

Specialized Training for the Student Intern

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Introduction

In a clinical profession such as ours, an obvious fact is that we personify the cumulative effects of the training we have experienced. We are aware of the impact this preparation has on our daily professional activities. We also recognize the significance of continuing our own education and of providing learning opportunities to others who are within our realm of responsibility. It is to this latter concern, training others, that our discussion will be directed. Specifically, we are interested in helping the student intern¹ acquire and practice the professional skills needed for rehabilitating adults with neurogenic communicative disorders, for making contributions within a multidisciplinary framework, and for pursuing the steady expansion of abilities beyond the training period. The question looming before us is whether or not we can stipulate the critical elements of an efficacious training program and detail ways to implement them. Before considering this multifaceted question, a review of some pertinent literature may serve to direct our discussion.

Background

Recognition of the pivotal role occupied by a clinical supervisor is inherent in the literature concerning training. The implication is that a qualified, effective supervisor will provide relevant clinical preparation. Given emphasis in the literature are identification of the qualities, skills and roles that characterize supervisors (Van Riper, 1965; Miner, 1967; Oratio, 1977; Schubert, 1978), the need for educating supervisors (Halfond, 1964; Stace and Drexler, 1969; Culatta, et al., 1975), prerequisites for supervision (Schubert, 1974; Oratio, 1977), and methods for analyzing supervisory activity (Culatta and Seltzer, 1977; Oratio, 1977; Schubert, 1978). In summarizing our profession's current status, the Committee on Supervision in Speech Pathology and Audiology (1978) cites these topics as unresolved and deserving of careful consideration.

An associated concern is the style of interaction distinguishing the supervisory process. Several articles urged a nondirective, clinician-centered approach (Ward and Webster, 1965; Pickering, 1977; Caracciolo et al., 1978b; Oratio, 1978) in which the supervisor is a facilitator enhancing the clinician's professional growth and independence. Starkweather (1974) suggested a client-centered emphasis using behavior modification

1. an individual who is (a) completing the last year of master's level coursework or beginning the first year of clinical work after acquiring a master's degree, or its equivalent, and (b) working at the training site at least 20 hours a week.

techniques and discussed its implications for training clinical skills. Oratio (1977) summarized these two styles and the traditional supervisor-centered focus in which specific instruction and modeling occur. Rather than perceiving these types of interactions as mutually exclusive, he expressed the viewpoint that they represented a range of approaches requiring coordination with the student. Others (Culatta, *et al.*, 1975; Gerstman, 1977; Caracciolo, *et al.*, 1978b) have also expressed the need for specifying expectations and requirements. It is implied that supervisory style should complement student requisites and evolve with changes in them.

The first suggestion favoring specialized, multidisciplinary training beyond a university program came from Darley (1969) who highlighted the major discrepancies between the ideal and the reality of clinical expertise as it is obtained in the course of academic preparation. He discussed the paucity of contact hours, patients, and variety of communicative disorders, the tendency to concentrate clinical experiences early in an academic career, and the lack of peer support for clinical pursuits found within the most enthusiastic doctoral program. His concluding statement was that the ultimate goal of providing sound patient care depends on

"...bolstering, enriching, and increasing clinical experience under the watchful eye of master clinicians in settings that provide interprofessional stimulation and influence, together with making a scientific attack on real-life questions that grow out of that clinical situation and are answerable only in it."

Leutenegger (1978), viewing university programs, discussed the pressures on them to provide comprehensive, contemporary training. He, too, suggested apprenticeship training, along with changes within the university setting, but noted that its appeal was contingent upon the strength and professionalism of the facility offering specialized instruction.

Although appreciation for the potential benefits of multidisciplinary training with particular patient populations exists, few models are presented in the literature. Lupella (1972) described the objectives of a postgraduate program conducted through the auspices of the Child Development Division of the Department of Pediatrics, University of Texas Medical Branch. Fellows rotated through five departmental clinics, one satellite program, and an elective clinic during the course of one year. Each phase of the fellowship promoted interdisciplinary training and opportunities to practice clinical skills. Lemme (1977) summarized a discussion in which three university-based programs offering an emphasis in aphasiology were outlined. The general consensus of the discussants was that the Clinical Aphasiology Conference represents the best forum for developing "model(s), criteria, requirements and guidelines for training aphasiologists."

