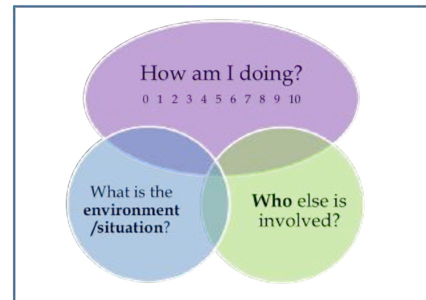
Please refer to Conversations about Conversations_1 for the initial context.

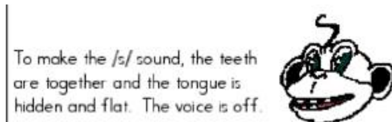
What I have described so far was what I built as tools which I might characterize as teaching the tasks of clinical practice: what the SLP does as part of being a professional, and/or the pragmatics of doing the job. Since it is one of my fundamental beliefs that everyone is a multimodal communicator, I used a range of presentation styles. As such, teaching someone who integrates a variety of means within their repertoire of modalities is not fundamentally different than the kinds of task analysis we do to provide classic "speech" intervention with someone with a phonological disorder (as one of many alternate examples within an SLPs purview).

The actual elements may be different :

- coaching an adult with an acquired disorder to recognize the person-partner-environment characteristics which warrant what strategy they apply, versus



- sharing with a child how to position their teeth and tongue in particular ways to produce specific sounds.



However, in both cases, my expectation would be that the student clinician make careful observations to determine their learner's strengths and stimulability, and to build strategically. I also always expected them to do more than present an opportunity and give feedback. These are existential distinctions between being a skilled professional and being like everybody else.

More often than not though, having ideas about *how* to teach is itself a profoundly new experience (across all learner profiles). My having relevant materials of instruction immediately available allowed for demonstrations and role-play. Here again, I often reminded the grad students that any feelings of discomfort or awkwardness with me were important practice for what they or their learner would likely experience in the clinic session.

True story, 3:

<table>
<tr>
<td>
Photo illustration of grad students' point of view of where I sat.</td>
<td>A handful of times, graduate student clinicians would say something along the lines of, "I just want to know what you know."

At least once, I got kind of exasperated about it. I said that wasn't fair: I earned what I know. I didn't know then what I know now. I worked through a ton of not-knowing before I got to even where I am. Further, I said, it wasn't my job to tell what I know. I considered it my job to help her cope with the not-always-knowing.

Neither of us dwelled on this perspective long: there simply wasn't time.

There was too much to do.</td>
</tr>
</table>

For the purpose of the discussion that follows, I'm going to reference how I might orient a graduate student clinician starting their first clinical semester, which immediately followed their having taken a grad-course dedicated to AAC. The graduate student would have demonstrated interest in AAC and likely have had some background with persons who have exceptional circumstances.

The learner in this example is an incredibly spunky early elementary school-age child who appeared interested in music, light, and motion. She was able to stretch her arms and close her hand in a grab but it was not clear if she was volitionally releasing/throwing or if those were just motor patterns she had habituated. Given significant support from an adult, she could ambulate, or she could independently scoot around on the floor, but most sessions she was in a wheelchair as a safety precaution.

Across vocalizations, facial expressions, and behavior moving towards or away from items, she presented to unfamiliar partners most consistently as "emerging" on the UW Augcomm Continuum of Communicative Independence (Dowden, 2004), and even folks who knew her well would characterize her as demonstrating scattered "emerging" skills within the Stage III: Unconventional Behavior of the Communication Matrix (Rowland & Fried-Oken, 1996). With the Augmentative and Alternative Communication Profile (Kovach, 2009), she demonstrated strengths with appearing to be socially curious and motivated to intentionally seek out items/experiences of interest, but for other areas (operational, linguistic, and strategic), she was extensively reliant on

her partners. Her mom was extremely resilient and open to technology; however, the reality of home life included additional siblings with pronounced needs, and lots of therapies. A priority was finding more functional and appropriate means of communication to reduce aggressive and disruptive behaviors suspected to be due to frustration and boredom.

In the broadest possible sense of goals, we wanted to:

- develop expectations of focused behavior so that we could start to have a more accurate sense of the learner's comprehension, and
- establish positive/productive causality with means of expression, not just reactivity.

