.

When we met, we reviewed their form, as well as discuss initial observations. For example, clothing and jewelry can often lend insight into a persons interests – talking openly about the role faith, sports/athleticism, politics, and movies/theatre has in a graduate student clinician's life has lead to important conversations around cultural influences and diversity.

In that first interaction, I also briefly shared about myself.

These are NOT me or my philosophy of supervision.   	I definitely did not want to give the impression that I was flippant about the process, or that I know/see all in some magical way. I have used in-the-moment line drawings, comics, and photographs as a means of illustrating how images/visuals are frequently incorporated into day-to-day life and support getting to know one another. In addition to photos on mobile technology, folks may have wallet photos, key chains, tokens or mementos (like a treasured fortune cookie fortune, or baseball game ticket stub).

These are MORE *me*.   	I chose these photos specifically because: (1) I have End Stage Renal Disease (ESRD). I currently have successful treatment with a transplant kidney; however, that means I have a diminished immune system. If they were ill, I expected them to take care of themselves by prioritizing rest and well-being, and that we would not meet in person until they felt better. I shared that sometimes I feel undisturbed about my health, and sometimes I have sadness and anger about it (the "FU2" part). Not only is this okay for me, and for them, but I took this as a practice chance hearing Big and/or Emotional news from someone else and receiving it with empathy and respect. (2) In terms of family: I am married, and have twin pre-teens.

Next, I explained how I viewed my role:

This is my philosophy of *teaching*:

(1). I strive to be thoughtful and intentional about providing opportunities to build resilience around discomfort and uncertainty.
- By engaging learning which is purposeful, the result of experience, multifaceted, and an active process.
- By introducing resources and strategies to support problem solving and connection.

(2). I want my principles and my actions to be aligned.

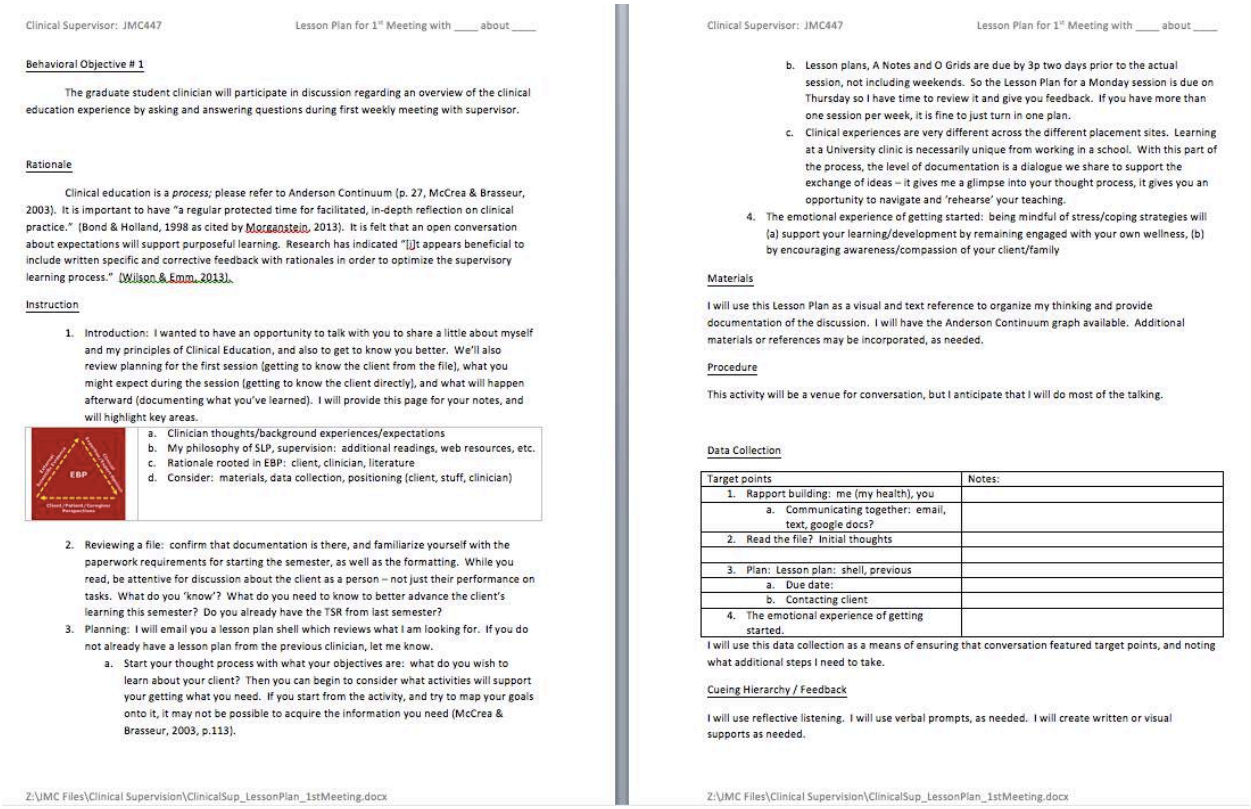
I talked a little about my verb choice. I struggle with the identifier, "speech-language pathologist" because it does not convey the *doing*. I don't speech-language pathologize, and I am not theraping. For some people, terms like "coaching, guiding, counseling" or "serving" resonate, and I share that as students progress in their career they will likely gravitate to a term or metaphor that best represents their self-concept.