One major step toward specifying training is currently being undertaken by the Veterans Administration. A task force under the leadership of Ms. Barbara Brown, an education specialist with the Associated Health Professions and Occupations Division of the Veterans Administration, has developed instructional objectives, evaluation forms, and learning experiences aimed toward establishing the professional skills needed by a speech pathologist to function in a hospital setting. A pilot study involving approximately ten training programs will be undertaken to field-test these materials, which are not currently available to the general public.

The broad issue of methodology has received attention within the more finite scope of developing tools for use in training programs. Early

articles focused on the advantages of videotape recordings (O'Neill and Peterson, 1966), means of observation permitting immediate supervisory feedback (Brooks and Hannah, 1966; Starkweather, 1974), and the virtues of demonstration therapy (Erickson and Van Riper, 1967). The decade of the 1970's contains two prominent trends, the development of competency-based criteria and of interaction analysis systems. Coincidentally, Culatta, et al. (1975) found that among the chief complaints of the 36 graduate trainees in their study were the poor definition of evaluative criteria and the lack of guidance for analyzing taped treatment samples.

The inquiry into valid criteria for assessing clinical competency in speech pathology has not been concluded; however, some steps have been taken and reported in the literature. Klevans and Volz (1974) offered a form containing 25 clinical attributes, each of which were operationally defined and judged on a seven-point scale of adequacy. The form was reviewed with students during orientation and ratings on each attribute were graphed at least twice during the training period. Shriberg, et al. (1975) reported on the development of the 38-item Wisconsin Procedure for Appraisal of Clinical Competency (W-PACC). Professional-technical and interpersonal skills were evaluated on a 10-point scale reflecting "the extent to which a clinician's behavior is independent of supervisory input." Reliability and validity data were obtained and considered reasonably confirmatory. Oratio (1976) collected criteria statements from 30 university programs and eliminated pre- and post-treatment variables and ambiguities. This process yielded 40 variables for assessing student clinicians engaged in a treatment session. Each variable was scored by supervisors on a 7-point scale of adequacy. Two factors emerged as critical to supervisors evaluating clinical competence; technical skills (10 variables) and interpersonal relationship with clients (8 variables). Haynes and Oratio (1978) found these same factors important to adult clients' perception of therapeutic effectiveness. Subsequent studies have led to the specification of 27 variables structured within five dimensions of clinician and client behaviors (Oratio, 1978). Since each of these efforts has been developed and tested within a university practicum setting, their direct application to a multidisciplinary program may not be valid.

Oratio (1977) discussed the importance of providing a means by which student clinicians could become self-critical of their therapeutic procedures. In his view, this essential ability leads to autonomous functioning and is most efficiently acquired by mastering an interaction analysis system. He reported over 80 systems are available, yet widespread use is hampered by the time-consuming analysis some systems require, a problem that could be alleviated with computer assistance (Oratio, 1979) or efficient sampling techniques that do not sacrifice accuracy (Brookshire, 1978b).

Three examples of interaction analysis systems are the Boone-Prescott System (Boone and Prescott, 1972), the Analysis of Behavior in Clinicians (ABC) System (Schubert, 1978) and the Clinical Interaction Analysis System (Brookshire, 1978a). The Boone-Prescott System is comprised of 10 categories divided evenly between clinician and client behaviors. Treatment events are categorized on a graph as the scorer listens to a 20-minute taped sample. Events and event sequences are tallied and summarized on a scoring form. The ABC System has 12 categories of clinician and client behaviors. It is used during treatment sessions to sample behaviors

observed every three seconds. The total number of each behavioral category observed is figured and converted to a percentage. Both types of data are graphed to plot changes over time. Brookshire's system of analysis has 39 categories which include parameters of treatment as well as clinician and client behaviors. Analysis is made from videotaped samples of treatment sessions. Specifically developed as a research tool in analyzing treatment with adult aphasic persons, it may have particular relevance to the clinical needs of aphasiologists.