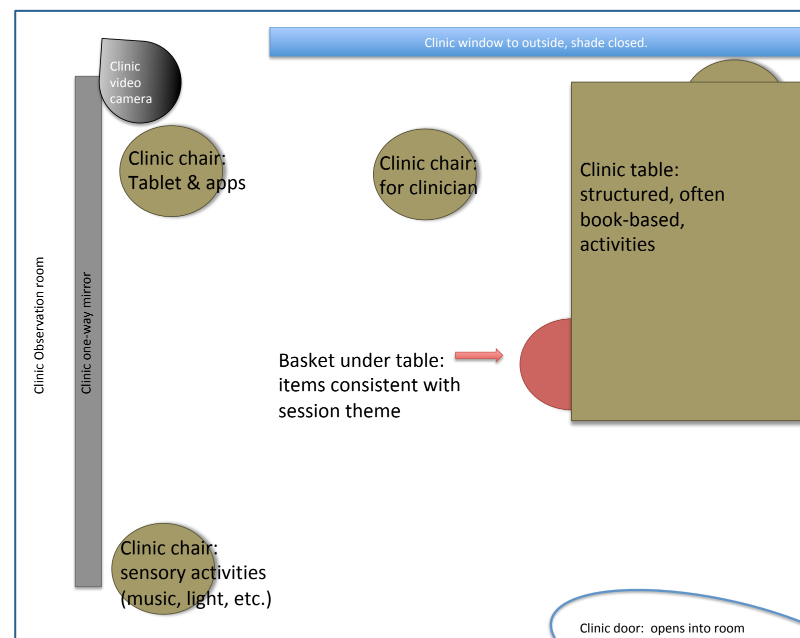
The specific wording of these goals varied some based on the individual clinician and how they related to the situation. Frequently they chose to build off of what the previous semester's had done, but I did not require that. In any case, writing goals would've come <u>after</u> they'd experienced up to 3 sessions of baseline/assessment of present levels, so they had to be prepared in the meantime.

After talking about the learner and the overarching goals, as well as any observations they may have made by watching other sessions and reading the learner's file, I would share my thought process around materials of instruction and practice.

For most learners I would encourage the graduate student to have in mind activities to last approximately 7 to 10 minutes, but it was absolutely fine to repeat the same activity in a session (either exactly or with slight variations on approach). For a 50-minute session, that means that they had to have conceptualized about 5 intervals/activities.

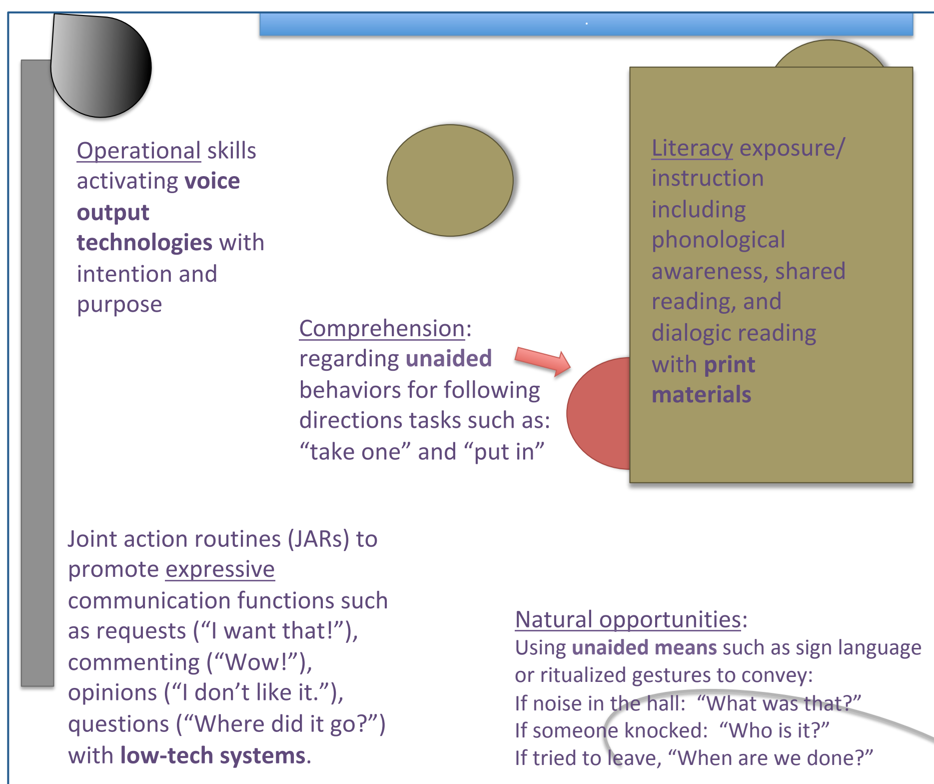
In the interest humanizing the clinic setting as much as possible so that generalization was supported, I tried to impart "less confined" opportunities with room staging. Whenever possible, clinicians would observe one another either directly or by video to get ideas about this; and I would help set up the room and talk through my thought process, or provide schematic outlines for their consideration.