I re-iterate in writing and speaking to them my commitment to our relationship.

I want to be very mindful and consistent that I am myself doing with them what I express is important to teaching.

Going through these introductions typically took the first 7 minutes of our half-hour consultation. I then had prepare them to be in a room with their learner, which necessarily included their readying a lesson plan, activities and materials, means of communication and organization, and data collection.

My lesson plan for that discussion was one page, double-sided. First, I oriented them to the overall structure – the areas covered, and what they meant to me. I did not read to them each section, but drew their attention to the key ideas (sometimes underlining or making additional notes by hand).



Clinical Supervisor: JMC447 Lesson Plan for 1st Meeting with ____ about ____

Behavioral Objective # 1

The graduate student clinician will participate in discussion regarding an overview of the clinical education experience by asking and answering questions during first weekly meeting with supervisor.

Rationale

Clinical education is a *process;* please refer to Anderson Continuum (p. 27, McCrea & Brasseur, 2003). It is important to have "a regular protected time for facilitated, in-depth reflection on clinical practice." (Bond & Holland, 1998 as cited by Morgenstein, 2013). It is felt that an open conversation about expectations will support purposeful learning. Research has indicated "[i]t appears beneficial to include written specific and corrective feedback with rationales in order to optimize the supervisory learning process." (Wilson & Emm, 2013).

Instruction

1. Introduction: I wanted to have an opportunity to talk with you to share a little about myself and my principles of Clinical Education, and also to get to know you better. We'll also review planning for the first session (getting to know the client from the file), what you might expect during the session (getting to know the client directly), and what will happen afterward (documenting what you've learned). I will provide this page for your notes, and will highlight key areas.

   a. Clinician thoughts/background experiences/expectations
   b. My philosophy of SLP, supervision: additional readings, web resources, etc.
   c. Rationale rooted in EBP: client, clinician, literature
   d. Consider: materials, data collection, positioning (client, stuff, clinician)

2. Reviewing a file: confirm that documentation is there, and familiarize yourself with the paperwork requirements for starting the semester, as well as the formatting. While you read, be attentive for discussion about the client as a person – not just their performance on tasks. What do you 'know'? What do you need to know to better advance the client's learning this semester? Do you already have the TSR from last semester?
3. Planning: I will email you a lesson plan shell which reviews what I am looking for. If you do not already have a lesson plan from the previous clinician, let me know.
   a. Start your thought process with what your objectives are: what do you wish to learn about your client? Then you can begin to consider what activities will support your getting what you need. If you start from the activity, and try to map your goals onto it, it may not be possible to acquire the information you need (McCrea & Brasseur, 2003, p.113).

