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eHearsay

Supervision & Ethics

OSLHA
Unlocking Communication
Ohio Speech-Language-Hearing Association
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Who We Are:

**Ohio Speech-Language-Hearing Association**

**MISSION:**
Empowering our members by providing opportunities for professional development, advocacy, and leadership development necessary to foster excellence in the services provided to individuals with communication and related disorders.

**HISTORY:**
Founded in 1945, the Ohio Speech-Language-Hearing Association (OSLHA) is a professional association representing speech-language pathologists and audiologists throughout Ohio. OSLHA is recognized by the national American Speech-Language-Hearing Association (ASHA) as the official professional organization for Ohio. OSLHA members provide services for the evaluation and rehabilitation of communicative disorders. Members work in a variety of settings including: clinics, health care facilities, hospitals, private practice, schools, and universities. Members must abide by the OSLHA Code of Ethics.

eHearsay Statement of Purpose

eHEARSAY, the electronic journal of the Ohio Speech-Language-Hearing Association, is designed to address the professional development needs of the state association.

Issues may be developed around specific themes and can include invited papers, research articles, review, tutorial, research forum, letter to the editor, clinical focus/forum or viewpoints.

eHEARSAY is published as a web journal annually. Continuing education credits will be available for each issue.
This first issue of 2014 focuses primarily on supervision and ethics (although there are other articles relevant to our professional lives).

Supervision is the act or function of supervising which means to direct or oversee the performance or operation of someone/something. A supervisor is a clinical educator, whose primary role should be to further the clinical skills of the student culminating in the PEY experience where the role changes to one of mentoring.

Unfortunately, many of us do not get “trained” on how to be an effective supervisor. Supervision is hard work!! Many professionals use their experience as a supervisee to shape the way we supervise others. This may be effective (if you had good experiences) or it may not be as effective as it could be. However this is an area in which we all should strive to become better at, after all, we’re shaping the next group of professionals. I know when I go to OSLHA’s convention, despite the fact that OSLHA offers mini-seminars on supervision (and ethics), I tend to choose sessions based on “getting the most bang for my buck” meaning sessions that will help me improve my skills/knowledge in an area relative to my clinical practice. We’re hoping this issue of eHearsay can help bridge that gap. This issue contains 5 articles specifically related to supervision (e.g., reflective practice, conflict resolution, facilitating clinical success and issues related to race and/or culture). The American Speech-Language Hearing Association (ASHA) has granted permission to OSLHA to reprint ASHA’s position statement and technical report on clinical supervision, as well as the knowledge and skills needed when providing clinical supervision.

Ethics refers to standards of behavior that tell us how human beings ought to act in various situations. SLP’s and Audiologists require the knowledge and discipline to identify ethical behaviors and potential ethical violations in order to avoid them. This is another substantial, dynamic topic that affects all of our members in all areas of practice. This issue offers two articles to help build the foundation. ASHA has also granted OSLHA permission to print three roundtable scenarios.

Thanks for taking time to read eHearsay!!

Laurie M. Sheehy M.Ed. CCC-SLP
eHearsay Editor

“While ethics are beliefs, one’s ethics are revealed in what one does, how one does it, and with what intention. The concept of ethical choices, acts, and behaviors is multidimensional.”

(Burnett, Prakup, Thornton, 2014)
Using Reflective Practice in Supervision/Mentoring

Sue Schmidlin & Lesley Raisor-Becker

Abstract
Using reflective practices in supervision is common place among many disciplines. However, traditional supervisory practices that lack reflective qualities are still common place in the field of speech language pathology. The purpose of this article is to introduce speech language pathology supervisors to strategies that will encourage critical thinking. Some of these strategies include: group/peer conferences, relinquishing the role of expert, and reflection through writing. The authors will also discuss strategies for dealing with “difficult” mentees.

Learning Objectives:
1. Identify the differences between traditional supervision (TS) & reflective practice (RP).
2. Identify the skills that are required for reflective practice.
3. Describe the effects of Transference on the supervisory process.

Theoretical Bases
Most supervisors understand that mentees are not able to immediately use and understand new information. This issue is explained by Piaget’s cognitive-constructionist theory, on which the principals of RP are based. The theory states the need for learners to construct their own knowledge, built through their experiences, to create their own mental models. Piaget’s theory contains two key principals related to RP: 1) Learning is an active process - the mentee must make errors through direct experience and engage in problem solving to find solutions and make accommodations, 2) Learning should be whole, authentic, and real – the mentee needs to engage in activities that are inherently interesting and meaningful to them, applying skills to a real situation more often than practicing skills in isolation.

Traditional Supervision vs. Reflective Practice
Some traditional methods are necessary and beneficial, so there is no need to replace all traditional supervision (TS) practice with RP. An integration of RP and TS, however, is needed if we are to apply Piaget’s learning principles to the supervisor-mentee process. The main differences between the two styles are described as follows: TS is case-focused, with the objectives of reviewing the facts of the case, discussing the intervention strategies, planning the lesson activities, and evaluating the client’s progress. In TS, the supervisor’s role is to teach, give guidance, advice,
 directives, and respond to the mentee’s questions. Most of the supervisor’s feedback consists of comments and suggestions. The realm of emotion is usually not explored, and the supervisor is viewed as “The Expert.” The mentee follows the supervisor’s directives so there is minimal opportunity to make mistakes, explore opportunities, or create solutions on her own. The mentee’s questions are usually process oriented (Where do I find the materials? How should I use these pictures in therapy?). Under TS roles, mentees are more likely to passively receive information, be reactive (and possibly defensive), and are likely to agree with the supervisor and happy to let the supervisor make all the decisions. With TS, both the supervisor and the mentee are more likely to harbor feelings about the case or each other that may negatively affect the supervisory and/or client relationship. These emotions may have nothing to do with the present, but may be the result of emotions from a similar experience in the past.

In contrast to TS, RP is relationship-focused and collaborative, and the objectives are related to generalizing clinical skills while sharing ideas about the planning and intervention for each case. The supervisor and the mentee share their views of the challenges of the case and disclose their own vulnerabilities related to the case. The supervisor is viewed as a supportive partner and active listener, and his/her role is to ask reflective questions in order to instill independent thinking (“Do you think the picture schedule was effective for this client? How did he respond to the craft activity? What can you do next time to get more responses from the client? What do you think the parent meant when she said ___?”). The mentee is asked to evaluate the client’s progress, is allowed to try her own ideas and make mistakes, and then engage in problem-solving to make changes, in a safe environment that is geared toward independent professional growth. The mentee’s questions and comments are usually reflective (What if I try switching the drill exercise to the end of the session? I think I need to challenge him more next time. I’ve got to find a way to keep him more focused.). The realm of emotions is often explored, usually through the use of questions (How did you feel when the client got tears in his eyes? What do you think he was feeling at that moment?) or, through the supervisor’s disclosure of her own emotions (I still get a little anxious before meeting a new client....). The mentee is encouraged to identify strengths and areas for improvement. Under RP roles, mentees are more likely to use critical thinking skills, express their true feelings, and take a more active role in decision-making.

Integrating Traditional Supervision and Reflective Practice

It is a daunting task to try to change methods that you have been using for a long time. The task of integrating TS and RP, however, can begin with one simple change. After a therapy session, let your first message to the mentee be a question rather than a comment. It can be as general as, “What went well?” or “What was your favorite part of that session?” The natural follow-up to those questions would be, “What would you change for next time?” and “What was your least favorite part of that session?”

Exploring the role of emotions can be intimidating at first, but it is an important component of RP because the supervisor and mentee become collaborative partners, not just for external and observable behaviors, but also for internal mental health constructs. The effect of the emotion of empathy, for instance, has been studied in the therapeutic relationship. In the article, Looking at and Along Communication Disorders, Matthew H. Rouse encourages clinicians to recognize the effect of genuine empathy in our therapeutic presence. He states that our clients are likely to engage more fully when we display – through grooming, attire, movement, posture, use of personal space, eye contact, attention, rate of speech, tone of voice, and silence-a presence that is welcoming, encouraging, and healing.

The supervisory relationship takes Rouse’s message a bit further by challenging the supervisor and the mentee to not only demonstrate emotion in nonverbal ways, but to identify and discuss the emotion and its effect. A relatively easy way to start talking about emotions is to give the mentee a short form before the session begins - to write down the emotions she felt before, during, and after the therapy session, and then use that form later, as a springboard for discussion.

Like a lot of new habits, the more a supervisor attempts to use RP methods, the easier and more natural these methods will become. Questioning techniques can easily be used each time a supervisor meets with a mentee. Another way is to send reflective questions via e-mail, voice message, or text message. These alternate...
ways will give the mentee more time to reflect before responding. Another good method for reflection is to have the mentee make an audio and/or video recording of the therapy session (with client’s permission) for the mentee to do a self-critique of her overall clinical skills for that session. The mentee might also be required to create and answer his/her own reflective questions about that session.

Skills needed for reflective practice
For successful RP in supervision, students and supervisors must embrace the notion of collaboration in which both parties share responsibility and control of power. For RP to ultimately promote professional development in students, supervisors must learn to let go of being the expert and instead create an atmosphere of mutual trust through self-disclosure (Ovens & Tinning, 2009).

Letting Go of Being the Expert
It may be difficult for some to understand why a person would willingly let go of the expert role when he/she has worked hard to attain degrees, experience, and credentials. However, there are many advantages to releasing the expert title. For example, when a person exerts themselves as an expert on a particular subject, he/she has set communication channels to usually operate in one way (top-down). In the role of expert, a person is responsible for weighing the consequences of clinical decisions, making decisions, and getting cooperation and/or accomplishing the tasks independently. Yet, the purpose of reflective practice for students is to encourage critical inquiry (Ovens & Tinning, 2009). When supervisors present themselves as a learner, they open the channel for two-way communication. Supervisors using a RP model, will actively listen, ask questions, and receive input from a variety of sources (Ward & House, 1998). Further, they will encourage their students to actively problem solve instead of coming to the “expert” for solutions.

Mutual Trust through Self-Disclosure
As part of social penetration theory, when supervisors build trust through self-disclosure they move from more superficial, relatively shallow levels of communication to deeper, more intimate conversations that will allow for student self-reflection (Taylor & Altman, 1987). This type of communication is imperative in a supervisory relationship that includes reflective practices. The information shared with supervisees can be descriptive or evaluative and can include thoughts, feelings, aspirations, goals, failures, successes, fears, dreams as well as one's likes, dislikes, and favorites (Tolstedt & Stokes, 1984). Some examples of appropriate self-disclosure with supervisees may include fears about lack of progress with a client. Also, supervisors may choose to share the mistakes that they have made in the past as an SLP. Ladany et al. (1999) suggest that revealing your motives, intentions, goals, values, and emotions can not only increase feelings of intimacy, but self-disclosure may generate greater cooperation and teamwork as well.

There are many factors that influence self-disclosure and researchers have found that people who are perceived as good listeners, trustworthy, accepting, relaxed, and sympathetic tend to elicit the most disclosure from others (Tokic & Pecnik, 2010). Therefore, in order to build a relationship with a student that will encourage revelation of thoughts/feelings around service to a client, supervisors must adopt a calm/relaxed and sympathetic attitude in supervision.

Using Group Conferencing to Enhance Reflection
Even if a supervisor feels that she is unable to incorporate RP methods into her conferences with each mentee, it might be easier to schedule a few group conferences and use RP methods in the group setting. This can be a very effective format because the mentees are usually eager to share their experiences and help each other by offering suggestions. It works well to send each mentee a list of reflection questions and then assign a question or two for the group’s next meeting. You can customize your own questions for your setting, or you can use the list in the Appendix. Here at the University of Cincinnati, we have found that these group conferences seem to “run themselves” very effectively. If a mentee asks the group to address an issue, the supervisor should “step back” and allow the group to offer solutions, give opinions, and discuss emotions in this safe, nonjudgmental environment. Our group conferences have been limited to 30 minutes, so the mentees do not waste any time getting the discussion underway with their most pressing issues. The mentees often feel comfortable sharing information in the group that they might have felt uncomfortable sharing in the individual session with the supervisor.
Using Writing Exercises to Enhance Reflection

Due to the fact that supervisors often do not have the time to conference with students on a continuous basis (i.e. after each session), reflective writing exercises may be the best avenue to encourage learning in the clinical experience. Although there are many forms of writing exercises that may enhance reflection, two types of writing will be discussed below---learning/reflective journals and parallel charts.

Learning/Reflective Journals

Learning journals come in many different forms and may include different types of media to encourage participation (e.g., blogs, iPad notes, etc.). Riley-Doucot & Wilson (1997) suggest that both the student and supervisor may use a learning journal to assess progress towards self-direction in their clinical work. These researchers further argue that supervisors should implement a three-step process of experiential learning through a reflective journal. The first step in this process is critical appraisal. In this part of reflection, students are encouraged to record their description of their daily clinical experience. This would include the students’ thoughts and emotions in a somewhat cathartic exercise. In this phase, emphasis is placed on the student’s own personal growth instead of supervisor evaluation; therefore, an academic writing style is not required. In the second phase of this exercise, students participate in a group peer-conference. In this conference, students may disclose their questions and/or reflections about their daily journal entries. As a facilitator, the supervisor may encourage students to integrate theoretical perspective with their practical experiences. Finally, in the last phase of this process, students are encouraged to document unique aspects of their learning from their own earlier reflections and peer discussion. In this higher-order reflection, Riley-Doucot and Wilson (1997) suggest that students become able to critically analyze clinical situations in relation to their own learning. Because this type of journaling requires that students reflect upon experiences multiple times, critical thinking is encouraged and students develop the ability to become their own evaluator. Generally speaking, what distinguishes a learning journal from other writing is that it focuses on ongoing issues over time and there will be some intention to learn from either the process of doing it or from the results of it. This suggests that it is not, simply, an events diary or a record or log.

While the method of Riley-Doucot and Wilson (1997) offers a unique approach to reflection through writing, a learning journal does not have to be as complicated. Supervisors may choose to utilize a reflective journal in different ways with success. For example, a supervisor may have the students simply answer a reflective question after each session. Or instead, they may encourage students to reflect upon the same clinical situation in multiple journal entries with a variety of prompts (e.g., take on the role of the client in this reflection, or take on the role of the caregiver, etc.). In whatever way a reflective journal is used, supervisors have the responsibility to read the reflections and provide a non-judgmental response to the student in a way that will encourage students’ critical thinking.

Parallel Charts

A parallel chart (first used by medical doctors in the early 1990’s) is a personal notebook in which a medical professional writes his or her own feelings about a clinical experience. For example, an SLP student might write in the official hospital chart that the patient is a 62-year-old woman with severe pharyngeal phase dysphagia, adding that she is “pleasant.” In the parallel chart, however, she could write that the patient reminds her of her maternal aunt and that she finds herself becoming angry at her unwillingness to complete the exercises given to her. Although it might seem as though these types of reflections would belong in a personal diary (and certainly, never shared), by giving students opportunities to state and share their intimate thoughts about their patients, it allows them to develop courage and insight for effective interactions with the patients that they serve.

Charon’s purpose in encouraging reflection among medical professionals was to help students focus on what they themselves were going through while they were treating a patient, and consequently, reflecting upon what their patients had to endure in the course of being sick. This type of reflection ensures that our students are providing the highest quality of care.

Dealing with Difficult Issues in Supervision

Despite the greatest intentions and use of reflective practices (like parallel charts and group conferencing), difficult issues sometimes arise. In her article, Handling a Hard Conversation, Judy Stone-Goldman describes the use of RP methods to prepare for difficult conversations. She states that, instead of trying to
prepare the right words, we should start by examining ourselves. Stone-Goldman advises that our emotional and mental states will affect the conversation, and we need to reduce the likelihood of letting our own ego, fears, and impatience get in the way. We need to remember that most situations are imperfect, and that even uncomfortable exchanges hold positive potential. Then we are better prepared to listen without trying to impose our agenda or pushing away uncomfortable feelings (Stone-Goldman 2013).

The emotional effect of past experiences is a psychodynamic construct called Transference, and can be described as, “We don’t see things as they are - we see things as WE are” (Nin A. 1969). In the supervisory relationship, Transference is the mentee’s unconscious activation of feelings for the supervisor, both positive and negative, that are actually displacements of reactions to significant others from the past (Corey, 2001B). Transference is often experienced as objective reality rather than as a subjective feeling. A common transference is: a strong need to please the supervisor and/or anxiety about performing well for the supervisor, thereby hiding true opinions and carefully monitoring what is said and done. Transference is almost always happening and is largely an unconscious process, but can be accessed through reflection (self-reflective questioning – What is making me fearful or nervous about this relationship? How is it similar to a relationship from the past?). The role of the supervisor is to be aware of this transference and to assist the mentee in developing his or her own sense of competence and problem solving ability.

A closely related psychodynamic construct is Counter-Transference. In the supervisory relationship, Counter-Transference is a reaction that a supervisor has toward a mentee that interferes with objectivity (Corey, 2001). This reaction can arise from unresolved personal issues, and sometimes even problem areas that the supervisor has worked through, that can be triggered through interactions with the mentee. To guard against Counter-Transference, the supervisor needs to “hold” her reactions for a few moments, then respond non-defensively and tolerate any unexpected feelings. Afterward, the supervisor should analyze this reaction to identify insights about the relationship with the mentee and a past relationship or event that has been triggered. The response to a simple self-reflective question such as, “What or who does this situation remind me of?” can be very valuable. Common Counter-Transference reactions are: 1) an intense need to help or “rescue” the mentee 2) a strong dislike of the mentee 3) feeling performance anxiety for the mentee 4) a need to be perfect; to solve all the problems. Supervisors who think they might be experiencing Counter-Transference should seek consultation with colleagues or other professionals.

Reflective Practice allows you to slow down and attend to attitudes and feelings that might otherwise be ignored. Reflection provides multiple opportunities to return to a particular issue: “I should have said this; I shouldn’t have done that” can be changed to “Next time I will _____” and “At our next session I will tell him ______.” It is never too late to repair a miscommunication.

Almost every supervisor has had to deal with the reality of having a mentee who is not making adequate progress. The reflective process can help the mentee focus on the specific issues, but some mentees have limited self-awareness. In that case, it is important to put the expectations in written form and thoroughly document the mentee’s performance related to each expectation. For instance, let’s consider this scenario: the written expectation is for the mentee to arrive 20 minutes before the client’s therapy session, but she arrived five minutes before the session, and seemed unprepared. Using RP methods after the session is over; the supervisor should sit down with the student and review the written expectation. The supervisor and the mentee should complete a form together, documenting the date, the behavior, and how the behavior affected the supervisor, the mentee, the client, and anyone else who was involved. The realm of emotion will be explored by asking the mentee to identify the feelings of the supervisor, etc. If the mentee is unable to correctly identify the correct emotions, the supervisor will intercede (“No, I was not angry – I was actually worried about you, and I was starting to feel concerned that I would have to take over your client at the last minute if you did not show up.”)