This is *one example* of how the things could be set up in the room:



I don't remember precisely when and I am also paraphrasing, but Dr. John McCarthy posted on the ASHA SIG 12 listserv discussion forum the value of having unique locations within a learning environment as a way of supporting learners to be oriented and engaged. This is also discussed in Learning to Listen, Listening to Learn (2012) by Lizbeth Barclay within "Strategies for Working with Students Who Have Challenging Behavior: Structuring the Environment, Activities, and Communication (p. 254-256). In short: Even when individuals had sensory or motor impairments, using different spaces within a room strategically could keep energy/flow in a learning session, help build associations, and organize experience.

With this in mind, here also is *one example* of how the communicative interactions might be orchestrated:



We would also discuss how the act of data collection might occur in an environment like this; for example, graduate student clinicians could keep post-its or notepads per intended target located near the area where it would be addressed, use clipboards to be able to move flexibly, or apps for tabulating. Important decisions we would discuss would include what, specifically, they were they keeping track of – variety of communicative functions, attempts, level of independence/prompting, effectiveness, means, accuracy, frequency, vocabulary, and so forth. Very frequently I anchored on the process: what do we know, and what do we need to know? Based on their sense of things, they had to resolve what they would look for to be able to take the next steps

(that is, what 'success' might look like so they recognized it when it occurred), and how they would take notes about that in the least obtrusive way. Finally, consistency: pick the approach, and then stick with it.

In an initial, getting-to-know you session, I'd recommend **comprehension** activities along the lines of:

Plan A: By email ahead of the session by a couple of days, ask the parent to bring 3 to 5 small familiar items from home, such as toys, books, and stuffed animals. The graduate student would also think of 3 to 5 objects of his own. All items would be placed in basket, and the target response would ultimately be for the learner to "take one out." At this point though, the clinician would hold basket and watch for three seconds the learner's eye gaze, touch, and/or grasp, then would respond immediately with indicators of interest. That one item would be removed for hand-*under*-hand/co-active exploration* and spoken interaction ("I see. You chose the [whatever]." If it was an item from the child's home, the clinician would respond to any means of expression and model/build an exchange such as, "You brought this from home" or "It is a soft doggy." The Vocabulary Selection Questionnaire for Preschoolers Who Use AAC from Fallon et al (2001) might be helpful to scaffold parent input in developing inventories of personalized vocabulary and related items to be featured.

If it was an item of the clinicians, the exchange would be modeling social closeness and information exchange: "I brought this. This one is mine. This is my [whatever]." After an interval of exploration, the target would shift to her response to the directive "put it in" and he would hold open a bag and wait for three seconds. Following this expectant pause, the clinician should bring the bag to capture the item and either wait for the learner to release it or gently hand-*under*-hand coax it out of her grasp.

Plan B: Have ready 3 to 5 items consistent with the learner's age. As mentioned: Folks who have complex communication needs often have complicated and full lives. As much as her parents may intend to bring familiar items, it may also be simply too much given everything else they are trying to organize. I typically had examples in my office and a bag ready both to practice and, if needed, to contain items on loan. All other aspects remain the same.

Data collection could note 10 trials (for the sake of easy pacing/math), and how many were clearly initiated within the 3-second opportunity. Based on observations, is there reasonable evidence this is an area which would benefit from instruction, modeling, and guided practice? If yes, were there sufficient opportunities to gauge if she needed additional time to complete the task (but seemed to understand the linguistic cue), or needed additional teaching about how to complete the task (appeared to understand

the linguistic cue but would benefit from additional practice in executing tasks of this nature).