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Clinical Supervisor: JMC447 Lesson Plan for 1st Meeting with ____ about ____

   b. Lesson plans, A Notes and O Grids are due by 3p two days prior to the actual session, not including weekends. So the Lesson Plan for a Monday session is due on Thursday so I have time to review it and give you feedback. If you have more than one session per week, it is fine to just turn in one plan.
   c. Clinical experiences are very different across the different placement sites. Learning at a University clinic is necessarily unique from working in a school. With this part of the process, the level of documentation is a dialogue we share to support the exchange of ideas – it gives me a glimpse into your thought process, it gives you an opportunity to navigate and 'rehearse' your teaching.
4. The emotional experience of getting started: being mindful of stress/coping strategies will (a) support your learning/development by remaining engaged with your own wellness, (b) by encouraging awareness/compassion of your client/family

Materials

I will use this Lesson Plan as a visual and text reference to organize my thinking and provide documentation of the discussion. I will have the Anderson Continuum graph available. Additional materials or references may be incorporated, as needed.

Procedure

This activity will be a venue for conversation, but I anticipate that I will do most of the talking.

Data Collection

Target points	Notes:
1. Rapport building: me (my health), you	
a. Communicating together: email, text, google docs?	
2. Read the file? Initial thoughts	
3. Plan: Lesson plan: shell, previous	
a. Due date:	
b. Contacting client	
4. The emotional experience of getting started.	

I will use this data collection as a means of ensuring that conversation featured target points, and noting what additional steps I need to take.

Cueing Hierarchy / Feedback

I will use reflective listening. I will use verbal prompts, as needed. I will create written or visual supports as needed.

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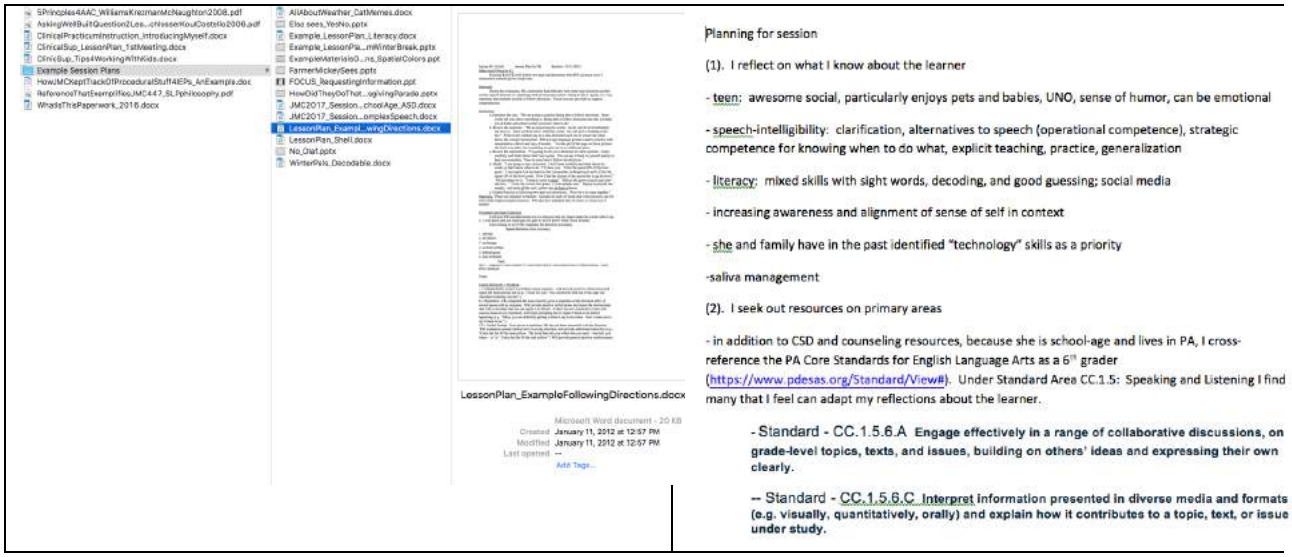
Key things I emphasized relative to #3. Planning were:

- Start from understanding what their objective was rather than from the activity (e.g., I am not fond of: "I have Connect Four ®, so we'll do that and I'll ask WH-questions.").
- Lesson plans at this level of detail are typically not possible for most SLPs outside of a university clinic; their function at this time in their career is to engage and document their thought process so that we can have a dialogue together. There may be other situations past grad school where it is valuable to script and outline, but one goal I have is that by the end of the semester we are no longer practicing this bureaucracy. I was always going to require to see their data and to know how that influenced their decision-making and that could take place by email narrative or during our in-person meeting. That said: Anything weird comes up, we return to a more directed level on the Continuum.
- The experience of fatigue, stress, and even shock they are feeling at the end of this meeting is real and valid; paying attention to it will inform their practice. I know that it *is* overwhelming – I anticipate that they are likely tired, possibly dehydrated, and there's a good chance that their mind is a blank. It's not that

> they don't care enough, or haven't paid attention, or aren't up to the task. It's that these *are* big, cognitively demanding topics, even in the best possible situation (like, they chose and want to learn this). AND these feelings are only a fraction of what persons, families, and school teams go through when they have catastrophic communication challenges. Knowing this, recognizing at least this much, convinces me that incorporating a variety of means like stories, photographs, print take-home materials, and a follow-up e-mail greatly increases the likelihood that the person will be able to cope and move forward.

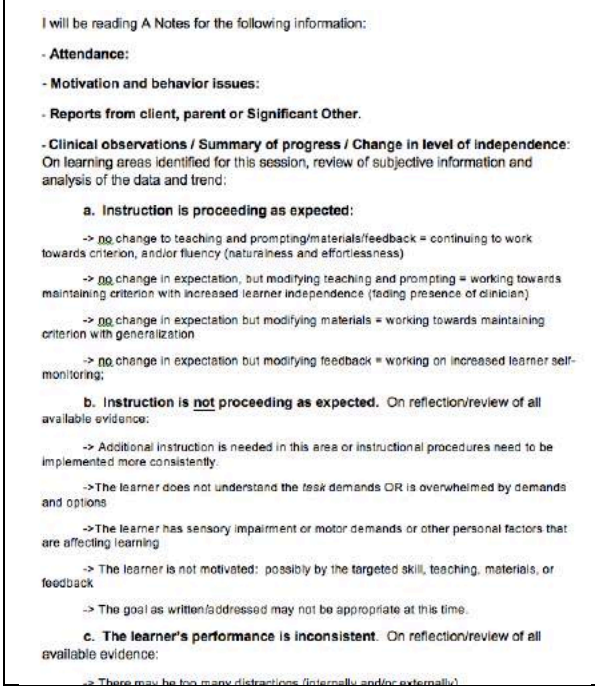
In my follow-up email to them, I extended access to digital cloud storage which included a variety of resources and example lesson plans. With many students, I would attach a discussion specific to their learner that detailed my thought process for an initial session. They were welcome to use what I provided, come up with a completely unique lesson plan, or a hybrid.



I encouraged the students to be mindful of what it felt like to review lesson plans and data collection created by someone else – what I gave them was one way of approaching the situation, not the only or best way. I said that I knew they may process and express themselves very differently than I did, and forcing the issue would actually result in being distracted during their teaching and/or compromise the accuracy of their data.

Lesson plans of this nature followed the stages throughout the semester clinic cycle: we reviewed documentation (session notes, often referred to as "SOAPs"), setting goals and taking data, and session structure for instruction (which I believe has important features distinct from assessment/establishing baseline phases).

Broadly with each category of clinical practice, I had supplemental materials and resources for their consideration.