In other situations, however, a mentee may feel that she is not doing well when her client is not making adequate progress. In this instance it is the supervisor’s job to assist the mentee in reflecting on the steps she has taken to help the client and the client’s
responsibility in the therapeutic relationship (regular attendance, attention to task, home practice, etc.). RP can help the mentee put this situation in the proper perspective, even when the outcome is not positive. Mentees often give themselves messages such as, “I must help every client, and I am fully responsible for making them better.” Through the use of RP, the mentee may come to a more realistic understanding of her competency and her role in the therapeutic relationship. This is also an appropriate time for the supervisor to disclose some instances from his/her past, when clients did not have good outcomes despite the supervisor’s best efforts. The supervisor’s objective should be to help the mentee achieve a delicate balance between caring for the client and having a healthy objective disengagement from the client’s outcome (Haynes, Corey, Moulton, 2003).

The use of RP can also help prevent some of the following nonproductive behaviors that supervisors sometimes find themselves doing: 1) **Hydroplaning**: skimming over the surface of an issue to find an immediate solution. 2) **Sitting on Pandora’s Box**: avoiding, downplaying, covering up serious issues, ignoring negative “gut” feelings, ignoring potential problems. 3) **Cheerleading**: acting as if everything will get better soon if we just forget about what happened and move on. 4) **Need to Please**: fear of offending the mentee; wishing to be admired at all costs.

In summary, the use of reflective practice strategies can help supervisors and mentees distinguish between factors in their relationship that are objective reality versus factors that are subjective feelings, such as transference and counter-transference. This allows the supervisor to let go of being the expert and frees the mentee to develop independent critical thinking and problem-solving skills. The supervisor may choose to use any of the strategies previously discussed: reflective writing assignments, peer conferences, reflective questioning techniques, etc. Any of these strategies will serve to help even the most “difficult” mentee to learn more about herself, more about her clients, and more about what it means to be a competent speech-language pathologist. •

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References


Conflict Resolution: A Necessary Tool for Supervision

Janice M. Wright

Abstract
This article will present issues relative to the use of conflict resolution rather than conflict management in the supervision of graduate students. Definitions of conflict will be discussed and the historical view of dealing with conflict in the triadic enterprise of the supervisor, the supervisee, and the client. Tools for identifying conflict style as well as techniques to use as a clinical supervisor for conflict resolution will be discussed.

The article author(s) Janice M. Wright, employed by the Ohio University, has no relevant financial or nonfinancial relationship to disclose.

Learning Objectives:
1. Define conflict resolution and management and understand the differences between the two terms.
2. State why conflict resolution skills are important to use in clinical supervision.
3. Discuss strategies to use when working through conflicts with supervisees.

As clinical supervisors, we are in the business of change. We attempt to change student clinicians by developing their clinical skills so that they can implement change in their clients. Clinical supervision is a triadic enterprise with the supervisor, the supervisee and the client serving as transacting entities within a network of interpersonal exchanges. (Gilliam, Roussos & Anderson, 1990). Interpersonal exchanges in this triadic enterprise can be filled with conflict because expectations, previous experiences, personal values and biases can be a source of error for both perceptions and judgments (Cogan, 1973). The concept of a triadic enterprise implies equality between the three parts when in fact as clinical supervisors we are in a position of power; we control the grades that student clinicians receive and the clinical hours they obtain. Using that power as leverage, we may seek to change the behavior of a student clinician who may lack internal motivation or recognition of their personal need for change. Therein lays the potential for conflict. Generational differences, misinterpretations of expectations or unexpected changes in duties or client load can further contribute to conflict between the supervisor and supervisee.

Research on clinical supervision has suggested for a long time that too few clinical supervisors have had enough formal training or education in the techniques needed for clinical supervision. It is common for professionals to take on the role of supervisor without adequate preparation. Prior experience and education in supervision is desired but not required by our professional association for a professional to become a clinical supervisor (ASHA, 2008). Conflict resolution is listed as one of the core competencies for supervisors and supervisees according to the American Speech Language and Hearing Association, however training in the area of conflict resolution is also not mandated by the association. Supervisors in conflict will use their own personal experiences with conflict as a model for how to (or how not to) resolve conflict.

The historical perspective of supervision may be characterized as working from the “outside in.” This has been interpreted to mean that the goal is to change, or modify, the overt patterns of behavior, knowledge and the skills of the supervisee by dominating talk time, controlling supervisory meetings and engaging in problem-solving without supervisee input (Dowling, 2001). This supervisory approach focuses on the cognitive areas related to the clinical process rather than on the affective content related to the clinical process. While the approach may result in apparent change in one environment, this change may or may not carry over to other environments because of a conflict that you as the supervisor may not have been
aware of. An example of a supervisor implementing what they would consider a successful change occurred with a supervisee who was not adhering to the clinic dress code. The supervisor noted the supervisee’s attire on three occasions, and in the historical method of dealing with strictly cognitive skills, brought the student into the office and informed her that if she did not adhere to the dress code she would receive a failing grade and lose clinical hours. The student immediately changed her style of dress and the conflict appeared to be resolved. But once the student moved out of the university clinic and onto her externship, the clinical supervisor at the externship site contacted the university clinic demanding to know why the clinic did not teach students how to dress for clinical placement. It was apparent that the conflict that the supervisor felt had been resolved; actually had not been, because it was managed rather than resolved.

A more recent strategy of supervision has been to work from the “inside out” in order to develop the affective content of supervision (Geller & Foley, 2009). The affective content approach has the goal of helping the supervisee understand the covert, internal processes and affective states that may impact their growth and development as a clinician. A more effective method of supervision could have been implemented in the previously stated case, if the supervisor and the supervisee worked towards conflict resolution rather than conflict management; the student might have gained an understanding of the bigger picture: why and how inappropriate clinical attire impacts her professional growth and development. She may then have generalized that knowledge to her externship site. The challenge for the clinical supervisor is to integrate analytical, technical and theoretical knowledge with broader constructs of how individuals operate during moment-to-moment interpersonal and experiential situations (Geller, 2001). The resulting paradigm shift may result in improved conflict resolution skills.

The definition of conflict can also be viewed from two perspectives. Maier (1993) in his research on the conflicts that occur in industry defined conflict in two ways. The masculine perspective involves suppressing conflict, because it is viewed as threatening and negative. In this view, conflict should be suppressed because it poses a problematic threat to the group or organization (Northhouse, 1997). A supervisor focusing on the cognitive areas related to the clinical process will support this definition of conflict because cognitive areas are concrete and can be defined, so a conflict can be suppressed. The feminine perspective of conflict involves interaction (affect) so that conflicts are laid out on the table and resolved by using compromise. From the feminine prospective the process is just as important as the conflict itself (Gibb, 1961). By adding affective content to the supervisory process a supervisor can demonstrate how to resolve conflicts in a way that will support the supervisee’s growth as a master clinician. It is important to identify that the end result is to teach conflict resolution not conflict management. Conflict management involves the act of supervising to accomplish an end. Conflict resolution involves developing methods to work through conflict. Conflict management is the masculine perspective of conflict, where resolution is the more feminine perspective.

Conflict is more than just a disagreement. Conflicts develop for a variety of reasons; sometimes we know why the conflict has developed and other times we do not. Conflict can trigger strong emotions and can lead to hurt feelings, disappointment and discomfort. Think back to your experience as a supervisee- did a conflict ever occur with your supervisor that was demoralizing and humiliating? A recent survey of millennial generation graduate students suggested that students would avoid attempts at direct conflict resolution rather than engage in some form of problem solving. These students would frequently discuss the conflict with peers or conform to the supervisor’s requests without discussion for clarification or attempts at resolution (Durant-Jones & Kwiatkowski, 2013). This suggests that the supervisor may be viewed as having the masculine, “do as I say” view of conflict. This view along with the supervisory style of continuously using “direct- active” can itself lead to conflict. If conflict is handled in an unhealthy manner, it can cause irreparable rifts and resentment and may lead to another generation of supervisors who did not learn conflict resolution as an important skill.

Conflicts arise from differences. In the case of the supervisee and clinical dress, the difference may have been that the student perceived the dress code as “old-fashioned” and so she continued to wear outfits that were clearly in violation of the clinic policy. The supervisor, working from the cognitive perspective, sought to change the behavior by demanding
compliance and using punishment to change the behavior (dress) of the student. Working under the belief that conflict should be suppressed; the supervisor saw the student’s compliance as success. This perception was not necessarily based on an objective view of the facts. Our perceptions of conflict are influenced by our life experiences, culture, values and beliefs. The student complied because of a perceived threat- loss of clinical hours- not because the conflict was resolved. If one or more of the individuals involved perceives a threat then there is an inherent conflict. The threat is not usually physical. It does not matter if the threat is real or not, since perception is 90% of reality for the individual who perceives a threat.

Conflict does not have to be negative and destructive. When handled effectively, conflict offers many benefits. Conflicts can clear the air and give both the supervisor and supervisee an opportunity to have a say. Conflicts provide supervisors a chance to clarify goals for and expectations of the supervisee. Conflicts offer supervisors a golden opportunity to fine tune their listening skills. Conflict can result in a tremendous learning experience for both the supervisor and supervisee. Learning to master the art of disagreeing without taking things personally allows the supervisor and supervisee to become stronger individuals. Learning to manage conflict boosts the self-esteem of both parties involved.

The trick to handling conflict is to walk that fine line between holding supervisees accountable for their clinical performance and simply solving problems for them. There are five common strategies for dealing with conflict: avoidance; competition; accommodation, collaboration and compromise. These strategies recommended by Rod Howell (2012) are proposed to address and solve problems through conflict resolution rather than conflict management. Each strategy has its advantages and disadvantages depending upon the leadership style of the supervisor and where on the continuum of supervision a supervisee may be.

**Avoidance** does not solve the problem; instead the parties involved in the conflict continue the relationship as if nothing’s wrong. The advantage to this strategy is that no obvious conflicts are seen by anyone else because no one addresses the problem. On the surface the supervisor/see relationship appears satisfactory; the student does not want to risk receiving a poor grade or not getting credit for the clinical experience and may complain to others but not address the issue directly. The supervisor may perceive a conflict and because of their higher authority will take over responsibility and address the conflict with solutions that benefit neither party.

**Competing or forcing** involves solving conflicts with no end in sight. When the supervisor has a strong personality, this may be a strategy that is used. The supervisor takes control and expects the supervisee to follow her lead. Gibbs (1961) describes the behavior exhibited by the supervisor in this case as projecting superiority. The supervisor communicates by her actions that she is superior in power and/or intellect and abilities. The beginning supervisee may not have any ideas, solutions or resources to end the conflict. As the supervisee moves through the continuum of supervision as proposed by Anderson, this strategy will backfire because now the supervisee has ideas and solutions but the supervisor is not willing to give up control, instead delivering messages such as “you should…”; “you need to …” or “you’d better…”. These messages may result in resentment and possible retaliation from the supervisee.

**Accommodating** involves one or more of the individuals involved in the conflict sublimating their views and concerns in order to preserve their relationship with others. In the case of the supervisee, accommodating to the supervisor will allow the supervisee to complete the program without making waves. A supervisor may encourage accommodation as a form of conflict resolution because it allows the supervisor to employ the defensive behavior of neutrality. The supervisee may initially express her concerns using a supportive behavior of describing the problematic behavior or situation without judgment. However if the supervisor responds with a defensive behavior of neutrality, not providing any opinion that can be interpreted as involved and interested, and if the supervisee is not allowed to express their concerns, then the conflict will continue.

**Collaboration** involves building teamwork and trust between the supervisor and the supervisee. Each person comes up with their own ideas to solve a conflict. This strategy employs more supportive behaviors. Collaboration allows for equality and problem orientation. Everyone has a part in correcting
the problem. The major disadvantage to this process is that it is time-consuming. The issue of time is often one of the chief complaints among supervisors. Gerardi (2004) states that poor communication, unclear rules, conflicting policies, time constraints, and fatigue are all barriers in developing strategies for conflict resolution.

**Compromise** calls for all parties to identify the most important goals and how to achieve them. Compromise allows for everyone to sacrifice some personal goals to achieve the one they agree upon. The supervisee and the supervisor agree to do their part to solve the conflict. This strategy embodies most of the supportive behaviors outlined by Gibbs (1961) that support a satisfactory supervisory relationship and can assist in the process of conflict resolution. Compromise allows for the two parties in conflict to describe the conflict without judgment (description), to respond to each other with an air of respect and communication reflecting that the partner is neither superior nor inferior (equality), to discover the best solution to a problem regardless of the source (problem orientation), to provide honest reactions portraying an aura of openness, trust and self-confidence (spontaneity), identification of the other person’s emotional state (empathy), and the application of active listening techniques (provisionalism). The difficulty with compromise is that the supervisor may perceive that seceding personal ambitions could be seen as a sign of weakness by the supervisee. Compromise, although the most beneficial, may not work at all if the demands of the conflict are too great for the supervisor and supervisee to agree.

The process of conflict resolution involves recognizing the problem, selecting the conflict resolution style needed in the particular situation and then working through the differences in order to develop a consensus on how to solve the problem. The supervisor must be aware of her personal style of leadership so that she can determine how her style differs from the supervisee and how that particular style can impact conflict resolution. The supervisor will not change the other person, but can change the way in which she reacts. In this process, when the supervisor changes her leadership style, the entire dynamic is radically altered. This self-awareness and self-identification is very important in order for the supervisor to develop a healthy response to conflict. Unhealthy responses to conflict include: an inability to recognize and respond to the things that matter to the other person, explosive, angry, hurtful and resentful reactions, isolation or shaming of the individual and/or an inability to compromise or see the other person’s side.

Leaders shape as well as express and mediate conflict. Leaders can influence the intensity and scope of conflict (Burns, 1978). Supervisors are, in essence leaders and in order to be an effective leader and deal with conflict efficiently, supervisors must understand their own emotional intelligence. Emotional intelligence is comprised of self-awareness, self-regulation, emotional awareness and humor. It is the ability to monitor one’s own and others’ feelings and emotions, to discriminate among them and to use this information to guide one’s thinking and actions (Mayer & Salovey, 2004). Self-awareness is the ability to determine personal issues that may cause conflict when interacting with the supervisee; self-regulation is the ability to ability to quickly reduce stress in the moment and remain calm and objective during a crisis; and emotional awareness is the ability to remain comfortable enough with your emotions to react in constructive ways even in the midst of an argument or perceived attack.

Supervisors use a variety of tools with student clinicians to help identify their strengths and areas that need to be developed in order to improve their clinical skills. Supervisors can take advantage of similar tools to determine their own conflict style. Tools such as the Kraybill Conflict Style Inventory (Kraybill, 1980) or the Thomas Kilman Conflict Mode Instrument (Kilman, 1974) were developed to measure responses to conflict situations. Conflict style inventories have been in active use since the 1960s. Many of the tools are based on the managerial grid developed by Robert R. Blake and Jane Mouton in their Managerial Grid Model (1985). One such measure, The Conflict Management Style Survey (1969) (Appendix A) was designed to help one become more aware of her characteristic approach or style in managing conflict. The survey identifies twelve situations that one is likely to encounter in personal and professional life. The survey asks the individual to study each situation and the five possible behavioral responses or attitudes carefully and then allocate ten points between them to indicate her typical behavior, with the highest number of points indicating her strongest choice. Any response can be answered with from zero to ten points as long as all five responses for a given situation add up to ten points. The individual
completing this survey is asked to choose a single frame of reference (e.g. work-related conflicts, family conflicts, social conflicts) and keep that frame of reference in mind when responding to all the situations. There is no right or wrong answer to these types of surveys. The sole purpose of the survey is to assist one in determining their typical conflict resolution style. Upon completion of all 12 statements a two dimensional grid is developed that helps to identify which of the five conflict strategies one may use in the single frame of reference chosen. This grid identifies if the supervisor has more concern for helping the supervisee develop personal goals or more concern about developing a relationship with the supervisee. The survey uses the five common strategies for dealing with conflict and provides an explanation for how this strategy can be effective or ineffective for a supervisor. The chart describes each of the five strategies, the goal and relationship orientation and the conflict result.

<table>
<thead>
<tr>
<th>Conflict Style</th>
<th>Goal Orientation</th>
<th>Relationship Orientation</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborator</td>
<td>High</td>
<td>High</td>
<td>Win/win</td>
</tr>
<tr>
<td>Compromiser</td>
<td>Negotiated</td>
<td>Negotiated</td>
<td>Mini-win/mini-lose</td>
</tr>
<tr>
<td>Accommodator</td>
<td>Low</td>
<td>High</td>
<td>Yield-lose/win</td>
</tr>
<tr>
<td>Controller</td>
<td>High</td>
<td>Low</td>
<td>Win/lose</td>
</tr>
<tr>
<td>Avoider</td>
<td>Low</td>
<td>Low</td>
<td>Leave-lose/win</td>
</tr>
</tbody>
</table>

In the conflict between the supervisee and supervisor over the dress code the supervisor used the controller style of management; the focus was on the goal of getting the student to change her dress for the clinic. The supervisor initially won, but in the long term lost because the behavior was not carried over to a different environment. The best strategy for resolving conflict is that of collaboration: a win/win situation where both the development of personal goals and the development of a relationship are highly valued. In the previously stated instance, the use of collaboration may have resulted in the supervisee generalizing the skill to other environments.

The change occurs with the supervisor; managing and resolving conflict requires the ability to quickly reduce stress and bring emotions in balance. A supervisor can ensure that the process is as positive as possible by sticking to the following resolution guidelines (Segal & Smith, 2012):

1. Do not wait; once you hear of or suspect a conflict, schedule a meeting
2. Make conflict resolution the priority rather than winning or being “right.”
3. Gather all the facts that are available; do so without emotion. Gathering the facts allows you to pick your battles.
4. Write down all of the information that you have; verbal-only references provide an opportunity for emotion. Writing allows for clarity and if the ground rules are set at the beginning, then a level of trust and comfort can be set.
5. Begin the meeting by stating the positives rather than focusing on the negatives. Focus on the present and be specific.
6. Have an end point, decide on goals – the goal may mean gathering more information. What is wanted – what will be committed to by all parties involved?
7. Address the negatives. The negatives may not be based in reality so debunking those myths is important.
8. Leave the table with a scheduled way to check on progress- this is often the most forgotten step. Agree upon the consequences if the agreement is not kept.
9. Pick your battles. The supervisee is worried about a favorable grade or accumulation of clinical hours; try to determine what the bigger picture is. How did the conflict develop?

A healthy response to conflict involves the capacity to recognize and respond to the things that matter to the other person. The supervisor must adopt a calm, non-defensive and respectful reaction to the conflict. The supervisor must also develop an ability to seek compromise and avoid punishing. A supervisor’s ability to provide clear expectations of their conflict resolution style will help to diminish conflict in the triadic enterprise. This requires a paradigm shift away from strictly focusing on the cognitive aspects of the supervisory process and give equal emphasis on the affective content.
The ability to successfully resolve conflict relies on the supervisor’s ability to model how to (Segal & Smith, 2012):

- Manage stress quickly while remaining alert and calm
- Control emotions and behaviors
- Pay attention to the feelings being expressed by the other person
- Be aware of and respectful of the differences that a supervisee brings to the conflict
- Teach and demonstrate that it is okay to disagree.