Competency requirements and interaction analysis systems invite student interns to continuously challenge their development of professional talents. One aspect of professional skill is the accuracy or appropriateness of on-the-spot decisions made during diagnostic and treatment sessions with patients. Levitt, et al. (1978) suggested that an interactive computer-based system could be used to simulate patient behavior or to represent actual clinical data on which procedural decisions are based. They presented an example of an audiological problem-solving task; however, intriguing potential exists for its application to speech pathology

The Inquiry

Our dialogue continues the thread of concern for training aphasiologists that has been established at past conferences and initiates the response to the mandate that "model(s), criteria, requirements, and guidelines" (Lemme, 1977) be developed. The issues that emerge are presented here to concentrate, not dictate, our deliberations:

1. Is specialized training distinguishable from clinical practicum in a university setting: If so,
 - a. what are the implications for the university's role in preparing students to receive such emphasis?
 - b. what are the responsibilities of the agency offering the training?
2. Should the intent of specialized training differ from the intent of meeting ASHA's minimum requirements for clinical hours or of fulfilling a Clinical Fellowship Year?
3. Is any clinic, hospital or rehabilitation center willing to provide training qualified to do so? If not, what are the standards a training facility should meet?
4. Is uniformity with flexibility a feasible, desirable goal for educating aphasiologists? If so,
 - a. what are the key structural elements of a training program?
 - b. what are the means for implementing each aspect of the program?

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Summary of the Round Table Discussion on
Specialized Training for the Student Intern

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Initial discussion between participants emphasized the shortcomings of clinical practicum provided in university speech and hearing clinics. Acknowledging the fact that university clinical programs vary quantitatively and qualitatively, certain features were thought to minimize their impact on adequately preparing students to function as clinical aphasiologists. Cited were 1) selection biases which limit the number, variety and rehabilitation potential of aphasic adults treated, 2) the lack of continuity in patient care arising from both the nature of the university calendar and the need to train several students given an inadequate caseload, 3) the absence of opportunity to interact with multidisciplinary teams, and 4) the higher priority generally assigned to academic preparation. One participant pointed out that the university clinic provides a low-risk environment in which students learn basic observational, diagnostic, and therapeutic skills. This was contrasted with the "think-on-your-feet" atmosphere of other settings, when one may frequently need to justify and support one's professional opinions. It was suggested that internships thus extend the opportunity to build poise and confidence into one's professional repertoire. Although different, in the opinion of this participant, both clinical settings offer necessary types of training.

If, in fact, a redesign of university-based clinical preparation is required, it was proposed that the process model be abandoned in favor of an environmental model. This raised the issue of the university assuming an advisory responsibility to channel students into specialized clinical settings. It was agreed that such pragmatic concerns as job prospects would have to assume prominence when a faculty member advised students. Even with specialized training seen as highly desirable, limited employment opportunities would place its worth in question. Another participant viewed clinical aphasiology as a relatively new specialty which resulted in either poorly-prepared clinicians endeavoring to treat aphasic adults or professionals avoiding both the additional training and the exposure necessary to interact efficaciously with this patient population. This concern prompted a discussion about ASHA establishing a mechanism by which specialized certification could be obtained, perhaps looking to psychology for program models. It was generally agreed that present standards for obtaining clinical hours and for completing a Clinical Fellowship Year are not sufficient. It was urged that participants contact their respective ASHA Legislative Council representatives and express their ideas for upgrading standards and instigating specialized certification. Ideally, speech pathologists completing phases of clinical preparation should not require supplementary on-the-job training.

A final issue discussed was competency assessment. ASHA has recently completed an attempt to evaluate the national examination required for the Certificate of Clinical Competence with results to be published soon. Discussants concurred that paper and pencil tests are generally a poor means of determining clinical competence. By specifying learning experiences and documenting each attempt to master an experience, the Veterans Administration's

pilot training program represents a performance-based determination of competence. Another approach might be the use of computer programs to simulate and emphasize the decision-making processes on which clinical judgements are based. As one participant noted, by developing clinical competence through good training programs and by having that competence reflected in measurable treatment outcomes, the problematic need to justify our professional existence and expertise ought to resolve itself.