My lesson plan on **documentation** reviewed principles of clinical writing, including on how professionalism might be conveyed differently in word choice and organization based on the setting – early intervention often has a different tone than rehab facilities, for example. With this, I directed them to Wilkerson, DL (2000) Documenting Clinical Service Delivery: Writing Style and Lexical Selection. *Contemporary Issues in Communication Disorders, 27:* 6-13.	The lesson plan on **session structure** discussed a distinction between directions (relaying what are the demands of the task), and instruction (teaching the skills needed to understand and communicate effectively); or between corrective/generic feedback ("Right! You got it!" or "No. Try again."), instructive feedback ("You looked at all of your choices and pointed to tell me about the cat!"), and rationale feedback ("Awesome! The more you practice like this, the more you can communicate to anyone, anywhere, any time you want.").
In addition, I provided what I personally look for in clinic notes and features that connect what happened in the session to how they will prepare for the next one*:*  I will be reading A Notes for the following information: - **Attendance:** - **Motivation and behavior issues:** - **Reports from client, parent or Significant Other.** - **Clinical observations / Summary of progress / Change in level of independence**: On learning areas identified for this session, review of subjective information and analysis of the data and trend: **a. Instruction is proceeding as expected:** -> no change to teaching and prompting/materials/feedback = continuing to work towards criterion, and/or fluency (naturalness and effortlessness) -> no change in expectation, but modifying teaching and prompting = working towards maintaining criterion with increased learner independence (fading presence of clinician) -> no change in expectation but modifying materials = working towards maintaining criterion with generalization -> no change in expectation but modifying feedback = working on increased learner self-monitoring; **b. Instruction is not proceeding as expected.** On reflection/review of all available evidence: -> Additional instruction is needed in this area or instructional procedures need to be implemented more consistently. ->The learner does not understand the *task* demands OR is overwhelmed by demands and options ->The learner has sensory impairment or motor demands or other personal factors that are affecting learning -> The learner is not motivated: possibly by the targeted skill, teaching, materials, or feedback -> The goal as written/addressed may not be appropriate at this time. **c. The learner's performance is inconsistent**. On reflection/review of all available evidence: -> There may be too many distractions (internally and/or externally)	*In addition,* we would talk about what it meant teaching children versus teaching with adults. As perspective on this, Knowles (1980) put forward a comparison of pedagogy and andragogy that I felt was useful in identifying distinctions in our own dynamic (as mentee-mentor), compared to interactions with themselves (as adults) and their child learners in the clinic. It also highlighted the shifts of how they might engage with the same child's parent or school teacher, which has social and emotional implications separate from teaching to an adult learner with complex communication needs. Finally, it was often an opportunity to touch base about generational mindsets.

In the Fall, second-year graduate students returned to the campus clinic having been at an off-site placement – often in more medical settings. I continued to provide digital copies of the same lesson plans, but the conversations around them were significantly more collaborative – hearing about their experiences elsewhere, talking about how their sense of themselves as SLPs was shaping , and building shared expectations. The most

significant difference in my approach with these students included two "reflection" activities.

Along with their personal surveys at the beginning of the semester, they were to set aside 15 minutes to review three references I provided and email me a 1-paragraph response to any one of them they chose. My materials for this activity were:

- the Cheshire Cat interaction from Alice in Wonderland (which comments on making choices to determine the path),
- the Anderson Continuum graph (1988), and
- a description of a typical supervision conference as presented in the literature (McCrea & Brasseur, 2003, p. 17).

I wanted to indirectly provoke them to consider how they wanted our relationship to proceed and to participate in having that dynamic shift. I deliberately picked a piece that was artful in nature, something graphic/analytical, and something which more closely resembled the types of readings they commonly did for coursework. I could never predict which students would respond to what piece, but it was consistently a productive activity and lent insight about how we could best utilize our final semester together.

At the mid-point in the Fall semester of their second year (closely aligning with ASHA's annual conference and the Thanksgiving holiday break), I emailed the students a second reflection task. Again, I requested they set aside 15-minutes for three different references and email me a 1-paragraph response to any one they chose. I also structured my materials with similar principles: something artful, something graphic/analytical, and a scholarly publication. These included:

- a YouTube link to a four-minute segment of the documentary, "Between the Folds,"
- the graph depicting the OODA decision loop by U.S. Air Force Colonel, John Boyd, and
- Finn, P. (2011). Critical thinking: Knowledge and skills for evidence-based practice. *Language, Speech, and Hearing Services in the Schools*, *42* (69-72).