Conflict resolution is a required skill for supervisors working with supervisees (ASHA, 2008) Conflict resolution in the case of the supervisor/see relationship means focusing on the present and being willing to forgive yourself and the supervisee. Remember that perception is 90% of reality for the individuals involved in conflict. As the supervisor you have to provide a balanced management of conflict. You can show strong leadership by being decisive yet flexible, self-confident yet able to enable others to be confident, being strong yet compassionate. The success of conflict resolution is measured not only by the achievement of the task but by the extent to which the task furthers the development of the supervisee and allows for successful supervision; in that the conflict has been resolved rather than merely managed (Mueller & Kell, 1972).

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Phone: 740-594-4276

References


from [http://www.helpguide.org/mental/eq8_conflict_resolution.htm](http://www.helpguide.org/mental/eq8_conflict_resolution.htm)
Appendix

Conflict-Management Style

In this section you will have the opportunity to examine your own conflict-management style and techniques you tend to use in conflict situations, particularly under stress. The exercises that follow will enable you to gain insight into strategies you might choose to incorporate into your behavior in handling disputes and differences.

Conflict-Management Style Survey*

This Conflict-Management Style Survey has been designed to help you become more aware of your characteristic approach, or style, in managing conflict. In completing this survey, you are invited to respond by making choices that correspond with your typical behavior or attitudes in conflict situations.

Section 1: Survey

This survey identifies twelve situations that you are likely to encounter in your personal and professional life. Please study each situation and the five possible behavioral responses or attitudes carefully and then allocate ten points between them to indicate your typical behavior, with the highest number of points indicating your strongest choice. Any response can be answered with from zero to ten points, as long as all five responses for a given situation add up to ten points, as shown in the following example:

EXAMPLE SITUATION: In responding to a request from another for help with a problem, you would:

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>4</td>
<td>A.</td>
</tr>
<tr>
<td>3</td>
<td>B.</td>
</tr>
<tr>
<td>2</td>
<td>C.</td>
</tr>
<tr>
<td>1</td>
<td>D.</td>
</tr>
<tr>
<td>0</td>
<td>E.</td>
</tr>
<tr>
<td><strong>10</strong></td>
<td>TOTAL</td>
</tr>
</tbody>
</table>
**Conflict-Management Style Survey**


Please choose a single frame of reference (e.g., work-related conflicts, family conflicts, social conflicts) and keep that frame of reference in mind when responding to all the situations. And remember as you complete this survey, that it is not a test. There are no right or wrong responses. The survey will be helpful to you only to the extent that your responses accurately represent your characteristic behavior or attitudes.

**SITUATION 1:** Upon experiencing strong feelings in a conflict situation, you would:

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<tbody>
<tr>
<td>A.</td>
<td>Enjoy the emotional release and sense of exhilaration and accomplishment</td>
</tr>
<tr>
<td>B.</td>
<td>Enjoy the strategizing involved and the challenge of the conflict</td>
</tr>
<tr>
<td>C.</td>
<td>Become serious about how others are feeling and thinking</td>
</tr>
<tr>
<td>D.</td>
<td>Find it frightening because you do not accept that differences can be discussed without someone getting hurt</td>
</tr>
<tr>
<td>E.</td>
<td>Become convinced that there is nothing you can do to resolve the issue</td>
</tr>
</tbody>
</table>

**TOTAL**

**SITUATION 2:** Consider the following statements and rate them in terms of how characteristic they are of your personal beliefs:

<p>| | |</p>
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>A.</td>
<td>Life is conquered by those who believe in winning</td>
</tr>
<tr>
<td>B.</td>
<td>Winning is rarely possible in conflict</td>
</tr>
<tr>
<td>C.</td>
<td>No one has the final answer to anything, but each has a piece to contribute</td>
</tr>
<tr>
<td>D.</td>
<td>In the last analysis, it is wise to turn the other cheek</td>
</tr>
<tr>
<td>E.</td>
<td>It is useless to attempt to change a person who seems locked into an opposing view</td>
</tr>
</tbody>
</table>

**TOTAL**

**SITUATION 3:** What is the best result that you expect from conflict?

<p>| | |</p>
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</thead>
<tbody>
<tr>
<td>A.</td>
<td>Conflict helps people face the fact that one answer is better than others</td>
</tr>
<tr>
<td>B.</td>
<td>Conflict results in canceling out extremes of thinking so that a strong middle ground can be reached</td>
</tr>
<tr>
<td>C.</td>
<td>Conflict clears the air and enhances commitment and results</td>
</tr>
<tr>
<td>D.</td>
<td>Conflict demonstrates the absurdity of self-centeredness and draws people closer together in their commitment to each other</td>
</tr>
<tr>
<td>E.</td>
<td>Conflict lessens complacency and assigns blame where it belongs</td>
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</table>

**TOTAL**
### SITUATION 4: When you are the person with the greater authority in a conflict situation, you would:

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</thead>
<tbody>
<tr>
<td>A</td>
<td>Put it straight, letting the other know your view</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Try to negotiate the best settlement you can get</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Ask to hear the other’s feelings and suggest that a position be found that both might be willing to try</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Go along with the other, providing support where you can</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Keep the encounter impersonal, citing rules if they apply</td>
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</table>

TOTAL

### SITUATION 5: When someone you care for takes an unreasonable position, you would:

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</thead>
<tbody>
<tr>
<td>A</td>
<td>Lay it on the line, telling him or her that you don’t like it</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Let him or her know in casual, subtle ways that you are not pleased; possibly distract with humor; and avoid a direct confrontation</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Call attention to the conflict and explore a mutually acceptable solution</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Try to keep your misgivings to yourself</td>
<td></td>
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<tr>
<td>E</td>
<td>Let your actions speak for you by indicating depression or lack of interest</td>
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</table>

TOTAL

### SITUATION 6: When you become angry at a friend or colleague, you would:

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</thead>
<tbody>
<tr>
<td>A</td>
<td>Just explode without giving it much thought</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Try to smooth things over with a good story</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Express your anger and invite him or her to respond</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Try to compensate for your anger by acting the opposite of what you are feeling</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Remove yourself from the situation</td>
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</table>

TOTAL

### SITUATION 7: When your find yourself disagreeing with other members of a group on an important issue, you would:

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</thead>
<tbody>
<tr>
<td>A</td>
<td>Stand by your convictions and defend your position</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Appeal to the logic of the group in the hope of convincing at least a majority that you are right</td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Explore points of agreement and disagreement and the feelings of the group’s member, and then search for alternatives that take everyone’s views into account</td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Go along with the rest of the group</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Not participate in the discussion and not feel bound by any decisions reached</td>
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</table>

TOTAL
**SITUATION 8:** When a single group member takes a position in opposition to the rest of the group you would:

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<tr>
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</thead>
<tbody>
<tr>
<td>A.</td>
<td>Point out publicly that the dissenting member is blocking the group and suggests that the group moves on without him or her if necessary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Make sure the dissenting member has a chance to communicate his or her objections so that a compromise can be reached</td>
<td></td>
<td></td>
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<tr>
<td>C.</td>
<td>Try to uncover why the dissenting member views the issue differently, so that the group’s members can reevaluate their own positions</td>
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<tr>
<td>D.</td>
<td>Encourage the group’s members to set the conflict aside and go on to more agreeable items on the agenda</td>
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<tr>
<td>E.</td>
<td>Remain silent, because it is best to avoid becoming involved</td>
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</table>

**TOTAL**

**SITUATION 9:** When you see conflict emerging in a group, you would:

<p>| | | | | |</p>
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<tr>
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<tbody>
<tr>
<td>A.</td>
<td>Push for a quick decision to ensure that the task is completed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Avoid outright confrontation by moving the discussion toward a middle ground</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.</td>
<td>Share with the group your impression of what is going on, so that the nature of the impending conflict can be discussed</td>
<td></td>
<td></td>
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<tr>
<td>D.</td>
<td>Forestall or divert the conflict before it emerges by relieving the tension with humor</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>E.</td>
<td>Stay out of the conflict as long as it is of no concern to you</td>
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</table>

**TOTAL**

**SITUATION 10:** In handling conflict between your group and another, you would:

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<tr>
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</thead>
<tbody>
<tr>
<td>A.</td>
<td>Anticipate areas of resistance and prepare responses to objections prior to open conflict</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B.</td>
<td>Encourage your group’s members to be prepared by identifying in advance areas of possible compromise</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>C.</td>
<td>Recognize that conflict is healthy and press for the identification of shared concerns and/or goals</td>
<td></td>
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<tr>
<td>D.</td>
<td>Promote harmony on the grounds that the only real result of conflict is the destruction of friendly relations</td>
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<tr>
<td>E.</td>
<td>Have your group submit the issue to an impartial arbitrator</td>
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</table>

**TOTAL**
**SITUATION 11:** In selecting a member of your group to represent you in negotiating with another group, you would choose a person who:

<p>| | |</p>
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<tbody>
<tr>
<td>A.</td>
<td>Knows the rationale of your group’s position and would press vigorously for your group’s point of view</td>
</tr>
<tr>
<td>B.</td>
<td>Would see that most of your group’s judgments were incorporated into the final negotiated decision without alienating too many members of either group</td>
</tr>
<tr>
<td>C.</td>
<td>Would best represent the ideas of your group, evaluate these in view of judgments of the other group, and then emphasize problem-solving approaches to the conflict</td>
</tr>
<tr>
<td>D.</td>
<td>Is most skilled in interpersonal relations and would be openly cooperative and tentative in his or her approach</td>
</tr>
<tr>
<td>E.</td>
<td>Would present your group’s case accurately, while not making commitments that might result in obligating your group to a significantly changed position</td>
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**TOTAL**

**SITUATION 12:** In your view, what might be the reason for the failure of one group to collaborate with another?

<p>| | |</p>
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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>A.</td>
<td>Lack of clearly stated position, or failure to back up the group’s position</td>
</tr>
<tr>
<td>B.</td>
<td>Tendency of groups to force their leadership or representatives to abide by the group’s decision, as opposed to promoting flexibility, which would facilitate compromise</td>
</tr>
<tr>
<td>C.</td>
<td>Tendency of groups to enter negotiations with a win/lose perspective</td>
</tr>
<tr>
<td>D.</td>
<td>Lack of motivation on the part of the group’s membership to live peacefully with the other group</td>
</tr>
<tr>
<td>E.</td>
<td>Irresponsible behavior on the part of the group’s leadership, resulting in the leaders’ placing emphasis on maintaining their own power positions rather than addressing the issues involved</td>
</tr>
</tbody>
</table>

**TOTAL**
Section 2: Scoring

- **Step 1:** When you have completed all items in Section 1, write the number of points you assigned for each of the five responses for the twelve situations in the appropriate columns on the scoring form below. Add the total number of points for each column, and then check that the totals for each column add up to 120.
- **Step 2:** Transfer your column total scores onto the form showing the ideal order.
- **Step 3:** Transfer the style names, in order of the highest score first, which shows your order, and then enter the scores in the adjacent blank spaces.
- **Step 4:** Identify your conflict management style using figure 29 – Style Explanation

### Scoring Form

<table>
<thead>
<tr>
<th>Situation</th>
<th>Response A</th>
<th>Response B</th>
<th>Response C</th>
<th>Response D</th>
<th>Response E</th>
<th>Total</th>
</tr>
</thead>
<tbody>
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### Ideal Order

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<tr>
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<td>C</td>
<td></td>
</tr>
<tr>
<td>2. Compromiser</td>
<td>B</td>
<td></td>
</tr>
<tr>
<td>3. Accommodator</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>4. Controller</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>5. Avoider</td>
<td>E</td>
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<tr>
<td><strong>TOTAL</strong></td>
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</table>

### Your Order

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<tr>
<td><strong>TOTAL</strong></td>
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</tbody>
</table>
1. **Collaborator (win/win) Score ________ High goal orientation /High relationship orientation**
   - The style of collaboration is both assertive and cooperative – the opposite of avoiding. Collaborating involves an attempt to work with the other person to find some solution which fully satisfies the concerns of both persons. It means digging into an issue to identify the underlying concerns of the two individuals and to find an alternative which meets both sets of concerns. Collaborating between two persons might take the form of exploring a disagreement to learn from each other’s insights, concluding to resolve some condition which would other-wise have them competing for resources, or confronting and trying to find a creative solution to an interpersonal problem.

2. **Compromiser (mini-win/mini lose) Score ____ Negotiated goal orientation/Neogotiated relationship orientation**
   - The style of compromising is intermediate in both assertiveness and cooperativeness. The object is to find some expedient, mutually acceptable solution which partially satisfies both parties. It falls on a middle ground between competing and accommodating. Likewise, it address an issue more directly than avoiding, but doesn’t explore it in as much depth as collaborating. Compromising might mean splitting the difference, exchanging concessions, or seeking a quick middle-ground position.

3. **Accommodator (Yield-lose/win) Score ____ Low goal orientation/High relationship orientation**
   - The style of accommodating is unassertive and cooperative – the opposite of competing. When accommodating, an individual neglects his or her own concerns to satisfy the concerns of the other person; there is an element of self-sacrifice in this mode. Accommodating might take the form of selfless generosity or charity, obeying another person’s order when one would prefer not to, or yielding to another’s point of view.

4. **Controller (win/lose) Score ____ High goal orientation/low relationship orientation**
   - The style of controlling is assertive and uncooperative – an individual pursues his or her own concerns at the other person’s expense. This is a power-oriented mode, in which one uses whatever power seems appropriate to win one’s own position- one’s ability to argue, one’s rank, economic sanctions. Competing might mean “standing up for your rights,” defending a position which you believe is correct, or simply trying to win.

5. **Avoider (leave-lose/win) Score ____ Low goal orientation/low relationship orientation**
   - Avoiding is unassertive and uncooperative- the individual does not immediately pursue his own concerns or those of the other person. He or she does not address the conflict. Avoiding might take the form of diplomatically sidestepping an issue, postponing an issue until a better time, or simply withdrawing from a threatening situation.
“Relativity Applies to Physics, Not Ethics”: A Tutorial on Responsible Conduct of Research for Student Researchers in Communication Sciences and Disorders

Shruti Deshpande & Aniruddha K. Deshpande

Abstract
Albert Einstein said, “Relativity applies to physics, not ethics.” One interpretation of this powerful statement is that compromising ethical standards negatively affects the quality of research and our overall progress. The aim of this tutorial is to provide a brief description of some of the issues that are important for the responsible conduct of research, as relevant to students involved in human research in the profession of Communication Sciences and Disorders (CSD). A brief historical perspective leading to the development and implementation of standards for the protection of human participants in research is discussed. The paper focuses on topics such as conflicts of interest, scientific misconduct, and ethical issues pertaining to mentoring and authorship, based on a hypothetical vignette. Finally, recommended readings and resources on research integrity, that the authors have found to be helpful, are provided.

The article author(s) Shruti Deshpande and Aniruddha K. Deshpande, doctoral students from the University of Cincinnati; received a speaking fee from OSLHA for presenting this topic at the 2013 convention. The author(s) have no relevant nonfinancial relationship to disclose.

Learning Objectives:
1. Describe the history leading to the development and implementation of standards for the protection of human subjects practice (RP).
2. State the issues that are important for the responsible conduct of research as relevant to students involved in human research in the area of Communication Sciences and Disorders (CSD).
3. Identify ethical issues in research in CSD.

The need for ethical guidelines for the care, safety, and overall well-being of patients and clients in the field of communication sciences and disorders (CSD) is clear to most professionals and student-clinicians. However, understanding the vital issues pertaining to the responsible conduct of research is also important. This tutorial focuses on ethics in research for students in CSD. Some of the reasons for the incorporation and the implementation of strict ethical regulations and guidelines for conducting research are: (1) research in CSD is focused on the involvement of human participants; (2) maximizing benefit to all individuals and minimizing harm is of utmost importance; (3) resources including time and money are required for conducting research; misconduct leads to wasted resources for the public, and can negatively affect public health to a great extent (Steneck, 2002); (4) the ASHA Code of Ethics (2010) clearly states that “Individuals shall honor their responsibility to the public” (Principle of Ethics III), and (5) the ultimate goal of research is the pursuit of truth.

Publishing is an integral part of research. There are several advantages of publishing widely such as (1) disseminating new research findings that support or refute previously published work; (2) defining new questions for future research and development; and (3) enhancing one’s ideas and methods through the peer-review process. For a more elaborate discussion on the advantages of the peer-review process, the interested reader is referred to Clapham (2005). The term “Publish or Perish” is often used in academia which lays the foundation for moving a discipline forward and ensures the success of individual researchers. Continuous research and publications serve as important criteria for successfully seeking highly competitive grants. Grant funding is vital in furthering one’s research goals and in disseminating research findings through publications.
The “Publish or Perish” approach is crucial for the advancement of a discipline and of science in general. However, temptations to succeed by involving oneself in inappropriate professional behavior and scientific misconduct are detrimental not only to the specific discipline but also to the scientific community at large. Examples of such misconduct may include possible conflicts of interest with funding agencies and falsification or fabrication of research results. Referring to the extraordinary pressures and temptations to succeed, Wheeler (1989, p. 11) wrote, “The pressure to publish promotes disreputable science.” Additionally, lack of understanding of what constitutes research misconduct is another factor that can negatively impact the research process. This may especially be true for students who are novice researchers.

The United States (U.S.) Office of Research Integrity (ORI) has laid the foundation for defining and communicating standards for Responsible Conduct of Research (RCR) and has investigated research misconduct (U.S. Public Health Service, 2005). In the field of CSD, the American Speech-Language-Hearing Association (ASHA) has systematically investigated ethical issues related to research and has worked extensively with the ORI to promote research integrity (ASHA, 2001; U.S. Public Health Service, 2005). Some examples of such efforts include (1) co-hosting a conference on promoting research integrity in the discipline and disseminating the proceedings (ASHA, 2001; U.S. Public Health Service 2001); (2) action initiated by ASHA to revise the Code of Ethics to include research integrity issues (ASHA, 2003); (3) dedicating a supplement of the Journal of Speech, Language, and Hearing Research to the topic of research integrity (Schlauch, 2011); and (4) continually providing numerous resources on research integrity on ASHA’s “Ethics in Research” website (http://www.asha.org/Research/Ethics-in-Research/).

The aim of the present tutorial is to provide a brief description of some of the issues that are important for the responsible conduct of research as relevant to students involved in human research in the discipline of CSD. Topics such as protection of human participants, conflict of interest, scientific misconduct, and ethical issues pertaining to mentoring and authorship will be discussed based on a hypothetical vignette. Training on these topics has been identified by the ORI as being important to maintain and promote responsible conduct of research. The main discussion is preceded by a brief historical perspective leading to the development and implementation of standards for protection of human research participants. Finally, a list of recommended readings and resources on research integrity is provided.