*A comment on hand-*under*-hand or "co-active exploration": I have come to have a deep abiding respect for the Guidelines for Encouraging Touch and Hand Use (Barclay, L., 2012, p. 59). My personal opinion has become that hand-over-hand manipulation, also sometimes called full-physical prompting, has little learning value – it has not been my experience that the learner internalizes the behavior/skill itself; instead, everyone habituates altogether different interactions and connections. The risk of compromised independence and loss of dignity has convinced me to avoid it as much as practicably possible.

For the purpose of sharing now, the following is a screenshot of how a structured task might be composed in PowerPoint. However, with a graduate student clinician I would have this prepared exactly how I would want these kinds of **print materials** to be used in a session (including with blank or foil pages).

Potential Objectives featured in Hide and Seek: Family Cat:
- The learner will have repeated opportunities to practice "no" conceptually, as a developmentally appropriate vocabulary, a means of expression "not that," and multimodal communication with either conventional means (such as: shaking head, saying or vocalizing a recognizable version or using a voice-output system which produces "no"), or nonconventional but consistently recognizable means (e.g., including but not limited to enhanced natural gesture, turn away, put hand open-palm forward).

Transition: "Now we're going to play hide and seek together. This way we can practice saying "no" [model]"
Introduction: "Being able to say "no" [model] is important. It's a way to let other people know what we do not want or do not like. It's a way of saying something is wrong or not true.

Directions: "Our silly cat is playing hide and seek! Look! Smokey is going to 'hide'. I will show you the pictures one at a time. Some of the pages will have Smokey. But some will have no Smokey. At my turn, I will ask, "is this Smokey?" You tell me: "No" [model] if there is no Smokey on that page. We will keep going until we find him!

Shuffle target card(s) along with a reasonable number of 'blanks' (easiest level), or foils (contrasting characters, when learner has established more success), and count to as though giving character chance to 'hide'. Then say: "Ready or not Smokey". Here we come!"

Data Collection: Can also note in a general way the learner's participation, interest, responsiveness to model, etc.
Trial 1: ______ Notes/comments: ______
Trial 2: ______ Notes/comments: ______
Trial 3: ______ Notes/comments: ______
Trial 4: ______ Notes/comments: ______
Trial 5: ______ Notes/comments: ______
Trial 6: ______ Notes/comments: ______
Trial 7: ______ Notes/comments: ______
Trial 8: ______ Notes/comments: ______
Trial 9: ______ Notes/comments: ______
Trial 10: ______ Notes/comments: ______

I = Independent; **VP** = Verbal prompt: coaching and instruction provided; **M** = Model; **PP** = Physical prompt such as hand under hand; **0** = In error, did not complete/participate

Notes / error analysis:

Wrap Up: We practiced saying "no" together to find Smokey! "No" is a powerful word.

- With a chronologically older individual who communicates at emerging or context-dependent levels such that 'no' remains a desired target, observe individual and key informants on what is most appropriate way to structure references. It may be that "Hide and Seek" is valued as inappropriate, so can change to something along the lines of "We see Smokey."
- Can use photographs of favorite people (family, friends, beloved characters from movies/shows/books, etc.), decks of cards commercially produced for matching or Uno kinds of games; or on index cards/white paper. Make decision based on interest of individual.
- Additional targets for information exchange (integrating asking "Where" questions, or answering about the cat's location), can easily be incorporated to promote increased communicative functions and practice.

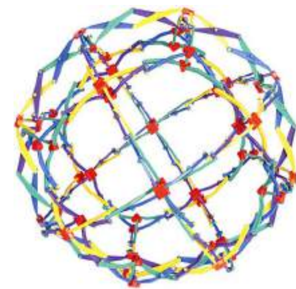
With introducing **operational** engagement with technology as a teachable skill, I would talk with the graduate student about establishing the physical-intentional relationship by coordinating the presentation of the tablet/app and ease of activation with a deliberate and consistent reaction from him or her. The ease of activating modern/capacitive touch screens has, in my opinion, lead to some unfortunate patterns. I have seen that very young children and individuals who present with inconsistent

cognitive associations are provided basic reactive apps such as fireworks or bubbles as leisure, reward, or distraction purposes. The result is kids and individuals who will tap indiscriminately and perseveratively at the screen and can be making it change the display and/or create noise. This is not the same as understanding the physical acts of single-point selection (that is, the body is only in contact with one area of the screen at a time), or the conceptual act of "I meant this specific thing, I did do exactly and only it, which resulted in an effect I intended." So I would recommend the clinician:

- choose an app activity which has a clear up/down on the screen: not just be held in any direction,
- establish from the outset that s/he is the holder of the tablet: not infinite and unrestricted access. This is distinct from when an individual uses a system for communication. In this situation, we are specifically teaching and practicing the skill of operating the touch screen with intention and effectiveness.
- sitting across from the learner, hold the tablet under own face to promote social engagement. Present it within reach for successful activation, and then immediately pull it back so that it cannot be patted.
- instruction, cues, and feedback all orient to the operation of the system: such as, "We are practicing touching the screen in <u>one</u> spot <u>one</u> time." or "Using the tablet this way makes it work better."

Notes from these scenarios should include behaviors suggesting previous experiences with tablets. In addition to attempting to tap it repeatedly versus use a singular effective activation, it would also be relevant if the learner attempted to grab it to herself or push it away, seek the 'home' button, or use swiping gestures. All of these, as well as identifying how it should be set up for clear viewing and sufficient volume, are important indicators for further teaching.

Using sensory materials to entice **expressive language/communication**, I encouraged the graduate clinician to start primarily with observing interactions during initial/baseline sessions for the opportunities to establish joint action routines (JARs); that is, repeated cycles of communication turns around key/anticipatable targets. I am a <u>huge</u> fan of Susan Lederer's work on first vocabularies (2009). I recommended and kept on-hand an array of simple musical instruments like a triangle, drum, or xylophone, and light-making (such as colored LED flash-lights), or tactile items (e.g., different textured balls, fabric).



Example: an expanding sphere often served well for a single message voice output device with the Lederer relational attribute, "big".

Data collection for these scenarios may be served by the <u>Signal Inventory</u> (Siegel & Cress, 2002). This would allow for collaborative discussions with persons familiar with the learner to recognize patterns in behavior that may be shaped to have more

consistent/symbolic function ranging from unaided means including vocalizations and enhanced natural gestures (Calculator, 2002), sign language vocabulary or recognizable approximations, to incorporating visual media like printed symbols, and/or integrating simple digitized voice output devices.

What I hoped this combination of approaches added up to:

- Taking the strengths of the particular learner and her family, the clinician and I would collaborate to manufacture circumstances with the expectation that behaviors would be demonstrated and communication could be built from there across a creative range of means.
- With optimism, consistency, positive regard, and connection as the foundation between the graduate student clinician and I, and then between the clinician and their particular learner: conversations about conversations would occur.
- That their interactions with me around a particular learner would broadly inspire thinking about the skill of teaching as a speech-language pathologist for many, very different learners.
- Finally, that their exposure to and practice with a wide range of resources would encourage them to know that without me or any other direct supervision they were able to process communication to resolve challenges with creativity and resilience -- including if someday one of those challenges may be a mentor/student to oversee.

True Story, 4:

Me to grad student clinician: "I just want to get some feedback – how am I doing with my emails? I'm really trying to make them more clear, and shorter."

Pause. Then she said, "I can tell you are. I mean…I know you are *really* trying. "

That is to say: how did I do with this? How did it all come together? I don't really know.

I know that I was *really* trying.

Photo metaphor of my pretty hopes.

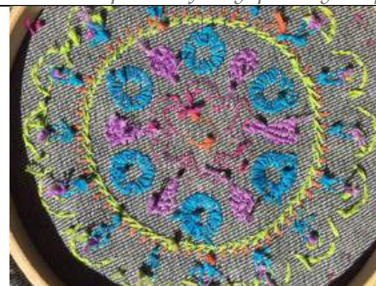


Photo metaphor of what is knot seen.

On subjective review, I did what was important to me more often than not:

- I communicated and taught with multimodal means,
- I put forward opportunities for graduate student clinicians to learn and increase their confidence in their ability to cope,
- If I'd said something was important, I also tried my best to do it.

I had some more objective or quantifiable measures which I valued to solicit engagement, feedback, and critical review from the students.

Midterm Student Evaluation
(page 1 of 3):

Mid-Term Evaluation of Supervision – 595A (Intervention)

With respect to the clinical supervision of Jessica M. Currall, please consider the following and answer honestly and completely.