My intention was to set a stage around a theme of "trust the process." At our next supervisory conference, I would establish that I highly valued explicitly talking about how SLPs sustain critical thinking outside of the academic habits of grad school even though that semester end is often a stampede of activity. I also provided resources about engaging in lifelong learning. Relative to the reflection itself, I <u>loved</u> this activity. It was always profoundly interesting what struck graduate students at that point in their lives. We had great discussions about how they related to coping with significantly less supervision; but if they made different connections than I had considered, I did not "correct" them.

There are a handful of other things I utilized as part of my clinical practice as a supervisor as part of the structure of the relationship (an outline for conferences), or within feedback of sessions. Specifically, the form I used for notes of observations

included both immediate comments/questions on what I had seen, and what were more trend-based reviews which connected what they were doing to those behaviors featured on the grading rubric. I used two print-outs of this sheet with carbon paper between so that they got immediate notes and I had a copy to keep. I liked that this underscored "low-tech" methods are useful across the range of clinical needs.

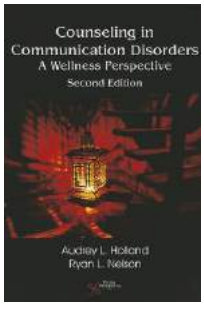
Time Observed: _____

Clinician: _____ Client: _____ Date: _____

Subjective:	Lesson Plan due:	Received:	Feedback:
	Develops approp weekly goals		Weekly activities rel to goals
	Rationale stated		Involved client/family
Objective:	Develops approp LTG goals		Develop D/C plan
	Consistent cueing hierarchy		Consistent feedback/reinforcement
	Time mgt.		Behavior mgt.
	Maintain/generalize in clinic		Maintain/generalize out of clinic
Assessment:	Intro	Wrap-up	Adequate # of trials/opportunities
	Clear directions		Universal precautions
	Approp. meaningful, fx'l materials		Variety of materials
	Implements plan		Knowl of technology/equip
	Prepares data sheets in advance		Consistently collects data
	Collects accurate data		
	Updates O grid (data changes)		Updates A notes (review client progress)
	Modifies cueing hierarchy if needed		Modifies goals if approp to data
	Flexibility in session (teaching)		Responsivity in session (behaviors)
	Interprets nonverbal		
	Paperwork: Administrative		Paperwork: Weekly
	Semester deadlines		Revisions
	Grammar/language/organization		
	Recommendations		
Plan:			
	Clinician's communication style		
	Counseling		Response to questions
	Ethics, ASHA		Professional appearance

It is highly likely that many of these ideas were inspired directly or indirectly by Linda Carozza's Science of Successful Supervision and Mentorship (2011). I don't know with specificity because, as with most of my experiences as an adult learner myself, I came into and incorporated information with a fair amount of blending. I know for-sure that I found it to be an incredibly supportive resource, and I particularly appreciated the style of teaching Carozza set up with a closure/review statement at the end of each chapter, thought-provoking questions for engaging my personal stance, and a forecast of what topics were upcoming.

While I am giving credit where credit is definitely due: I love Dr. Audrey Holland's work. Counseling in Communication Disorders: A Wellness Perspective, 2nd Edition, co-written with Dr. Ryan Nelson (2013), is beautiful and presents a framework around being an SLP that inspires and heartens me.



Dr. Holland has contributed presentations and materials to SpeechPathology.com that I very much appreciated; and there are a number of other courses available there and from directly from the American Speech-Language and Hearing Association (ASHA) about supervision by other contributors that I benefited from completing. The more I looked for ways to develop how I related to my role in a graduate student's experience, the more I found and the better I felt.

Please refer to:
ConversationsAboutConversations_2, and
ConversationsAboutConversations_References