**History**

The regulations and standards put forth by federal agencies like ORI and incorporated by scientific bodies like ASHA and the American Academy of Audiology (AAA) in the form of policies, codes, and education (Macrina, 2007) for conducting research ethically, are based on certain historical milestones. The purpose of research is to pursue truth and knowledge in a way that maximizes benefit and minimizes risk to the public. However, undue risk (e.g., physical, emotional, social, psychological) to research participants in the past has led to an international need for implementing regulations in order to carry out research ethically. Some historical milestones that have led to the incorporation of ethical regulations, and thereby protection of human participants, are briefly described below.

**Nuremberg Code (1945-1947)**

Nazi physicians and scientists committed atrocities and inhumane ‘experiments’ on vulnerable participants without their consent, often resulting in torture, brutal crimes, and murder. Such participants included the ill, the elderly, individuals with physical and mental disabilities, and prisoners of war in Nazi-governed Germany (Coleman, Menikoff, Goldner, & Dubler, 2005). Trials against the involved physicians and scientists were held in Nuremberg, Germany from 1945-1947 and several individuals accused of the research-crimes were sentenced to death or imprisonment. The Nuremberg code arose as a result of these trials, and it mandates the requirement for voluntary consent of human participants prior to participation in research (Coleman et al., 2005). The principles of the Nuremberg Code can be found at http://www.hhs.gov/ohrp/archive/nurcode.html.

**Declaration of Helsinki (1964) and the Beecher Article (1966)**

The Declaration of Helsinki chronologically followed the Nuremberg Code and expanded and revised some of the principles introduced in the Nuremberg Code. The guidelines in the declaration mention ethical principles
for research involving human participants. The declaration especially focuses on the need for the review and approval of research proposals by an ethics committee prior to the recruitment of human participants or the use of identifiable human data for research studies. The Declaration of Helsinki was originally adopted by the World Medical Association in Helsinki, Finland and has undergone several iterations and revisions since then. The Declaration of Helsinki can be retrieved at:


During the same period, a well-known Harvard anesthetist and researcher, Henry K. Beecher, M.D., published an article on examples of ethically questionable studies (Beecher, 1966). This article is available online at:


The Declaration of Helsinki and the Beecher Article led to the need for creating a body that oversaw and regulated research from an ethical point of view. At several research institutes in the U.S., the Institutional Review Board (IRB) serves as the ethical body that oversees research practices. In several other countries, ethics committees oversee the process of protection of research participants.

**Tuskegee Syphilis Study (1932-1972)**
The Tuskegee Untreated Syphilis Study, carried out from 1932-1972 on African-American male participants, involved the enrollment of participants without informing them about the true intent of the research, i.e. study of progression of syphilis (Gray, 1998). In order to fulfill their aims, researchers did not inform the participants of a proven cure, penicillin, which became available for the treatment of syphilis in the 1950s. Their dishonesty precluded the participants from seeking treatment, resulting in several deaths (Coleman et al., 2005). As a result of the concerns raised by the Tuskegee Syphilis Study, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was convened. This led to the creation of the Belmont Report. More information on the Tuskegee Syphilis Study is available online at:


**The Belmont Report (1979)**
The Belmont Report was written by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research in 1979 and involves three basic principles: (1) respect (autonomy of all individuals and protection of individuals with diminished autonomy); (2) beneficence (minimizing risk and maximizing benefit for study participants); and (3) justice (ensuring fairness in terms of the benefits and burdens of research). Informing participants of the benefits and risks of a study; possible treatment options and alternatives; providing participants opportunities to ask questions; and the right to voluntary and informed consent prior to participation in a study are some of the practices incorporated in research as a result of the principles of the Belmont Report. More information on the Belmont Report can be found at


Based on the Belmont report, the Common Rule was established by the U.S. Department of Health & Human Services and the Food and Drug Administration in 1981 and published as rules and regulations in 1991. The Common Rule governs the Institutional Review Boards of different institutions and is especially important for the execution of government-funded research in the U.S. It includes rules for protection of vulnerable research participants (pregnant women, fetuses, neonates, children, prisoners). The Common Rule is available online at:


**Recent Dilemmas Pertaining to Ethics in Research**
Research is ever-evolving and so are ethical issues pertaining to research. One such issue involves the use of the ‘HeLa Cells,’ a tissue-culture line including genetic material obtained from a woman called Henrietta Lacks (Callaway, 2013). Henrietta Lacks suffered from cervical cancer. Following a biopsy in 1951, physicians at the Johns Hopkins hospital obtained cells from her. The bi-specimen thus obtained was developed into the first human cancer tissue-culture that has widely been used by biomedical researchers all over the world and known as the HeLa Cells. Several scientific advances have been made over the years using HeLa cells resulting in more than 75,000 research articles (Callaway, 2013). Some of the notable research contributions include development of the vaccine for polio, investigation of...
the pathophysiology of viral infections, cloning studies, gene sequencing and expression experiments, and clinical trials for making advances in cancer research (Skloot, 2010). However, before harvesting the cell line, the informed consent of Henrietta Lacks or her family was not sought. While there were regulations and guidelines that researchers were required to follow before involving human participants in research endeavors (discussed above), there were no specific guidelines for obtaining human bio-specimens. Henrietta Lacks’ kin were concerned about the use of the HeLa cells without appropriate informed consent. Another concern for the family was that the information from the genome could be used to identify Lacks’ family members through cross-referencing with genealogy DNA databases (Callaway, 2013). In collaboration with the National Institutes of Health, the Lacks’ family has made the HeLa cell database available for research under a restricted access system, i.e. permission needs to be sought to access this information. More than 60 years after the cells were first obtained, the HeLa cells controversy has led to the initiation of the redrafting of several rules pertaining to ethical issues in research at the national level (Callaway, 2013).

Protection of human participants is a very important aspect of research integrity. However other aspects of RCR, such as minimizing conflict of interest (COI), engaging in mentor-protégé relationships ethically, being mindful of ethics involved with authorship/publications, and avoiding research misconduct (fabrication/falsification/plagiarism) are equally important for producing science with integrity. These aspects are addressed through a hypothetical vignette followed by a discussion.

Vignette
Jim, a doctoral candidate, is talking excitedly with his fellow Ph.D. student about how lucky he is to be able to work with Dr. X. Dr. X is a well-known audiology researcher who conducts research on the effectiveness of various auditory prosthetic devices (hearing aids and cochlear implants) on speech perception.

Issue 1: When Jim’s friend compliments him on the successful participant recruitment for Dr. X’s and Jim’s research projects, Jim smiles. Jim does not mention to his peer that Jim often ‘encourages’ his undergraduate students (to whom he serves as a teaching assistant) to participate in his research studies. For instance, he awards them bonus points for agreeing to participate in the research studies. Although Jim’s study is about investigating benefits of auditory prosthetic devices on speech perception, he routinely convinces patients to participate in his research study by claiming that their participation will help them perceive the ‘s’ and ‘sh’ sounds better.

Issue 2: Dr. X is a very busy researcher who has limited time to talk with his students and research assistants. He does not meticulously ensure that his lab is running efficiently as long as the results of his studies are convincing. When the results are in accordance with his hypotheses, Dr. X does not ask too many questions. Jim is aware of this pattern and there are times when he has “tweaked the results just a little bit” so that the results fit with the hypotheses. Sometimes Jim tries to submit the same data to two different journals so that he can get two articles out of one dataset.

Issue 3: On another occasion, Jim invites Dr. Z, a well-known cochlear implant researcher, to be an author on a paper he is writing although Dr. Z indicates that she is too busy to help him in any way with his project. Jim extends the invitation because he feels that if Dr. Z is a co-author on his manuscript, it will be easier for him to get the article accepted and published.

Issue 4: Jim enjoys extensive liberty in his lab although he is only a student-researcher. As a result of his busy schedule and because he trusts Jim blindly, Dr. X has given Jim the full responsibility to write manuscripts and submit them for publication. Jim is either asked to make his own decisions or to talk to a post-doctoral fellow every time he approaches Dr. X with questions. Sometimes Jim does not receive adequate and appropriate help from the post-doctoral fellow in his lab.

Issue 5: Jim is sometimes the beneficiary of gifts from hearing aid and cochlear implant companies ‘for being a passionate budding researcher.’
The following is a discussion of the ethical issues pertaining to the above vignette.

**Issue 1: Protection of Human Participants**

As discussed earlier in the historical overview, research at most institutions in the U.S. is regulated by the IRB of that institution. The duty of the IRB is to prospectively review research proposals and ensure the protection of human participants prior to, during and after the study. The IRB approves research protocols from an ethical point of view and ensures protection of all participants, especially the vulnerable ones (pregnant women, fetuses, children, prisoners). Individuals who may be negatively impacted due to the researcher’s position of authority can also be considered vulnerable and hence need to be protected. For example, when Jim encourages his students to participate in his research study, the students need to be protected. Such instances need to be fully disclosed to the IRB and an approval must be sought prior to recruiting vulnerable participants. The IRB ensures that the consent document is drafted to clearly articulate various aspects of the study to participants. For instance, the following aspects of the study need to be explained in the research proposal and the consent document submitted to the IRB: (1) the purpose of the study; (2) the procedures involved; (3) the task(s) of the participants; (4) enumeration of tasks that are experimental in nature; (5) potential risks and benefits of the study; (6) description of privacy and confidentiality measures; (7) information about all research personnel involved, contact information of the principal investigator; and (8) a paragraph conveying information that participation in the study is completely voluntary, refusal to participate or withdrawal after participation will result in no penalty or loss of any benefits to which the participant is entitled (Shoup & Arango, 2012). After IRB approval, it is essential that the researcher strictly follows the approved protocol and regulations. Any issues/problems with the implementation of the protocol need to be promptly reported to the IRB.

In the above vignette, two ethical concerns/breaches can be noted: (1) recruitment of Jim's students (vulnerable participants) without the approval from the IRB, and (2) mentioning potential benefits of the study to participants in order to recruit them when the benefit has not been clearly articulated in the approved IRB protocol or consent forms. Although it is possible that participation in the study may result in indirect benefits to participants in terms of speech perception, lack of an IRB approval to make such a claim could be considered unreliable and deceptive.

**Issue 2: Scientific/Research Misconduct**

“Forcery, fakery, and plagiarism contradict every natural expectation for how scientists act; they challenge every positive image of science that society holds.” (LaFollette, 1992, p. 1). “Research misconduct means fabrication, falsification, or plagiarism in proposing, performing, or reviewing research, or in reporting research results. Fabrication is making up results and recording or reporting them. Falsification is manipulating research materials, equipment, or processes, or changing or omitting data or results such that the research is not accurately represented in the research record. Plagiarism is the appropriation of another person’s ideas, processes, results, or words without giving them appropriate credit.” (Public Health Service, 2005, 42 CFR §93.103). The following document by the ORI provides comprehensive information on research misconduct: http://ori.dhhs.gov/sites/default/files/rcrintro.pdf.

“Tweaking” the results of the study as described in the vignette constitutes falsification. Jim also tries submitting the same data-set to two journals. Is that an act of plagiarism? Under most circumstances, journals do not review work that has already been published or is under consideration for publication by another journal. Redundant publications “can overemphasize the importance of findings” (Kassirer & Angell, 1995, p. 449). This can be harmful in medical and health-related research because it can overestimate the incidence of a health condition (Wheeler, 1989) or the usefulness of a technique or an intervention procedure (Scanlon, 2007). Additionally, redundant submissions are often considered unethical because they result in wasted resources such as reviewers’ and editors’ time. They may consume valuable journal space preventing other notable research from getting published (The Office of Research Integrity, 2013, available online: http://ori.hhs.gov/plagiarism-14). Submitting the same data-set to two separate journals for publication can often constitute self-plagiarism and may result in copyright infringement (Scanlon, 2007). Redundant publications are permitted only under exceptional circumstances and with the permission of the editors of both the journals (The Office of Research Integrity, 2013, available online: http://ori.hhs.gov/plagiarism-
Such circumstances may include expert reviews, translated work, abstracts published in conference proceedings that are later elaborated into a full-length research articles, and duplicate submissions to journals with completely different readership (Blancett, Flanagan, & Young, 1995). Disclosing the duplicate nature of a publication to the readers and/or appropriately citing previously published work when there is similarity, however does not constitute self-plagiarism. For an elaborate discussion on self-plagiarism, the interested reader is referred to an online resource by the Office of Research Integrity: http://ori.hhs.gov/avoiding-plagiarism-self-plagiarism-and-other-questionable-writing-practices-guide-ethical-writing. In the above vignette, submitting redundant work to different journals without seeking permission from the editors of both journals, could be considered as an act of self-plagiarism and therefore, be unethical.

**Issue 3: Authorship**

‘Publish or Perish’ is a commonly used phrase in academic settings. Publications are deemed important for academics in order to get grants and funding, to seek tenure, and are considered to be associated with the ‘worth’ of a researcher (Jones & Mock, 2007). The pressure and demands associated with publications might lead to unethical behaviors with respect to authorship. Some ethical concerns could be denying credit to individuals who have significantly contributed to the research (Jones & Mock, 2007) or giving an individual credit for authorship when their contribution has been minimal or nil. Such issues concerning authorship have been cited and described in the literature as follows:

- **Gift, courtesy, or honorary authorship.** Enlisting individuals who have not made substantial contribution to the manuscript as authors constitutes fraud (Wislar, Flanagan, Fontanarosa, & DeAngelis, 2011). The reason for gift, courtesy or honorary authorship could range from returning a favor, succumbing to pressure, to inviting the positive attention of journal editors and reviewers to a manuscript because a highly reputed individual in the field is enlisted as a co-author.

- **Authorship by authority.** Authorship by authority is defined as a form of gift, courtesy, or honorary authorship to a person in authority although their critical intellectual contribution to the publication is minimal or negligible.

**Ghost authorship.** In ghost authorship, the individual who has written the manuscript is not given credit through authorship and his name does not appear in the byline of the manuscript. For example, in the medical literature there are reports of individuals and agencies (ghosts) that are hired by pharmaceutical companies to control or shape several steps in the research, writing or publication of the manuscript so as to maximize positive publicity or minimize negative publicity of their product/service (Sismondo & Doucet, 2010). Ghost authorship may have legal ramifications.

The International Committee of Medical Journal Editors (2013; http://www.icmje.org/ethical_1author.html) has recommended the following guidelines for an individual to seek authorship on a manuscript:

1. Substantial contribution to conception/design of the research
2. Substantial contribution to analysis and interpretation of data
3. Drafting the article/revising intellectual content
4. Providing final approval of the version to be published

All the above conditions should be met to obtain credit for authorship. Most journals require all authors to confirm that their contribution to the manuscript is substantial so as to minimize the incidence of unethical authorship.

**Issue 4: Mentoring**

Holton (1986) refers to mentors as “scientific parents” (as cited in Sigma Xi & The Scientific Society, 1999, p. 56). In addition to the scientific advising and support a mentor provides, there have been several reports in the literature emphasizing the importance of the mentor’s role in the ethical training of their protégés (Barnes, Hermes, & Brooks, 2006; Faden, Klag, Kass, & Krag, 2002). The need to provide formal training in ethics at different stages of an individual’s scientific career has also been underlined (Eisen & Berry, 2002). In the above vignette, Dr. X’s role as a successful mentor appears to be lacking. As a result of his extremely busy schedule, Dr. X is unavailable to (1) provide scientific and ethical mentoring; (2) personally answer his student’s questions or ensure that they are answered by a senior, knowledgeable member of the lab; (3) ensure that the ethical reputation of his lab/lab-members is upheld. Lack of mentoring and the temptations to succeed have led Jim to make inappropriate decisions that constitute
as research misconduct. For instance, he did not seek the permission of each journal’s editor before submitting redundant manuscripts to two journals. While it is helpful to promote independence for personal growth, the lack of availability, support, and guidance may be detrimental to Jim’s scientific and ethical growth. The mentor has a responsibility to provide “education and moral guidance” to his protégé (Shamoo & Resnik, 2009, p. 68). Jim, as the protégé, shares an equal onus of acting responsibly, asking questions, and seeking guidance from his mentor.

**Issue 5: Conflict of Interest**

ASHA’s Code of Ethics (2010) states, “Individuals shall not participate in professional activities that constitute a conflict of interest” (III B). The presence of Conflicts of Interest (COI) (e.g., personal, professional, financial, legal, scientific, etc.) can impair objectivity, decrease effectiveness and can lead to harming research participants and the public (The American Psychological Association’s Ethical Principles of Psychologists and Code of Conduct, 2003). In the above vignette, accepting gifts from cochlear implant and hearing aid companies may be a potential COI for Jim as he works closely with patients who use hearing prostheses.

In the medical literature, there exist several studies (Hodges, 1995; Marco, Moskop, Solomon, Geiderman, & Larkin, 2006; Steinman, Shlipak, & McPhee, 2001) and extensive reviews (e.g., Wazana, 2000) to indicate the biases that arise as a result of gifts. Sometimes, gifts worth less than $50 are known to affect decisions of physicians, researchers and medical residents (Marco et al., 2006). Incentives can have an impact on the objectivity and effectiveness of researchers and students in CSD as well (Margolis, 2008). Gibbons, Landry, Blouch, Jones, Williams, Lucey, and Kroenke (1998) studied physicians and patients’ attitudes to industry-sponsored gifts and suggested asking oneself, “Would I be willing to have it generally known that I accepted this gift from the industry?” (p. 25). This question may act as an internal guide to help make decisions. This leads to an important guideline to err on the side of caution and to report anything that can be remotely perceived as a COI.

**Closing Remarks**

This article provides the reader with a glimpse of the need for research regulations and guidelines. The vignette is straight-forward and is purposefully exaggerated to help the reader identify pronounced ethical breaches. However, individuals are faced with ethical questions and dilemmas on a regular basis in the clinical and research domain alike. Some dilemmas might be apparent while others might be subtle. Through this article and the suggested readings in the appendix, the authors hope that the readers get a comprehensive understanding of the concepts related to ethics in research. This will help readers to make appropriate and just professional choices. After all, as Albert Einstein has said, “Relativity applies to physics, not ethics.”

**Acknowledgement**

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**References**


Federal Register, 70(94), 28370-28400, codified at Code of Federal Regulations, Title 42, Part 93.


Appendix

Recommended Readings

Articles

Books

Websites
An introduction to the Responsible Conduct of Research, Office of Research Integrity: http://research.ucmerced.edu/docs/ORI%20Introduction.pdf
Bioethics Resources on the Web, National Institutes of Health: http://bioethics.od.nih.gov/
Integrity in Scientific Research: http://www.aaas.org/spp/video/
Ethics in Research website, ASHA: http://www.asha.org/Research/Ethics-in-Research/
The Office of Research Integrity – General Resources: http://ori.dhhs.gov/general-resources-0
Hot Topics in Ethics

Michelle L. Burnett, Barbara L. Prakup & Gregg B. Thornton

Abstract
This tutorial is offered in response to frequently asked questions regarding ethics. The authors offer some definitions of terms and provide guiding principles for ethical decision-making. References that the reader may consult to deepen understanding of the topics presented are provided. It is our hope that this tutorial is instructional for the reader and serves to empower professionals to develop ethical practices in all areas of professional life including service delivery, supervision, networking, and educating the general public.