Preparation / Planning	Poor Not Appro. I disagree		Neutral			Strong Appropriate I agree	
At the start of the semester, I was provided sufficient information/opportunity to learn about the client.	1	2	3	4	5	6	7
At the start of the semester, I was provided sufficient information/opportunity to consider my expectations for supervision.							
I was/have been directed to resources which supported my ability to plan for sessions.							
Example materials have been offered which were appropriate/supported my learning.							
I feel/have felt compelled or pressured to do only what Jessica said.							
I have more to say about Preparation/Planning							
This is what I would like moving forward:							

Supervisory Conferences	Poor Not Appro. I disagree		Neutral			Strong Appropriate I agree	
I feel safe to ask questions or express opinions about…	1	2	3	4	5	6	7
my personal well-being.							
my professional development (my learning and/or practice needs as an SLP).							
the client intervention (teaching the client communication skills).							
the client behavior during intervention.							
the relationship between this experience and what I learned in *classes*.							
the relationship between this experience and what I have *read about*.							
the relationship between this experience and what I *did/heard on mini-externship*.							
what the heck Jessica means when talking or in email – sometimes I feel overwhelmed by how she explains things.							

End of Semester Student Evaluation:
(page 1 of 1):

Student Rating of Teacher Effectiveness
Intervention

	Poor		Neutral			Strong	
1. Please rate the quality of the **learning experience**.	1	2	3	4	5	6	7
2. Please rate the quality of the **instructor**.	1	2	3	4	5	6	7

	Poor Not Appro. I disagree		Neutral			Strong Appropriate I agree	
3. Planning: clinician – I felt encouraged to think independently, make connections between my data and teaching, and develop my plan/materials.	1	2	3	4	5	6	7
4. Planning: supervisor – I felt Jessica was adequately prepared for observations / discussions / instruction (as needed).							
5. Conferences: Jessica was open to questions							
6. Conferences: Discussion met my needs.							
7. Observations: Feedback was meaningful							
8. Documentation: The process was responsive							
9. EBP: My learning felt connected to experience, the specifics of the situation, and evidence/research base.							
10. Guiding principles of AAC (Williams et. al, 2008 ; Reichle et. al, 2016) were represented: a. Communication is a basic right with no pre-requisites, b. AAC must adapt to different environments/needs, c. AAC must be individualized & appropriate to each user, d. AAC must support full participation in society e. All communicators have the right to be involved in all aspects of research, development, and intervention							

If you have any questions or comments, or would like to provide additional feedback/information, please use the back of this page. Your insights are GREATLY appreciated!

I intentionally required this be declared (not anonymous), as part of an opportunity to define expectations.

A variety of options were available to support anonymous reporting.

Averages of total student responses to questions 1 and 2 by semester were included in my annual performance review.

I also found resources for self-evaluation that I could draw from:

I came up with this "SWOT" for myself based on the model in Kerr, J. (2015, July). Examining Our Attitudes toward Clinical Supervision. *SpeechPathology.com*, Article 2748. Retrieved from: http://www.speechpathology.com

I also tried this survey I compiled after reading: Paramenter, J. & Wright, J. (2011). Self-Assessment in Supervision: The Use of the Rubric as a Means of Self-Assessment. *SIG 11 Perspectives on Administration and Supervision, 21*: 68-75. doi:10.1044/aas21.2.68. By this rating scale though, I cannot honestly give myself more than a "2" or "Developing." I never achieved the level of consistency I wanted.

SELF-ASSESSMENT IN SUPERVISION RUBRIC
1

COMPETENCY AREAS (ASHA, 2008)

I. Preparation for the Supervisory Experience p. 2
II. Interpersonal Communication and the Supervisor-Supervisee Relationship p. 3
III. Development of the Supervisee's Critical Thinking and Problem-Solving Skills p. 4
IV. Development of the Supervisee's Clinical Competence in Assessment p. 5
V. Development of the Supervisee's Clinical Competence in Intervention p. 6
VI. Supervisory Conferences or Meetings of Clinical Teaching Teams p. 7
VII. Evaluating the Growth of the Supervisee Both as a Clinician and as a Professional p. 8
VIII. Diversity p. 9
IX. The Development and Maintenance of Clinical and Supervisory Documentation p. 10
X. Ethical, Regulatory, and Legal Requirements (Not included in rubric at this time)
XI. Principles of Mentoring (Not included in rubric at this time)

More information available at: http://www.asha.org/policy/ks2008-00294.htm#sec1.2.4