The article author(s) Michelle L. Burnett, employed by the Cleveland Hearing & Speech Center, and Barbara L. Prakup, employed by Cleveland State University, have no relevant financial or nonfinancial relationships to disclose. The article author, Gregg B. Thornton, receives a salary for his job as the Executive Director of the Ohio Board of Speech-Language Pathology & Audiology (OBSLPA); he has no relevant nonfinancial relationship to disclose.

Learning Objectives:
1. Describe common ethical issues that practitioners and students encounter in various work settings.
2. State similarities and differences in ethical guidelines and requirements adopted by ASHA and the Ohio licensure board and identify specific statements from each that address specific dilemmas.
3. State how the profession’s code of ethics can be an effective resource to preventing ethical conflicts.
4. List other resources/strategies for following best practices to resolve ethical concerns.

What are ethics? Why do we need them? How are they applied to our practice? These are some of the questions which are asked frequently with regard to the professions of Speech-Language Pathology and Audiology. This tutorial will offer some definitions of terms as well as rationale for treatment of the topic of ethics in speech-language pathology and audiology. This article will offer principles by which a practitioner may be guided in ethical decision making. Additionally, the contents herein are intended to be instructional for the reader who may be in a position to act on an ethical dilemma. Finally, this article will suggest references that the reader may consult to deepen their understanding of the topics presented. It is the authors’ hope that the reader will be empowered by knowledge of these resources to develop ethical practices in all areas of professional life including service delivery, supervision, networking, and educating the general public.

What are ethics?
Practicing professionals in the fields of audiology and speech-language pathology generally know what the word “ethical” means. When the question “What are ethics?” arises, it is difficult to know how to respond. Ethics might conjure thoughts of behaviors, morals, rules, principles or beliefs. In the dictionary, ‘ethics’ is described as a plural noun used with a plural or singular verb. Ethics is defined as (emphasis added) (1) “a system of moral principles: the ethics of a culture; (2) the rules of conduct recognized in respect to a particular class of human actions or a particular group, culture, etc.: medical ethics; Christian ethics; (3) moral principles, as of an individual: “His ethics forbade betrayal of a confidence.” Ethics is also described as a plural noun: (4) that branch of philosophy dealing with values relating to human conduct, with respect to the rightness and wrongness and to the goodness and badness of the motives and ends of such actions.” (Ethic, n.d.).

When looking at other sources, ethics have been described by others in many ways. Albert Schweitzer said “Ethics is nothing else than reverence for life” (Schweitzer, n.d.). Bill Moyers states, “Our very lives depend on the ethics of strangers, and most of us are always strangers to other people” (Moyers, n.d.). Corliss Lamont pointed out that “the act...of choosing among various courses of conduct is central in the
realm of ethics.” (Lamont, n.d.). Jane Addams concurred with the thought that our actions reflect our ethics saying, “Action indeed is the sole medium of the expression of ethics.” (Addams, n.d.). So, for the purposes of this article and in the workday, it is suggested that the readers think of the word “ethics” as a verb. While we can’t rightly define ethics as a verb, the actions that depict one’s values and principles are inextricably tied to the behavior in which one chooses to engage. This link is most aptly presented by Lao Tzu who said:

Watch your thoughts, for they become your words;
Watch your words, for they become your actions;
Watch your actions, for they become your habits;
Watch your habits, for they become your character;
Watch your character, for it becomes your destiny.

(Lao Tzu, n.d.).

While ethics are beliefs, one’s ethics are revealed in what one does, how one does it, and with what intention. The concept of ethical choices, acts, and behaviors is multidimensional. When we evaluate our options and assess our own choices, do we take the time to consider our own motives? When we evaluate the actions of others, do we consider the possible intentions? Perhaps more importantly, do we seek to learn the intentions/motives behind the observable actions? Looking at and acting on situations that pose ethical dilemmas requires a process to ensure thorough examination of the many factors that may be involved. Ultimately, the decisions we face in providing care for people in need require choices to be made; choices grounded in ethics.

Personal ethics can vary. Within the moral code inherent to a given culture, there is some latitude regarding demonstration of ethics. In the example above from the dictionary: “His ethics forbade betrayal of a confidence.” (Ethic, n.d.). Many people generally agree that keeping a confidence is important, but each will make different decisions about what to tell to whom and when. One person might hold a confidence more strictly than another. Likewise, the same person might make different choices about revealing a confidence depending on the context. Individual interpretation of the moral code is likely to influence personal choices and actions. Therefore, professional training of audiologists and speech-language pathologists incorporates education about various professional ethics that serve as the basis for decision making and subsequent action.

Ethical Guides
There are several documents that provide guidance with regard to ethical conduct relative to performing job duties. These documents are available from the American Speech Language Hearing Association (ASHA; Code of Ethics) and the American Academy of Audiology (AAA; Code of Ethics). Each state association has a code of ethics. In our case the Ohio Speech-Language Hearing Association (OSLHA) Code of Ethics is available at http://www.asha.org/practice/ethics. The Ohio Board of Speech-Language Pathology and Audiology (OBSPA), which regulates professionals also uses the Ohio Administrative Code 4753-09-01 (http://codes.ohio.gov/oac/4753-9). Additionally, employers generally have policies and procedures and other practice guidelines detailing expected conduct in the performance of job duties. All of these documents will provide guidance in making ethically sound choices in all aspects of service delivery and these principles and rules in these documents provide support and counsel when considering an ethical dilemma.

Periodic review of these documents is important as they are regularly updated and revised. While similar in scope and spirit, each of these documents is different from the others. While this might be confusing, the reader is encouraged to carefully analyze and abide the most stringent principle among all guiding principles and rules. These documents provide cogent reminders of the full scope of professional responsibilities in the practice of audiology, speech-language pathology, and the hearing and speech sciences. As stated in the opening paragraph of the Preamble of the ASHA Code of Ethics:

The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by speech-
language pathologists, audiologists, and speech, language, and hearing scientists. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose (Ethics, 2010).

There are four principles that guide our reasoning and choices and each encompasses a body of rules that provide specific reference to various behaviors in the execution of job duties.

**Principle of Ethics I**
Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner.

**Principle of Ethics II**
Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance.

**Principle of Ethics III**
Individuals shall honor their responsibility to the public by promoting public understanding of the professions, by supporting the development of services designed to fulfill the unmet needs of the public, and by providing accurate information in all communications involving any aspect of the professions, including the dissemination of research findings and scholarly activities, and the promotion, marketing, and advertising of products and services.

**Principle of Ethics IV**
Individuals shall honor their responsibilities to the professions and their relationships with colleagues, students, and members of other professions and disciplines. (Ethics, 2010).

The Ohio Speech Language Hearing Association (OSLHA) Code of Ethics [http://ohioslha.org/a_codeOfEthics.htm](http://ohioslha.org/a_codeOfEthics.htm) is modeled after the ASHA Code of Ethics as are many other state association’s codes of ethics. The Ohio Administrative Code (OAC) 4753-09-01 Code of Ethics (Ohio Administrative Code, 2012) applies to all professionals licensed in Ohio as audiologists, speech-language pathologists, or speech, language, and hearing scientists, or as aides/assistants to these professions and it details specific rules of conduct within two guiding principles.

The OAC is written to ensure consumer protections and essentially advises the ethical conduct of professionals in our fields.

(A) Preamble: Licensees shall hold tantamount the health and welfare of person(s) served.

(B) Fundamental rules considered essential. Violation of the code of ethics shall be considered unprofessional conduct (Ohio Administrative Code, 2012).

Rules outlined in OAC 4753-09-01 Section (A) address the licensee’s respect for and protection of the inherent worth, integrity, dignity and rights of each person served across the spectrum of professional activities in which we engage. Rules in Section (B) essentially provide the “do’s and don’ts” related to professional behavior, maintaining records and confidentiality, supervision, research, and business practices (now including telehealth; Ohio Administrative Code, 2012).

The reader is reminded that the ASHA Code of Ethics compels reporting of suspected violations of the Code of Ethics (see Principle IV, Rule M: Individuals who have reason to believe that the Code of Ethics has been violated shall inform the Board of Ethics) (Ethics, 2010). ASHA, OSLHA, and the OBSLPA each have officers of ethics and each are contacted regularly with questions and concerns. Each of these organizations has a website with the procedures for filing and responding to complaints/concerns outlined. Each of these organizations is in contact with each other when necessary regarding ethical concerns that are brought forth for review.

At ASHA, the Board of Ethics reviews complaints and determines actions. The ASHA Board of Ethics Final Decision could recommend a range of sanctions from reprimand to censorship or withholding, suspending or revoking membership and/or the Certificate(s) of Clinical Competence. A final decision is made after a complete review is conducted of all provided evidence. Similarly, the state licensing board adjudicates complaints toward rendering a final decision that can include reprimand, require actions to rectify the situation, and/or suspend or revoke licensure. Table 1 below provides the total number of investigations undertaken by ASHA annually from 2006 - 2012. These data include all disciplines.
Table 1. ASHA Complaint Totals for 2006 – 2012

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Complaints Received</th>
<th>Hearings Conducted</th>
<th>Petitions for Reinstatement after Revocation of CCC and/or Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>21</td>
<td>23</td>
<td>2</td>
</tr>
<tr>
<td>2007</td>
<td>25</td>
<td>24</td>
<td>1</td>
</tr>
<tr>
<td>2008</td>
<td>36</td>
<td>41</td>
<td>2</td>
</tr>
<tr>
<td>2009</td>
<td>32</td>
<td>43</td>
<td>0</td>
</tr>
<tr>
<td>2010</td>
<td>22</td>
<td>25</td>
<td>2</td>
</tr>
<tr>
<td>2011</td>
<td>21</td>
<td>30</td>
<td>0</td>
</tr>
<tr>
<td>2012</td>
<td>17</td>
<td>24</td>
<td>3</td>
</tr>
<tr>
<td>TOTALS</td>
<td>174</td>
<td>210</td>
<td>10</td>
</tr>
</tbody>
</table>

While ASHA does not keep statistics on the categories of processed claims, the reader is referred to a recent article in the ASHA Leader which presented nine ethical dilemmas that are frequently addressed (Bupp, 2012). The topics presented in this tutorial include documentation, employer demands, use and supervision of support personnel, clinical fellowship mentoring/student supervision, client abandonment, reimbursement issues, business competition, impaired practitioners, and affirmative disclosures (requirements to reveal past of criminal or professional discipline history). Reviewing this article will provide some general information regarding the types of inquiries ASHA receives.

At the State level, detailed information is tracked regarding investigations conducted and complaints filed.

Table 2. OBSLPA Investigation Totals for 2012

<table>
<thead>
<tr>
<th>Cases carried over into FY 2013</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cases opened in FY 2013</td>
<td>83</td>
</tr>
<tr>
<td>Cases closed FY 2013</td>
<td>53</td>
</tr>
<tr>
<td>Hearings Conducted</td>
<td>1</td>
</tr>
<tr>
<td>Consent Agreements</td>
<td>20</td>
</tr>
<tr>
<td>Cease &amp; Desist Letters</td>
<td>4</td>
</tr>
<tr>
<td>Referrals to Prosecutor</td>
<td>0</td>
</tr>
<tr>
<td>Advisory Letters</td>
<td>8</td>
</tr>
<tr>
<td>Warning Letters</td>
<td>59</td>
</tr>
</tbody>
</table>

Given the existence of these sets of rules and guidelines that are seemingly comprehensive and clear, it is almost hard to imagine that ethical dilemmas present themselves. Yet, in fact, they do. As the world around us changes, as our scopes of practice grow or are altered by advancements in technology and our knowledge of the brain and speech, language and hearing mechanisms, new questions arise and it is necessary to revisit these principles and rethink the application of these values in our day-to-day practices. For example, while it may have been easy to recognize that as a professional you would not date or become personally involved with a student/patient/client/research subject, what about being friends on Facebook? Is that a violation of the Code of Ethics? Are there inherent detriments to the welfare of the person served in doing so? Is a professional able to maintain an appropriate professional relationship and objectivity in doing so? Situations such as these pose new choices and in these new situations we need to continue to act in a manner that preserves the highest standards of integrity and ethical principles in our professional interactions.

Identifying who can violate our Code of Ethics

Generally speaking it is the professional speech-language pathologist, audiologist or speech-language or hearing scientist who is compelled to uphold the standards of care detailed in the Codes of Ethics. To the
extent that employers and/or supervisors may or may not be credentialed in audiology or speech-language pathology, it behooves the SLP or audiology professional to ensure that employers and supervisors are aware of the principles and standards set forth in these documents as well. Since many practitioners report that they feel uneasy with reporting potential ethics violations, it is important to examine why such reports are necessary and helpful to the professions.

**Understanding the importance of reporting suspected ethical violations**

Beyond the fact that the ASHA COE compels us to do report suspected violations of the COE, there are additional reasons for reporting (potential) infractions. Some infringements of the COE might be inadvertent or unintended. Most of us are acutely aware of and attentive to the welfare of those we serve and do not knowingly act in a manner that would be inconsistent with the Code of Ethics. Other infractions are blatant, willful choices that are made knowingly (e.g., fraud in billing or false representation of skills). Ultimately, our Codes of Ethics exist to ensure that the persons served are protected and that professionals do no harm. The question(s) that arise regarding a specific situation all tie back to one of the four principles listed above in the ASHA Code of Ethics (welfare of the persons served, competence of the professional, accurate representation of the professions and appropriate business practices, and appropriate professional relationships). Not reporting suspected violations of the Code of Ethics could result in essentially contributing to or perpetuating the problem or, at the very least, not facilitating a solution.

Many professionals, when faced with an ethical question, will assess his/her own motives and seek advice from colleagues as well as the various documents or organizations mentioned here to assist with our decision making process. However, when a professional observes something done by someone else in practice that raises an ethical eyebrow, questions arise, such as where to turn first, whether to act, and if so, how? The remainder of this article will provide information regarding that decision making process and the processes in place for taking action.

**Application of ethics to guide behavior**

The above statistics might make you think that ethical violations are reported frequently or as a matter of routine. However, in preparing the workshops and this tutorial the authors learned that professionals frequently indicated they do not confidently know what to report to whom and when. When a potentially ethical concern arises, the observer must determine whether it is an ethical, moral, or legal matter. Depending on the answer to that question, the scope and sequence of reporting is determined. There is a process to first determining whether the problem is ethical, moral, or legal.

The very first step in the decision making process is to gather information. Assemble as many facts as you can, including the intentions of those involved. In addition to reviewing the applicable Code of Ethics principles and rules, also ask others with experience or knowledge. This may include a supervisor, department head, an ethics or quality officer, a mentor, a member of the ASHA Board of Ethics, the state association Ethics Chairperson, or a member of the state licensing Board. After gathering the facts and seeking advice, consider various courses of action and the impact each would have on the welfare of persons served, your own education and competence, and public perceptions (this encompasses not only our professions, but your and your employer’s reputation). To aid in this process of gathering information and determining the course of action, ASHA offers the following framework on ethical decision making.

The ASHA Code of Ethics requires that we report an ethical concern if we even think there is an ethical violation. The Board of Ethics determines whether or not a violation has occurred. This flow chart is designed to help the individual professional ask that first question: “Is this an ethical dilemma here?” and then also determine the course of action to take if the problem is found to be an ethical dilemma. The flow chart in Figure 1 may be helpful in providing a systematic process for analyzing ethical questions. The flow chart appears complicated at first glance, but a brief explanation of how to move through the chart may be useful.
Begin at the upper left corner of the flow chart ("Am I facing an ethical dilemma?). The first question invites the user to define the ethical dilemma by outlining the relevant facts and the people involved in the situation. This is a particularly good place to begin (e.g., outlining the problem), since these questions help the user define the ethical dilemma in terms that do not rely heavily on feelings or impressions. These questions are crucial in preparing for the next step in the process. Progressing from left to right in the flow chart, the practitioner is invited to then state the dilemma clearly. This is done based on gathering all relevant information that describes the situation and comparing the data with the particular standard(s) within the code of ethics that believed to be in question. Progressing down the right side of the flow chart, the next step involves analysis of all relevant facts in light of documented standards. In the analysis phase, the practitioner is encouraged to relate specific observed behavior and consider which elements of ethical code or law may have been violated. From the lower right corner of the flow chart, the practitioner considers the questions in each of the ovals moving right to left on the bottom row. These questions invite consideration of courses of action and potential conflicts. Once a proposed course of action has been developed, the practitioner moves upward in the flow chart to evaluate the proposed course of action in light of ethics, social roles, and self-interests in order to be sure that decisions are made in a logical and equitable manner. The practitioner then proceeds to the right, in the center of the flow chart to assess if consensus can be reached regarding the proposed course of action. If consensus is reached, the process concludes. If consensus is not reached, the flow chart directs the practitioner to repeat the analysis of the dilemma and progress once again through the “loop” on the bottom of the flow chart until consensus can be reached.

Once the professional has identified an ethical dilemma, s/he must then know how to file that concern with the appropriate authorities. Depending on the nature of the situation, there may be a clear cut first step. If the situation is occurring in the work place, many employers have compliance specialists who are available to assist in resolving ethical dilemmas or just clarifying the existing work policies that address the situation. It is important to know the internal policies and procedures of the workplace and follow those when addressing conflicts. Accurate, objective, and timely documentation of all aspects of the process cannot be over emphasized. Documentation of what is being observed, reported, to whom, and when, as well as what was said or done in response to reporting is
critical and essential. Documenting the reporting and resolution process is much like clinical documentation, which we all are trained to do. Keeping notes date- and time-stamped and as detailed as possible as well as documenting the facts and stated intentions is important. Documentation might include email correspondence or a journal/log of your actions and the actions of relevant others, with dated entries.

Various individuals, such as the state association’s ethics chairperson, state licensing board, and/or appropriate members of ASHA or AAA can be very helpful with regard to resolving ethical dilemmas. Each organization supports discussing circumstances of situations without filing a formal complaint and in this way is available to professionals in a consultative capacity. Additionally, the ASHA Website (www.asha.org) and ASHA Leader contain relevant information that may be helpful to review prior to discussing the situation with anyone (Center for the Study of Ethics in the Professions, 2013; Ethics Resources, 2013). Depending upon the nature of the situation, you may consider seeking legal counsel from a private attorney who specializes in employment law. After reports are filed, each organization has its own specific procedures for investigating complaints. We will review each (ASHA, OBLSPA, and OSLHA) separately.

ASHA’s Response to Complaints
The Board of Ethics is charged by the ASHA Bylaws with the responsibility for interpreting, administering, and enforcing the ASHA Code of Ethics. Complaints must be submitted in writing, using the “Complaint of Alleged Violation of the ASHA Code of Ethics” form (Complaint Form for Alleged Violation of the ASHA Code of Ethics, 2013) and a written attachment that includes the facts of the situation, as well as any other documentation that supports the allegations. Anonymous complaints are not accepted. The ASHA website provides guidelines regarding what to include in the complaint, what to redact from other records submitted, etc. Although it is not required, ASHA does appreciate citing each provision of the ASHA COE believed to be violated. Once the complainant submits the form and supporting documentation, a copy is provided to the Board of Ethics and the respondent (person against whom the complaint is made).

The Director of Ethics sends an acknowledgement that the complaint was received to the complainant. Complaints are reviewed by the Board of Ethics at the Board’s next meeting (Board meets three times per year). The Board processes the complaint. During the process the respondent will be asked to respond to the complaint and provide any documentation that supports his/her position or refutes assertions in the complaint. The Board renders a final decision based on the information provided. The respondent is able to appeal this final decision after it has been reached.

OBSLPA’s Response to Complaints: What happens to information once it is reported to the Ohio licensure board?
The powers and duties of the licensure board are enumerated under Ohio Revised Code section 4753.05. Under section E, the board shall investigate all alleged irregularities in the practices of speech-language pathology and audiology by persons licensed under Chapter 4753. This also includes any violations of this chapter or rules adopted by the board. As a result, the board has a duty to investigate any information received alleging irregularities against a licensee.

The board has policies and procedures governing the investigative process to ensure an individual’s due process (Ohio Board of Speech-Language Pathology and Audiology, 2013). The board investigative process starts with the receipt of information. Any person who wishes to make a complaint against any person licensed pursuant to this chapter shall submit the complaint in writing to the board within one year from the date of the action or event upon which the complaint is based. Information may be submitted via standard mail or e-mail.

The information received is referred to the board’s investigator for review and follow-up. The investigator may contact parties for additional information. When all information has been gathered by the investigator, the case is referred to the board’s Investigative Review Group (IRG) Committee. One board member serves as chair of the IRG, along with the board’s Executive Director, Investigator, and Assistant Attorney General. The IRG determines whether there is sufficient evidence to substantiate the alleged violation(s). If the information is substantiated, then the IRG will make a recommendation to the full board to initiate an adjudication process.
The board’s adjudication process may entail issuing a Notice of Opportunity for Hearing (NOH) letter to the licensee. The NOH letter informs the licensee of the allegations giving rise to the proposed disciplinary action. The licensee may request a public hearing in which to refute the allegations, present witnesses and other documentation in support of their position, question witnesses that may be called to testify in support of the allegations, and offer explanation. The board is required to follow this adjudication process before imposing any formal disciplinary action against a licensee. The hearing may be presided over by an attorney hearing examiner or may be heard by the full board. One exception is that the board member who served on the IRG Committee is recused from participating in the adjudication process. At the conclusion of the administrative hearing, the board will deliberate and determine whether disciplinary action is warranted. If disciplinary action is warranted, the board will issue an adjudication order. The adjudication order will list the findings of fact, conclusions of law, and impose a sanction. The board’s sanction may be a reprimand, suspension, probation, or revocation of the license. The licensee may appeal the board’s adjudication order to the Court of Common Pleas in the county of residence.

In lieu of holding an administrative hearing, the board may also enter into a Consent Agreement with the licensee to resolve the issue. A consent agreement is a document in which all parties agree to the facts, conclusions of law, and the disciplinary sanction. A consent agreement cannot be appealed. The board’s adjudication order or consent agreement is reported to the licensee’s employer and the national Healthcare Integrity and Protection Database (HIPDB). The disciplinary action is a public record and remains on licensee’s file indefinitely.

**OSLHA’s Response to Complaints**

OSLHA members and others are able to contact the OSLHA Ethics Committee with concerns/questions. OSLHA’s primary role is to educate membership regarding ethical issues. OSLHA’s ethical chairperson can respond to questions and link members to other sources. OSLHA does not make judgments on ethical issues, as that is the role of the ASHA Board of Ethics and OBSLPA.

All three organizations respect the confidentiality of the complainant and the respondent. Information is shared on an as needed basis among ASHA, state licensing board, and the state association in accordance with the bylaws and procedures specific to each organization.

**Summary**

This tutorial has explored several questions regarding ethics, such as “What are ethics?” and “Why do we need ethics?” It is necessary to consider these questions in order to develop a sound and systematic approach to potential ethical dilemmas. This tutorial was written after hearing the questions and concerns of convention session participants. Many of the participants expressed that they did not feel adequately prepared to identify and assess potential ethical issues. The authors have made an attempt to direct the reader to some resources and tools that may assist in the analysis and, hopefully, resolution of ethical questions. While issues regarding ethics may cause initial concern, they need not cause anxiety for the professional who encounters a professional concern. Hopefully, these resources can enhance the ability to consider and explore questions of ethics in the workplace and ensure the best care for the individuals served. ♦

**Authors Note:**
The authors of the present tutorial bring a broad spectrum of knowledge and experience to bear.

- Michelle Burnett, MA, CCC-SLP, BRS-FD has worked in hospital, private practice and not-for-profit community clinic settings. For the past 13 years, she has served as Director of Clinical Services for the Cleveland Hearing and Speech Center, overseeing the clinical operations and program development. Michelle brings the perspective of a practicing clinician as well as clinical director. She has served OSLHA as an alternative representative to the American Speech Language Hearing Association’s State Advocates for Reimbursement Network (ASHA STAR network) (2004 – present), Non-Profit Representative (2008-2010), Ethical Practice Chair-Elect (2010-2011), Ethical Practice Chair (2011-12), Vice President (2011-12), President (2012-2013), Past-President (2013-2014).
Barbara Prakup, Ph.D., CCC-SLP has served as a Speech-Language Pathologist for over 30 years and has held clinical, managerial and academic positions. She currently serves as a home health Speech-Language Pathologist for Summa Health System. Barbara brings the perspective of a practicing clinician, professor, supervisor and researcher. She has also served OSLHA as Ethical Practice Chair-Elect (2011-2012) and Ethical Practice Chair (2012-2013).

Gregg Thornton is the Executive Director of the Ohio Board of Speech-Language Pathology and Audiology. He is responsible for managing board operations and executing all directives issued by the Board. Gregg is an attorney and has over 24 years of experience in state government. Gregg brings the legal perspective to ethical questions as they relate specifically to Speech-Language Pathology and Audiology practice. Gregg serves OSLHA by facilitating communication between the association and the state board and educating practitioners on board policies and applicable law.

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Parenting: The Front Line of Bullying Prevention in a Socioecological Perspective

Lisa Pescara-Kovach

Abstract

According to Bronfenbrenner’s (1979) socioecological model, an individual’s entire socioecological system must be taken into account if one is to understand behavior. The current manuscript examines bullying through a socioecological lens, with special focus on parenting style. In the bullying dynamic, children are either engaging in the bullying (bully), subjected to bullying (victim), or participate in, and are subjected to, bullying behaviors (bully-victim). Findings indicate that authoritarian and permissive parenting are linked to bullying behaviors, while uninvolved parenting is linked to children becoming bully-victims. The ideal parenting style is authoritative, in which a household operates in a democratic fashion. It is the responsibility of the parents, educators, audiologists, and SLPs to exercise an authoritative interaction style in effort to diminish bullying and its detrimental effects.

The current manuscript describes the role of parenting style in a child’s involvement in bullying. We must work together with a systemic approach to put an end to bullying behaviors. Bullying is a matter of life and death for many involved as it is thought to be a situational trigger in a number of youth suicides (e.g., Rebecca Sedwick, Phoebe Prince, Megan Meier, Corinne Sides, and Jared High) as well as a catalyst in incidents of targeted violence. Seung Hui Cho of Virginia Tech as well as Eric Harris and Dylan Klebold alluded to having been bullied in the years prior to killing 32 and 13, respectively (Pescara-Kovach, 2005).

All members of society who live and work with children and adolescents must be aware of their role in bullying prevention and intervention. It is of critical significance to get to the root of WHY a child feels the need to torment others and how we are contributing to that behavior. Truthfully, the root often lies in a combination of contextual factors and personal factors. Many of the personal factors are influenced by the contextual factors.

In a meta-analysis to determine the factors that predict bullying and victimization, Cook, Williams, Guerra, Kim, and Sadek (2010) found that several family/home environment, community factors, and school climate factors impacted a child’s likelihood of becoming a victim or bully. These contextual factors are in need of consideration when developing best practice in bullying prevention and intervention. Further, several individual-
level factors are associated with involvement as a bully (e.g., externalizing), victim (e.g., peer status, social competence), or bully-victim (e.g., peer status, social competence) (Cook, Williams, Guerra, Kim, & Sadek, 2010). It may be the case that the contextual factors (e.g., parenting style) have a direct impact on the individual factors.

Certain characteristics make a child vulnerable to being bullied by his or her peers. At greater risk of victimization are those students who receive services for special needs (Rose, Monda-Amaya & Espelage, 2011). According to Sullivan (2006), children with observable disabilities are bullied twice as often as those with undetectable disabilities and both groups are targeted more often than children without disabilities. Swearer, Espelage, Vaillancourt and Hymel (2010) also found that children with disabilities are involved in bullying behaviors. Twyman, Saylor, Saia, Macias, Taylor, and Spratt (2010) state that children who are autistic, experience learning disabilities, and/or attention-deficit/hyperactivity disorder (ADHD) are at an increased risk of being bullied by their peers. As far as the deaf community, McCrone (2004) declared that bullying is as common in deaf/hard-of-hearing students as it is among hearing students (Bauman & Pero, 2010). Though research specifically examining bullying in the deaf/hard-of-hearing community is rare, recent research (Bauman & Pero, 2010) indicates that more frequent victimization was reported. Though these findings were not statistically significant, they do parallel the argument that an observable disability makes one more likely to be bullied and, consequently, increases the likelihood of internalizing and externalizing effects on the victim.

Bullying, by definition, is the persistent, intentional harming of another individual. Bullying is perpetrated by a single individual or several individuals. In order for an act to be considered bullying behavior, it must occur on more than one occasion. That is, bullying is repetitive in nature. Further, bullying involves an imbalance of power in which one is not in a position to defend himself or herself (Olweus, 1978; 1993; 2002). The power need not be in the physical domain. Social power may be the defining measure of the imbalance. According to Rose and Espelage (2012), bullying is far more complex than originally thought. Specifically, one cannot declare a single individual a bully, victim, or defender because an individual may take on the role of each at different times, depending upon the broader social environment (Espelage, Holt, & Henkel, 2003; Salmivalli, 2010; Espelage, Green, & Polanin, 2012). By extension, there are victims, bullies, and bully-victims (act as aggressor and are victimized).

There is a difference, among experts in the field, in categorizing the various forms of bullying. Quite often, bullying is separated into two forms: direct bullying and indirect bullying. Direct bullying is defined as that which is overt, of the physical, verbal, or cyber nature. Indirect bullying is covert, of the relational nature. A clearer understanding of the types of bullying occurs when bullying is labeled as taking one of four distinct forms: physical, verbal, relational, and cyber.

Physical bullying is the threat of, or actual, direct bodily contact that inflicts harm (Crick & Grotpeeter, 1995). Verbal bullying is the overt use of language to bully another individual. Verbal bullying takes the form of teasing, name-calling, or other audible insults. In terms of gender differences, verbal bullying is perpetrated almost equally by males and females whereas relational bullying, covert use of language to harm others relationships with others, occurs more often among females than males (Bjorkqvist, 1994; Bjorkqvist, Lagerspetz, & Kaukiainen, 1992; Espelage, Mcbane, & Swearer, 2004; Lagerspetz, Bjorkqvist, & Peltonen, 1988; Turkel, 2007). Cyberbullying is the use of electronic media to bully another individual. Cyberbullying can be both relational and verbal in nature. Relational cyberbullying occurs when one tries to defame someone’s reputation through negative posts or comments on such social networking sites as Twitter, Ask.fm, Facebook, Instagram, etc. Verbal cyberbullying occurs through repetitively hostile texts, comments, or e-mails directed toward another individual. In truth, cyberbullying is one of the easiest forms of bullying to perpetrate due to online disinhibition (Suler, 2004). Though the advent of technology has brought us benefits, it has also created a new, harmful type of rejection. The danger in cyberbullying lies in the fact that bullies can target their victims without making a personal, human connection to that individual. By extension, the separation between the bully and his or her victim lends itself to a loss of inhibition. As described by Suler, the Online Disinhibition Effect is a phenomenon that describes one’s tendency to psychologically disconnect himself or herself from the victim. This disconnect is dangerous...
due to the fact that bullies are free to victimize others while, at times, forgetting that there is a human being on the receiving end of the negative comments, messages, threats, websites. This problem is so pervasive that law enforcement officials are beginning to change their mindset as to the severity of the effects of cyberbullying. Case in point is the Rebecca Sedwick case. Rebecca Sedwick was a 12-year-old girl who committed suicide by jumping to her death off a tower at a cement plant. Two young females, ages 12- and 15-years, faced potential felony stalking charges. The charges are suggestive of the fact that law enforcement realizes that the young perpetrators’ behaviors were connected to Rebecca’s decision to end her own life.

Being bullied leads one to suffer internalizing or externalizing effects. Short-term internalizing effects that have been found to occur in victims include physical symptoms (Gini & Pozzoli, 2009), but also feelings of loneliness (Asher, Hymel, & Renshaw, 1984; Asher, Parkhurst, Hymel, & Williams, 1990), depression (Reijntjes, Kamphuis, Prinzie & Telch, 2010; Rigby, 2003; Strauss, Forehand, Freme, & Smith, 1984; Vosk, Forehand, Parker, & Rickard, 1982), low self-esteem (Hymel, 1983) and increased risk of suicidal thoughts and attempts (Brunstein-Klomek, Sourander, & Gould, 2010). Recent research suggests that being involved in bullying behaviors has a long lasting impact as well. Copeland, Wolke, Angold, and Costello (2013) found that victims of childhood bullying continued to suffer anxiety-related disorders (e.g., panic disorder, agoraphobia, generalized anxiety) into young adulthood. Those children, who were classified as bully-victims, were at increased risk of agoraphobia (females only), suicidality (males only), and depression into young adulthood (Copeland, Wolke, Angold, & Costello).

Some victims may internalize the pain from being bullied, only to eventually become bullies themselves. It has been established that there is a connection between being bullied by classmates and targeted violence (Pescara-Kovach, 2005). The majority of our nation’s school shooters had been bullied from the point they began in a formal educational setting. Dollard, Doob, Miller, Mowrer, and Sears (1939) posited the Frustration-Aggression Hypothesis in a time before school shootings were prevalent. The hypothesis supports the claim that aggression is often the end result of being continuously frustrated. Further, the school shootings suggest a link between being bullied and externalizing problems such as increasing aggression, anger, and hostility. School shooters typically fit within the bully/victim classification. Specifically, they had been bullied significantly in the past, and internalized the effects, only to become bullies themselves. The shooting incident is often the final act of bullying where they feel they have the ultimate power in a setting in which they felt continuously powerless and frustrated.

As previously mentioned, Espelage, Holt and Henkel (2003) and Rose and Espelage (2012) support the notion that bullying is not a simple act that is void of influence from social-ecological factors. Specifically, in an effort to understand what lends itself to an individual engaging in bullying or becoming a victim, one needs to examine an individual’s broader social environment (Espelage, Green, & Polanin, 2012). The school environment has been examined and is typically addressed in bullying prevention and intervention programs. In an exhaustive review of research, Cook, Williams, Guerra, Kim, and Sadek (2010) stated Family/home environment, school climate, and community factors significantly predicted involvement for bullies and victims, indicating the important role social context plays in the development and maintenance of bullying (p. 77).

It has been established that an educational environment that condones bullying behaviors, or ignores acts of bullying, sets the tone for continued bullying. Another social-ecological factor worth examining is parenting style. Baumrind (1967, 1971, 1973) described four styles of parenting: authoritarian, permissive, uninvolved, and authoritative. In classifying parenting styles, Baumrind referred to combinations of four dimensions of parental behavior: clarity of communication, control, maturity demands, and nurturance.

With authoritarian parenting there is little clarity in communication, high levels of parental control, extreme maturity demands on the child (e.g., “act like an adult!”), and very little nurturance. The child is expected to be submissive and to obey authority without question. The child’s opinion is not valued. Rules are enforced without explanation. For example, an authoritarian parent’s reaction to a website created
by his/her child for the purpose of bullying a hearing impaired classmate might be “That is MY computer!!! You don’t EVER use my computer again!” Household rules and restrictions rest in control issues. Children in authoritarian households are subjected to scare tactics and potentially abusive situations, while never getting a clear explanation of why he or she should not engage in bullying acts against a classmate.

The authoritarian parenting style often leads a child to exercise this type of interaction style with his or her classmates (Espelage, Bosworth, & Simon, 2000; Shields & Cicchetti, 2001). In other words, a child who is reared in an authoritarian home may exhibit authoritarian behaviors toward classmates. According to Marsiglia, Walczyk, Buboltz, and Griffith-Ross (2007), children raised in authoritarian households have lower self-esteem and poorer social skills than their classmates, both of which may contribute to bullying behaviors. In addition, poor communication, control over others, maturity demands, and cruelty are modeled at home. These children lack the disposition and related knowledge of how to treat others with respect and acceptance. Further, these children feel powerless and victimized at home and, as a result, may become angry at their own living circumstances and displace that anger through victimizing their classmates, particularly those who appear most vulnerable. Wells and Rankin (1988) found, in their examination of parenting styles linked to violent behaviors in children, that harsh, extremely strict parents were those whose children were the most violent.

A permissive parenting style is also linked to an increased likelihood that a child will victimize classmates. Permissive parents lack parental control (Baumrind 1967, 1971, 1973) and do not set rules. This type of parent feels the need to be the “cool” parent. He or she withholds discipline, even when a child engages in destructive behavior towards a classmate. In terms of communication, the parent often holds back his or her true feelings, while allowing the child to express negative thoughts and actions. There is more concern with developing a friendship than establishing rules. What they fail to realize is that withholding an explanation of right and wrong will result in the child making the wrong choices quite often. For example, if a child in a permissive home describes that he or she created a website dedicated to the defamation of a classmate, the permissive parent would not communicate his or her disappointment with the child. In contrast, this type of parent would make an excuse for his or her own child, while placing blame on the victim. Children reared in this type of environment have a tendency to develop overly high self-esteem, which has been implicated in a child’s propensity to commit acts of violence against others (Baumeister, Smart, & Boden, 1999). Further, if a child is not held accountable for his or her misdeeds, the child will not understand that s/he is responsible for his or her own actions and, like his/her parents, will also blame the victim. When a child views a classmate as inferior, he or she is more likely to bully without remorse.