Rating Scale

Understands	Developing	Competent	Skilled	Mastery
1	2	3	4	5
Can explain & discuss key supervisory issues; has studied supervisory applications; is familiar with the tasks and functions of supervising.	Integrates supervisory knowledge and skills with a limited degree of consistency in routine supervisory tasks.	Applies supervisory knowledge and skills with consistency in routine supervisory interactions and responsibilities.	Demonstrates, applies, and integrates supervising knowledge and skills with a high degree of consistency and effectiveness in most situations.	Is especially skillful in demonstrating, applying, and integrating supervisory knowledge and skills with the highest degree of consistency and effectiveness in routine and complex supervisory interactions

SELF-ASSESSMENT IN SUPERVISION RUBRIC
2

Competency Area: I. PREPARATION FOR THE SUPERVISORY EXPERIENCE	Date of Review	Rating 1	2	3	4	5
A. Knowledge Required						
1 Be familiar with the **literature** on supervision and the impact of supervisor behaviors on the growth and development of the supervisee.						
2 Recognize that **planning** and **goal setting** are critical components of the supervisory process both for the clinical care provided to the client by the supervisee and for the professional growth of the supervisee.						
3 Understand the value of **different observation formats** to benefit supervisee growth and development.						
4 Understand the importance of implementing a **supervisory style** that corresponds to the knowledge and skill level of the supervisee.						
5 Understand the basic principles and dynamics of **effective collaboration.**						
6 Be familiar with **data collection methods** and tools for analysis of clinical behaviors.						
7 Understand types and uses of **technology** and their application in supervision.						
B. Skills Required						
1. Facilitate an understanding of the **supervisory process** that includes the objectives of supervision, the roles of the participants, the components of the supervisory process, and a clear description of the assigned tasks and responsibilities.						
2. Assist the supervisee in **formulating goals** for the clinical and supervisory processes, as needed.						
3. **Assess** the supervisee's knowledge, skills, and prior experiences in relationship to the clients served.						
4. Adapt or develop observational formats that facilitate **objective data collection**.						
5. Be able to select and apply a **supervisory style** based on the needs of the clients served, and the knowledge and skill of the supervisee.						
6. **Model effective collaboration** and communication skills in interdisciplinary teams.						
7. Be able to **analyze the data collected** to facilitate the supervisee's clinical skill development and professional growth.						
8. **Use technology as appropriate** to enhance communication effectiveness and efficiency in the supervisory process.						

Comments:

Goals:

Other things I *could* have tried:

- tracked client outcomes to match if goal attainment and/or satisfaction was consistent from semester to semester,
- took a semester off of all of this to contrast if there was a difference in client outcomes from this level of supervisory oversight,
- set specific, measureable goals for myself based on student evaluation feedback,
- built a graph which monitored scores across semesters or graduating classes,
- followed up with past graduate student clinicians in some formal and/or systematic way about whether or not they remembered what we did together and/or applied any of it in their own supervisory or mentorship roles, and/or
- established and monitored student emotional resilience over time.

But I didn't do any of those.

These kinds of follow-through would make the teaching that occurs in supervisory relationships matter at the level demanded by the science of evidence-based practice. I know that there are a lot of ambiguities and assumptions embedded in my truth, and my ego would very much like to believe that what I did was meaningful (so that probably compromises my objectivity. I mean, you know…probably).

For extensive references to the literature, reliable and valid data gathering, and empirical analysis to have been possible, would have also required changes to the schedule rubric (that is, how much of my time per week was allocated per student-learner dyad). I would've benefited from mentorship in research: practical guidance on how to set things up, keep things going, and spread the word. As it was, I already felt overwhelmed and insufficient within the clinical practicum.

In addition, there were plenty of areas that I did not get into with much depth; and, across settings that host graduate student clinicians, there are clearly important elements of clinical practice that I have no knowledge of at all. Areas of supervision and mentorship with explicit teaching opportunities, developing resources, and timelines would be very different for non-campus placements or in overseeing a CFY. Considering the context must also be included if there is to be external and consequential validity for these kinds of approaches.

True story, the end: This narrative is at its close, for me. Now it is time for me to live my principles, trust the process, and choose another path.

I <u>loved</u> learning with graduate student clinicians: most assuredly, I wish to thank each of them for how much they contributed to my understanding. My thanks, one and all.

Please refer to Conversations About Conversations_References