It may be the case that permissive parenting results in children who feel free to express their intentions and feelings toward others – no matter how negative. By extension, the child may not think through the pain it causes another child if he or she insults or physically harms that child. This occurrence would take place due to the child’s history of not being corrected for expressing freely his or her negative thoughts and feelings. While freedom of expression is important, a parent need also stress the importance of preserving the dignity and self-worth of others. A permissive parent desires his or her child’s approval and friendship. While the intentions are good, the resulting lack of empathy may lead the child to engage in bullying behaviors without grasping the fact that bullying causes detrimental effects on the victim. In fact, Wells and Rankin (1988) reported that the second highest level of violent behavior came from children reared by permissive parents. In numerous conversations with relationally aggressive females, I have found that many lack empathy and cannot come to understand that it is not o.k. to socially isolate someone. They are often quite dismissive and state, “Well, she can find other friends.” or “We’d be her friend if she was more like us.” In truth, how can children know right or wrong if they were never told that their behaviors are hurtful. If a child spends his or her early stages of development without being corrected for transgressions, that child will have a harder time grasping the concept that bullying is wrong.

Uninvolved parenting has negative results as well (Steinberg, Lamborn, Darling, Mounts, & Dornbusch, 1994). Uninvolved parents are emotionally and/or physically disconnected from their children. Communication occurs infrequently. Children are
children rarely become involved in bullying behaviors. From a socioecological perspective, authoritative parenting should be taught as the first step in the prevention of bullying. Home is the first strong contextual influence on a developing child. Households, not just schools, are systems that impact a child’s development and his or her likelihood to be involved in bullying behaviors. If all children were raised in an authoritative household, it is likely that bullying incidents would decline. The foundation set in the preschool years would serve as a factor that decreases the likelihood of bullying. Democratic parenting is a key factor in bullying prevention and intervention. Democratic parenting is the first line of prevention in a socioecological approach to bullying prevention.

The information regarding the link between parenting style and bullying behavior must be shared with every individual who is working with children, including speech-language pathologists (SLPs) and audiologists, as those who are involved in early intervention must familiarize themselves with best practice in bullying prevention. In fact, the Department of Education’s Office of Special Education and Rehabilitative Services (OSERS) understands the importance of bullying prevention and intervention, in particular, with those students at risk. On Tuesday, August 20, 2013, OSERS released information to school districts, advising them that students with disabilities, who are bullied, continue to have the right to receive free appropriate public education (FAPE) in the least restrictive environment. In addition, if the perpetrator of bullying is also a student with a disability, he or she must have an individualized education plan (IEP) review in effort to assess the additional supports and services needed to attend to the bullying behavior.

Clearly, parents may be the identified factor in terms of what is leading to the bullying behavior. As such, the link between parenting style and bullying behavior must be shared with the parents of perpetrators, and victims, of bullying behaviors. The OSERS message was delivered in the form of a “Dear Colleague” letter and also stresses the fact that those children who are bullied deserve protection from the perpetrators of the bullying behavior. The letter further states that a refusal to allow free appropriate public education in the least restrictive environment may be considered a violation of the Individuals with Disabilities Education Act (IDEA).
If SLPs and audiologists are able, they should share the information with parents in effort to thwart the development of bullying behaviors and victimization. For example, if a professional detects a permissive or authoritarian style, he or she should share the knowledge that the specific type of parenting has the potential to lead to bullying behavior. If the SLP doesn’t feel comfortable addressing the parents directly, at the very least, that individual should model authoritative interaction with every child.

Bronfenbrenner stated that one can only fully comprehend human development by taking an individual’s entire socioecological system into account. His viewpoint needs to be carried into the practice of parenting and educating children in effort to address bullying. Given that we know that certain characteristics lend themselves to a child being bullied, we need to pay special attention to at-risk individuals. If we know, based upon research (Bauman & Pero, 2010), that more frequent victimization is reported in the deaf/hard-of-hearing population, SLPs and audiologists must familiarize themselves with best practice. The front line of best practice is prevention. Parents, audiologists and SLPs must work together to utilize the authoritative style in effort to assist all children to be void of any bullying characteristics.

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Orofacial Myology – Sharing a Confined Space

Patricia K. Fisher

Abstract
This article is an overview of the oral mechanism as shared space with many other professionals. Background of the field of Orofacial myology and ASHA’s official policy statements are considered. The goals of Orofacial myology as well as a summary of the training necessary are outlined. This article reviews the present research and suggests possible goals for future research.

Learning Objectives:
1. Define orofacial myofunctional therapy.
2. Review orofacial myology history and how it relates to speech-language pathologists.
3. Outline basic treatment levels for an orofacial myology program.

Generally speaking, some speech-language pathologists (SLP) regard the oral mechanism as their domain. In reality, this “space” is shared with many other professionals. Speech Pathologists do work there along with otolaryngologists, dentists, dental hygienists, physicians, osteopaths, orthodontists, physical therapists, occupational therapists, chiropractors, etc. These other professionals continue to increase their awareness and understanding of orofacial issues and total health. With increased knowledge those professionals are addressing more issues that were once considered the purview of the SLP. It is difficult to allocate the “space” precisely; still SLPs need “space” on the orofacial treatment team. What is the historical space of orofacial myology and where is it going?

In 1975, a formal position paper acknowledging orofacial myology within the profession of Speech Language Pathology was released. That paper, “Position Statement on Tongue Thrust,” was from the American Speech-Language and Hearing Association (ASHA) Joint committee on Dentistry and Speech Pathology-Audiology. This was the official position of ASHA and The American Association of Orthodontists (AAO) until 1988. The findings were inconclusive and recommended further research. In 1988 an Ad Hoc Committee on Labial-Lingual Posturing presented a new position paper that contributed to the rescinding of the 1975 statement. In March of 1991, ASHA’s governing board accepted the new position statement. In 1993, ASHA’s official policy provided guidelines for Speech Language Pathologists that recognized that SLPs without specialized training should not assume that they are qualified to work with Orofacial Myology Disorders (Mills, 2001).

At the October 2013 International Orofacial Myology Convention in Washington, D.C. the first speakers were Gloria D. Kellum, Ph. D. and Michelle M. Ferketic, M. A., SLP/CCC. They reviewed the history of orofacial myology, advancement of orofacial myology within the profession of speech pathology and identified information supporting assessment and treatment of orofacial myology. In 1989, Ms. Ferketic was on the Ad Hoc Committee on Lingual Labial Posturing and in 1991 the Joint Ad Hoc Committee with the International Orofacial Myology (IAOM; Kellum, 2013). As a contributing researcher, Dr. Kellum and others sponsored the resolution (1989) to review ASHA’s original position statement (Kellum, 2013). Sadly, the original position statement from ASHA called for “more research” in the area of orofacial myofunctional concerns and may have been interpreted negatively by ASHA members at large. This perception resulted in stalled progress in research instead of activating researchers in the field.

Historically, the International Association of Oral Myofunctional Therapy held its first meeting in 1972 while the members were attending an ASHA convention in San Francisco. Later the organization changed its name to The International Association of Orofacial
Myology (IAOM). A comprehensive review of the history of this organization is summarized in the book, Orofacial Myology International Perspectives (Hanson, 2003). The original core group according to anecdotal records consisted of six members, including Bill Zickefoose, Dick Barrett, Marv Hanson, Galen Peachey, Barbara Moore, and Fern Canady. A few dentists, dental hygienists, and speech pathologists also attended. In 2011 the IAOM celebrated its 40th Anniversary during its annual convention in Cincinnati, Ohio.

The IAOM now has members from 17 countries with 193 members that have completed the advanced training level of Certified Orofacial Myologist (COM). Today the IAOM consists of professionals in the fields of speech pathology, medicine, dental hygiene, dentistry and other allied fields. All of these professionals require training and experience beyond that received for their professional degrees. Orofacial Myology premises and doctrines are entrenched within professional disciplines including speech pathology, dentistry, dental hygiene, and physical medicine. Consistency in terminology should increase communication and research across professional disciplines. The IAOM monitors courses and training of professionals to assure that the highest standards of professional skill and knowledge are maintained. Membership requires academic preparation in the physical sciences, social/behavioral sciences, oral medicine, orofacial myology, speech pathology, education, and growth and development.

“Orofacial myofunctional therapy (OMT) is not speech therapy. OMT is therapy to correct muscle function problems which influence dental occlusion, facial shape, chewing, swallowing, and tongue lip, and jaw resting posture.” (Mason, 2009). Most Oral Facial Myology (OFM) patients also have speech concerns, but this is not well researched (Fisher, 2013). While the theoretical tenets of orofacial myologists are derived from dental science; orofacial myology is not dental treatment either. Orofacial Myologists participate on interdisciplinary teams. They have already established “collaborative clinical interests and interactions with university-related teams and with general dentists, dentists specializing in temporomandibular joint (TMJ) disorders, orthodontists, oral and maxillofacial surgeons, pediatricians, allergists, ENT specialists, cranio-osteofathes, and craniofacial pain management physicians and dentists. The rapidly evolving field of

Orofacial myology maintains a commitment to collaborative interactions with potential referral resources in medicine and dentistry” (Mason, 2009). A summary of research, “The Legacy of Exercise: What New Research Tells Us About Time Honored Treatment” was presented at the IAOM convention in Washington in October of 2013. This collaboration and support from ASHA’s SIG 5 indicates the rapid change in this interest area (Clark & Solomon, 2013).

Probably the most discussed issues in Speech Pathology includes questions about “evidence based” practices (Lof, 2008). Certainly, there are legitimate questions about activities that utilize nonspeech oral motor exercises (NSOME) (Bowen, 2005; Lof, 2008). Still, some clients with oral sensory-motor deficiencies have distinctive needs that require clinical judgment. Orofacial myology treatment involves an individualized regimen of exercises to re-pattern oral and facial muscles. Exercises are used to correct tongue and lip resting postures as well as to develop correct chewing and swallowing patterns. Each client is unique and programming is individualized.

Some research has focused on tongue strength and endurance dimensions (Bunton, 2008). This author questions the usefulness of that information and suggests that a more significant area of research might focus on the oral sequences or habit patterns used in breathing, swallowing, and speaking. It is also the opinion of this author that the biological functions of the oral mechanism for deglutition are as a primary function. The overlaid function of speech is secondary to the needs for breathing and nutrition. Hence, first consideration in working in this area must be primary function with the secondary function of speech addressed when primary considerations are managed (Fisher, 2013). Other overlaid functions would be the use of the oral mechanism for musical production or musical instrument playing.

Frequently the terms Orofacial Myology Disorder and “tongue thrust” are used interchangeably. In actuality there is a difference between the two diagnoses. “Orofacial Myology Disorder” (OMD) demonstrates differences in the position and/or function of the muscles of the face, mouth, lips and tongue. These differences (in dental, skeletal, or muscular structures) may hinder correct swallowing, speech, and/or oral rest postures. Subtle differences may also negatively impact
dental and facial growth patterns. “Tongue thrust” refers to the improper placement and function of the tongue during swallowing and is considered a specific sub-category of “Orofacial Myology Disorder” (Berkert, 2012). This author prefers “Orofacial Myology Disorder” (Fisher, 2013) because it encompasses a more complete portrayal of the areas of concern such as:

- the incorrect positions/postures of the lips, tongue or jaw
- unusual pattern movements of the lips, tongue and jaw
- noxious sucking habits (thumb, digit, tongue or object sucking)
- structural differences
- speech differences
- musical instrument playing difficulties

One of the most recent orofacial myofunctional therapy results, published by orofacial myologist/speech language pathologist JoAnn Smithpeter and orthodontist and Department Chair David Covell (AJODO, 2010), compares the relapse rate of orthodontic appliances with and without orofacial myofunctional therapy. Results indicated that:

1. OMT with orthodontic treatment was efficacious in closing and maintaining closure of dental open bites in Angle Class I and Class II malocclusions, and it dramatically reduced the relapse of open bites in patients who had forward tongue posture and tongue thrust. Correcting low forward tongue posture and tongue thrust swallows minimized the risk of orthodontic relapse.

2. Speech errors and oral habits were associated with relapse but were often correctable with OMT. Retention of speech errors did not necessarily preclude correction of tongue rest posture and swallows.

3. In addition to dental anterior open bites, common denominators in both cohorts at the initial OMT examination were forward tongue rest posture and tongue thrust swallows, and the only common denominators in the stable experimental subjects were palatal tongue rest posture and swallow (Smithpeter, 2010)

These results were positive for effective outcomes with treatment. This evokes several questions. Who should provide this treatment? Where are the trained and certified providers? Where should the training be obtained? What research is necessary? Possibly there are still questions about ASHA’s true position for the profession. Maybe it really is a “space” issue. Whatever the reasons, there is a need for research and trained service providers. Hopefully, skilled therapists won’t miss these needs because, as the saying goes “they can’t see the forest for the trees.”

Some countries (i.e. Japan and Brazil) routinely include orofacial myofunctional therapy (OMT) within their formative professional educational programs in dental hygiene, dentistry, and speech pathology. In the US and Canada, clinical training courses are mostly taught on a professional continuing education basis through the internet, in seminars or in real time internships (Berkert, 2012).

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Appendix

Sample Orofacial Myology Treatment Program
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Level I: Education.
Level I reviews the evaluation results and provides guidance in considering the various treatment procedures. Successful treatment is based on a partnership with the family and patient. This phase of treatment can acknowledge, discuss, and calm the family’s feelings (guilt or fear). The family can be guided to focus on the importance of correction for dental health, muscle function, eating and speech production. Education establishes the basis for motivation and commitment to the program. Since patients and their families are an active part of the overall treatment process, it is important to understand what they think and the level of their expectations. The family and patient should feel comfortable asking questions, expressing concerns, and making suggestions. When families accept this type of responsibility, they are more likely to actively participate in the daily practices.

Level II: Training of Musculation/Mechanics.
Level II continues the education phase and addresses the beginning of functional training to establish correct lip closure (lip competence), to increase use of nasal breathing, and to establish independence of tongue/jaw movements.

Level III: New Pattern Incorporation.
Level III focuses on the pattern precision and accuracy of movement of the tongue to initiate the swallow in union with the lower facial muscles of expression (Orbicularis oris, Quadratus Labii Superior, Caninus, Zygomatic, Buccinator, Risorius, Triangularis, Quadratus Labii Inferior, and Mentalis). At Level III, specific attention is given to functional activities of eating; saliva swallows at rest or between speech production and the resting postures of the tongue, lips, and jaw. Liquids, soft foods, and firm substances are introduced to increase the use of a natural swallow pattern. Biting, chewing, positioning the bolus and swallowing are addressed. If speech issues have been found, they are directly introduced at this level. Issues concerning playing musical instruments can also be addressed at this level.

Level IV: Daily Living Activities.
Level IV concentrates on establishing the new swallow and resting postures into life routines. Goals of Level I (education), Level II (musculation training), and Level III (pattern precision) are reinforced in daily activities. Level IV requires the family, patient and therapist to look seriously at the daily living routines and integrate the new skills in all daily activities.

Level V is Retention.
At Level V the patient begins to teach his new patterns and skills to his family, therapist and other beginning clients. When the patient is able to clearly communicate the concepts and demonstrate the techniques to others, he is more likely to have mastered the skills. Retention is a positive phase for the patient. He sees himself as being his own therapist.

Note: These levels are an outline of progression for treatment. Each patient will benefit most if individual needs are assessed and considered. Treatment is not “cookie cutter” or “one size fits all.” Orofacial myologists should consider treatment of the overall mechanism for primary function and then consider the overlaid secondary functions.
What’s on Your Side of the Mirror?
Reflective Practice for Clinical Supervisors in Speech-Language Pathology and Audiology

Judy Stone-Goldman

Abstract
Working as a clinical supervisor requires speech-language pathologists and audiologists to sustain multiple relationships with students, clients, and clients’ families. For these relationships to be effective and beneficial for all involved, supervisors must be able to maintain internal balance, which includes both emotional calm and mental clarity. Because the demands and emotions of teaching/helping relationships can easily disrupt balance, supervisors must be proactive in taking care of and responding to their internal states. Reflective practice is suggested as a way to for supervisors to increase their self-awareness and explore the feelings and thoughts triggered in supervisory work. Through reflective practice, supervisors become able to recognize emotional and mental reactions signaling imbalance, understand and reduce the possible factors that contribute to these reactions, and work on improving the internal skills that help sustain well-balanced teaching/helping relationships.

Learning Objectives:
1. Describe the difference between emotional balance and emotional imbalance.
2. Define what a trigger is and give two examples in supervisory work.
3. Give three examples of how reflective practice may be applied to supervisory work.

If you are a clinical supervisor, you spend considerable time paying attention to others and standing apart from events. You watch students in their therapy sessions (often from a darkened room). You monitor clients’ programs to make sure treatment is appropriate and progress is adequate. You refrain from providing students all the answers or rushing to show what you would do to solve a problem. Even when in the room with a student and client, you reduce or minimize your direct involvement so that the student can take charge. In moments of review and evaluation, you are often still thinking about people or concerns outside of yourself.

The supervisor’s focus on others within clinical supervision is necessary, but what gets lost when the supervisor is cut from the equation? Is there another way to frame clinical supervision—one that includes rather than excludes supervisors’ experiences? Could such a reframe add to supervisors’ effectiveness as well as their satisfaction? In this article we shift from a conventional focus on the student to a reflective focus on the supervisor. This change in focus allows us to explore our experiences of and reactions to supervision, and to see all our experiences (including the less pleasant ones) as potential sources of learning and growth. Fundamental to the reflective focus is the belief that by examining feelings, beliefs, and reactions, we can gain greater self-awareness, which in turn increases our ability to solve problems, change response patterns, and work effectively with others (Mann, Gordon, & MacLeod, 2009).

Supervision and Relationships
Relationships are at the heart of our work in speech-language pathology and audiology (Geller & Foley, 2009; Luterman, 2008). They are the vehicles for instruction, support, and human connection, and the healthier they are, the more fruitful our contribution as supervisors becomes. When we enter into a teaching or helping relationship, as we do with students as well as with clients, we bring our inner selves—our emotional and mental states. Those states directly influence the direction and quality of the relationships. If we are not
at our best emotionally or mentally, we risk bringing heightened emotional energy, distractions from personal worries, or unclear thinking into the relationship. These unhelpful emotions and thought patterns make us less able to fulfill our ethical responsibility to maximize the welfare of people we serve (American Speech-Language-Hearing Association [ASHA] Code of Ethics, 2010).

Further complicating supervision is that for each student supervised, the supervisor is actually in multiple relationships—supervisor/student, supervisor/student/client, supervisor/client, supervisor/student/client/family. These relationship combinations are subsystems in the larger supervision relationship system (Bowen, 1978; Crouch & Roberts, 1987), and they all present their own challenges. Within each subsystem a supervisor may need to cope with variations in culture (Butler, 2003), crossgenerational communication (Durant-Jones & Kwiatkowski, 2013), personality/temperament (Baggs, 2012), and other sources of possible conflict (Victor, 2013). In addition, participants in these subsystems (including supervisors, students, and clients/families) shape the relationships with their varying strengths and limitations.

Given the interpersonal complexity in supervisory relationships and possible obstacles, we should not be surprised that relationships range from the powerful to the weak, and that some relationships end up draining supervisors’ energy and spirit. In addition, supervisors face many personal and professional demands apart from supervision. Despite one’s best efforts, the combination of external pressures and immediate challenges can lead to a sense of being thrown off balance. When that happens, a supervisor may experience a loss of patience and perspective and may find it difficult to be attentive, open-minded, and emotionally available in interactions. Losing balance, and suffering from the resultant emotional and mental reactions, is a hazard of helping relationships (Stone-Goldman, 2011a). The concept of balance and its importance to supervisors are discussed in more detail below.

What Is Emotional Balance?
Emotional balance is a state of emotional calm and mental organization, with a sense of being grounded and stable (Stone-Goldman, 2011a). When balanced, we are clear about our feelings and rational in our thoughts, even in the face of challenging or painful interactions. Because emotional balance encompasses both psychological and cognitive features, several different theoretical models can contribute to our understanding. We will consider two here, although there are others that could also provide insight. Those two theories are from psychodynamic and cognitive schools of thought.

Psychodynamic School of Thought
From a psychodynamic perspective, balance can be understood as the state of having good emotional regulation and clear psychological boundaries. In this balanced state, an individual is appropriately separate from others’ feelings and thoughts, but is still able to engage interpersonally with well-managed emotions, empathy, and mental clarity (Adams, 2005). Another way to say this is that when balanced, one is free from emotional reactivity and countertransference.

Emotional reactivity is a state of responding too quickly and intensely to a stimulus (Carthy, Horesh, Apter, & Gross, 2010), and it is typically associated with feeling anxious and out of control. Emotional reactivity often accompanies countertransference. Countertransference refers most broadly to the many reactions and feelings a professional has in response to clients (Kennedy & Charles, 2001). In fact, countertransference has many possible definitions (Blum & Goodman, 1995), with some definitions emphasizing the professional’s personal issues and others emphasizing the ways a client’s and professionals psychological states interact (Gabbard, 2001). The differing definitions of countertransference reflect changing theoretical and clinical perspectives since Freud’s work (Gelso & Hayes, 2007) and continue to be a source of discussion. The most important point for our purpose is that because of countertransference, a supervisor will have internal reactions to working with students, and these reactions will influence the relationship dynamic unless examined and managed.

Consider, for example, a supervisor who has strong responses evoked by working with a particular student. These responses, which may include feeling states (e.g., anger, dread), thoughts (e.g., distrust, expectation of disaster) and actions (e.g., criticizing, grading harshly), speak of the supervisor’s life history and needs, although the supervisor may not be aware of the associations. The supervisor may believe he or she is
focusing on the student’s performance but in fact is responding out of personal, internal, unconscious needs (Katz & Johnson, 2006; Trowell & Bower, 1995). Obviously such responses do not meet the needs of the student and will not further the student’s education or capacity to help a client.

**Cognitive School of Thought**

From a cognitive perspective, balance can be understood as having rational, conscious thinking patterns. When balanced, one is free from cognitive distortions, which are thinking patterns that are extreme, based on false assumptions, or otherwise lacking in judgment or rationale (Beck, 1995). Distorted thinking patterns may emerge when one is stressed, anxious, or fearful, and they quickly give rise to negative emotions (Burns, 2008). Once these thinking patterns dominate, the individual sees him or herself and others through a distorted lens. Challenging or painful circumstances can evoke cognitive distortions in professionals, just as they can in clients.

Cognitive distortions interfere with the clear, unbiased thinking a supervisor needs to instruct, evaluate, and support students at different levels of experience (Kirschner, Sweller, & Clark, 2006). For example, a supervisor whose thinking is polarized, such that events are all good or all bad, will see only the extremes in a student’s work and be unable to provide nuanced feedback appropriate to the student’s level. A supervisor whose thinking involves jumping to conclusions, will make assumptions about a student’s expectations, motivations, or plans and thus fail to engage in open discussion. Cognitive distortions may also affect a supervisor’s perception of his or her own work, leading to emotions such as worry and guilt, which in turn may impact relationships with students. See Beck (1995) and Burns (2008) for examples of many other cognitive distortions.

The Emotionally Balanced Supervisor

The emotionally balanced supervisor is well regulated emotionally and suffers from neither countertransference nor distorted thinking. He or she is able to enter a relationship fully available to the student (and other members of the relationship), with a stable emotional presence and a clear mind. The supervisor’s attention is, appropriately, on the student and others in the relationship, and the supervisor’s perspective remains unclouded by internal reactions or confused thought patterns.

This description of balance is inviting—who wouldn’t want to be in such an emotionally calm and mentally clear state? Unfortunately, as human beings we have emotional vulnerabilities that are likely to show themselves in teaching/helping relationships (Geller, Dwyer, Gerts, Sampelayo, & Tusa, 2010). Daily stressors, emotionally charged people and circumstances, and frustrations inherent in our work all present threats to our balance (Stone-Goldman, 2011a). As we shift toward imbalance, cognitive distortions and countertransference responses may take hold without our awareness, and our tendency towards emotional reactivity may increase. Expecting unbroken balance is unrealistic for most of us; thus learning more about balance and how to sustain it becomes an important area of professional development.

**How Do We Manage Balance?**

Managing balance requires us to understand ourselves—how we respond emotionally, how we think, and how we behave. Such understanding is neither selfish nor frivolous; rather, it is an essential ability that contributes to performing to our highest level as supervisors (Geller et al., 2010). Viewed this way, cultivating balance can be seen as part of our professional responsibility. To this end, we need to develop self-awareness and become responsible for our psychological experience (Geller, 2008; Klein, Bernard, & Schermer, 2011; Trowell & Bower, 1995).

To become self-aware, we must recognize and understand our internal states and how they relate to our behavior. We all have the capacity to deepen our skills for monitoring and interpreting our feelings and thoughts, but we must bring conscious effort to the process. In the course of daily life, we rely on many automatic and habitual ways of thinking and responding, and we may ignore certain inner cues. To develop self-awareness means a commitment to paying attention to ourselves and a willingness to be open to whatever we discover.

To assume responsibility for our psychological experience, we must work with what we learn about our internal states and response styles, trusting that understanding our thoughts and feelings will give insight into our relationships (Geller & Foley, 2009;
We must be willing to find ways to calm and refocus ourselves as well as improve and expand upon the ways we respond. Our goal is to have more and better options when we notice internal imbalance. In this way we commit to developing a “best self,” who will then be available to serve students and clients most effectively.

Of course, the question then becomes, what is our avenue for developing self-awareness and becoming responsible for our psychological experience? The answer offered here is *reflective practice*. Reflective practice is the approach that will allow us to build a conscious inner life, through which we build skills for balance.

Reflective Practice

Reflective practice is an on-going act of self-examination and exploration of one’s thoughts and feelings in response to life experiences (Boud, Keogh, & Walker, 1985). Its goal is to bring one to deeper levels of understanding, which can lead to better understanding of oneself, new perspectives on problems, and strategies for change. Mann et al. (2009) discuss the many definitions of reflective practice.

Reflective practice can be applied in many ways and for different purposes, but it always entails the examination of self. For a supervisor, who is more accustomed to paying attention to others, this attention may be unexpected. One can say that through reflective practice, a supervisor brings into focus a relationship dyad that often gets ignored: that of the supervisor and self. By exploring oneself, the supervisor is then able to bring a clearer, more balanced attitude into supervisory experiences.

Reflective practice is already part of professional practice in many fields. Psychologists and psychoanalysts have long viewed reflection as a means of understanding oneself and the client within psychotherapy (Isenberg, 2012), and on-going reflection has been described as a key to a counselor’s maturation from novice to seasoned professional (Rønnestad & Skovholt, 2003). After Schön (1987) introduced the term *reflective practitioner* within education, an increasing number of applications emerged in healthcare, including nursing education and practice (Levetten-Jones, 2007), physician training (Kohn, Bernardo, Huck, & Cable, 2011; Shapiro, Kasma, & Shafer, 2006), and interdisciplinary rehabilitation teamwork (Kember, 2001).

In speech-language pathology and audiology, reflective practice has been gaining in visibility. Conference presentations (Caty, Doyle, & Kinsella, 2011; Geller, 2008; Robke & McGinley, 2011; Stone-Goldman, 2012; Strube, Hilliard, & Gooch, 2012), publications (Geller & Foley, 2009; Stone-Goldman, 2011a), policy statements (American Speech-Language-Hearing Association [ASHA] 2006), and continuing education opportunities (Geller et al., 2010; Stone-Goldman, 2011b) all point to the role reflective practice is taking within the professions.

Reflective practice can be directed towards many aspects of professional growth and development (Caty et al., 2011; Strube et al., 2012) and student training (Louko, Bryant, & Zebrowski, 2011). Even within the topic of supervision, there are various ways to approach reflective practice (Geller & Foley, 2009; Hudson, 2010; Stone-Goldman, 2011b). Despite differences in focus and approach, all share the goals of self-examination for the purpose of improving awareness and professional effectiveness.

Where We Need Reflective Practice: Emotional Hotspots

Most of us have emotional hotspots, those places where we feel easily agitated or hurt and where impulses are heightened. At one time or another, these emotional hotspots get touched, and we find ourselves thrust into unexpected emotions and unplanned responses (Gelso & Hayes, 2007). When we respond in this unexpected and unplanned way, we have been triggered and thrown into imbalance. Being triggered is not just a psychological event; it entails neurologically based stress circuits that get aroused and activated (Mitrovic, Fish de Pena, Frassetto, & Mellen, 2011).

When we are triggered, our ideas about the “right things to say” or our intention to be patient and thoughtful can go by the wayside. Instead, we say something we regret or feel ourselves flailing about in a sea of emotions. We usually respond more intensely than we wish, perhaps defensively or angrily (Orsillo & Roemer, 2011). Often we have side issues brought to the surface, whether personal problems that relate to the present conversation, a memory of another
professional interaction, or a long-standing life issue (Katz & Johnson, 2006; Mitrovic et al., 2011).

In our work supervising students, potential triggers abound. Because triggers are both individual and contextual, something that triggers one person may not trigger you. At the same time, some scenarios are common potential triggers for supervisors. Consider whether any of the following situations would be a trigger for you (Stone-Goldman, 2013a):

- A student fails to follow up on your suggestions or gives you many excuses and rationalizations for incomplete work
- A student behaves in a way that reminds you of your sister/daughter/brother/son/mother, etc.
- A student has habits you consider particularly unpleasant
- A student’s behavior strikes you as disrespectful
- A student points out mistakes you’ve made
- A student is more skilled and creative than you are

Triggers may seem to make sense at first glance. After all, isn’t it frustrating to deal with a nonresponsive student? Isn’t it normal to get angry when patient care is compromised by a student’s inaction? Aren’t some students just hard? In fact, triggers frequently do relate to situations that are problematic or disappointing. At the same time, they are often about our view of ourselves and our role: we feel inadequate, disrespected, or powerless. Such inner responses are characteristic of countertransference (Gelso & Hayes, 2007), and they may lead us to defend or attempt to prove ourselves. Whether a trigger seems “legitimate” or merely startling, it throws us into imbalance, and we are then prone to reacting in less productive ways.

Triggers often connect with some part of our life story. We hold many values, beliefs, and response styles learned in childhood, which continue to operate on conscious and unconscious levels (Papero, 1990; Skynner & Cleese, 1995). Over time, we add to our expectations of how things “should be” and how people (especially students) “should behave.” All these experiences, memories, and expectations are ready to be brought to the fore with a triggering moment. In addition, we all have insecurities that get tapped into, as well as many memorable experiences (for better or worse) that, once evoked, color our current responses (Katz & Johnson, 2006). Because our reactions typically reflect multiple psychological and experiential factors, we may not immediately understand a trigger’s meaning, and even a superficially innocuous statement could be a personal trigger.

Being triggered can be confusing, embarrassing, and disruptive. It is, without question, a human response that happens to even the most experienced and skilled supervisors. No matter the meaning assigned to a particular reaction, the imbalance from a triggered response signals a need for internal awareness and adjustment. Our maturation and skill are reflected not by a complete freedom from being triggered but by a willingness to explore our internal responses and change our attitudes and beliefs. We become able to see the trigger as an opportunity to learn about and improve ourselves.

Using Reflective Writing to Cope with Triggers
To understand our triggers, we must be able to think about them quietly and contemplatively, with an attitude of curiosity and open-mindedness (Orsillo & Roemer, 2011). For this we need time and privacy. You may already have activities that provide a way to turn inward, such as meditation, yoga, or walking in an area of natural beauty. Such activities can be times of reflection, but they do not readily allow you to preserve your thoughts or review them at a later time. Being able to review your thoughts is key to deepening and advancing your reflections (Stone-Goldman, 2011a). For this reason, writing is an ideal method for reflective practice. Numerous authors have contributed to the theory and practice of reflective writing (Bolton, 2001; Boud, 2001; Kacewicz, Slatcher, & Pennebaker (2007); Stevens & Cooper, 2009).

Reflective writing is spontaneous, minimally structured, personal writing, a form described by both professionals and artists (Bolton, 2001; Cameron, 1992; Dowrick, 2009; Goldberg, 1986; Kacewicz et al., 2007). It is not academic or professional and thus does not have to conform to a specific format or meet rules for spelling or grammar. Its goal is to allow the writer free and uncensored self-expression on designated topics. The act of reflective writing bears a similarity to journal writing (Boud, 2001), although reflective writing for professional exploration brings in different elements than are typically used in journaling (Louko et al., 2011; Stone-Goldman, 2011a). You may write by hand or on a
keyboard, at a time of your choosing, for short or long stretches. By reading your writing afterwards, highlighting ideas that strike you as important, and writing more about these ideas, you can advance and deepen your reflection. See Stone-Goldman, 2011a, for detailed instructions on the writing procedure.

Reflective writing can serve multiple purposes. At its most basic it can be a tool for venting. Sometimes we need to release emotions or angry/irritated thoughts around an experience. Writing has been shown to be a valuable approach for people dealing with traumatic and stressful events (Pennebaker, 1997) or chronic health issues (Baikie & Wilhelm, 2005). Pennebaker developed a research paradigm that has been used over many years for studying the benefits of expressing emotions through writing. Simply getting words onto paper can provide us relief from internal pressure, as if we are “emptied” of some of the stress.

Beyond venting, however, reflective writing offers an opportunity for deepening our understanding, forging connections among apparently disparate topics, and discovering solutions to problems (Baikie & Wilhelm, 2005). This is where reflective writing becomes particularly powerful to us in dealing with triggers. Through our writing we describe the experience of being triggered, seek to understand its larger meaning to us, and develop strategies to handle the situation better the next time.

Writing in Response to Triggers
Understanding our internal states requires us to communicate with ourselves. One of the ways to do this is to ask ourselves questions, which we then answer through our writing (Plack & Greenberg, 2005). There are many questions one can pose to learn more about triggers—about the event that triggered us, our reactions, and our associations and memories. Any question can be an entry point into the writing, and as we write, new questions are likely to present themselves. We do not need to worry about “the right question” any more than we worry about “the right place to start” or “the right reflection.” Our goal is to enter into the writing process without trying to control it; we let go of expectation and trust that whatever we write will take us a step closer to ourselves (Herring, 2007).

Reflecting After a Trigger. Reflecting after we’ve experienced a trigger, called “reflection-on-action” (Mann et al., 2009; Schön, 1983), gives us an opportunity to recover from and benefit from what might have been an unpleasant experience. We have the chance to vent our feelings, analyze the experience, release tension that might have accrued, and plan different ways of responding. The sooner after a trigger we write, the more we can deal with the feelings and thoughts surrounding the trigger.

Here are some questions you can ask yourself when reflecting after an event:

1. What am I feeling right now? What thoughts are going through my head?
2. What is the meaning to me of this situation/comment? Does it remind me of anything from my past? Why might I have responded so intensely?
3. If I step back from the situation, how could I see it differently or respond differently?
4. Is there anything I need to explore, something personal or professional that extends beyond this situation?

Once we have given ourselves time for such reflection, we are likely to find ourselves calmer and less prone to negative thinking. We may still have uncomfortable feelings—from anger to disappointment to sadness—but they are less likely to inspire our next words or actions. We arrive at clearer, more reasoned ideas about handling a situation effectively. In other words, we become more balanced.

Reflecting Before a Potential Trigger. Reflecting before a potential trigger, called “anticipatory reflection” (Pinsky, Monson, & Irby, 1998; Schön, 1983), is ideal because it gives us the chance to prepare ourselves for a difficult situation, making us less vulnerable to triggers. Examples of such situations might be meeting with a student with whom you’ve been struggling; joining a student in a session, when you want to avoid the tendency to take over too quickly; or meeting with a student to discuss unsatisfactory work. By reflecting ahead of time you can identify the challenges and potential triggers, clarify your intentions and goals for the conversation, rehearse possible ways of expressing yourself, and identify personal issues that might intrude. Taking a few minutes to reflect before such an
event may also calm you and start you off on a more relaxed note.

Here are some questions you can ask yourself when reflecting before an event (Stone-Goldman, 2013b):

1. When I look ahead to this meeting/situation, what feelings and thoughts come to mind?
2. What associations (memories/related experiences) do I have to this event (including the people) that might confuse me or interfere with the present interaction?
3. What would I like to communicate/handle? What would it look like if I were successful?
4. What hazards do I see—potential triggers? ways I might respond that I don’t like? defensive reactions?

Of course, just because we reflect before an event does not guarantee we will remain perfectly balanced. We may still find ourselves responding to triggers. As with any skill, we will become more capable and more confident with practice. That does not mean we necessarily get to a place where we are always balanced and free from triggers, but the frequency of triggering events should decrease, and reactions should diminish in intensity (Orsillo & Roemer, 2011). Perhaps you will even find yourself noting your triggered responses with a sense of humor, saying, “There I go again!”

Understanding your fallibilities, keeping your sense of humor, and gaining in humility will go a long way to reducing the sting of being triggered.

Reflecting On-the-Spot. In reading about triggers, you may have wondered, “What can I do at the moment of the trigger? Isn’t there a way I can handle it at the time?” These are good questions, and the answers are a combination of “yes” and “no.”

Making reflective practice part of your routine will increase your awareness. Over time, you will be more prepared for triggers and you will recognize your response patterns before they unfold fully. By tuning into the cues that indicate you are getting imbalanced, you can learn ways to “back off” from the intensity that signals a triggered response. In this way you will be able to monitor yourself during interactions, which will allow you to calm yourself and adjust potential responses before speaking or acting in a heightened manner. This is reflecting on-the-spot in real time, called “reflection-in-action” (Hewson, 1991; Schön, 1983), a skill related to mindfulness (Shapiro & Carlson, 2009).

Reflecting on-the-spot is a skill that takes time to develop. The more you improve your reflective skills, the more you will move towards successful on-the-spot reflection. Here are some tips to use in the short term to help you develop your awareness and self-monitoring (Orsillo & Roemer, 2011; Shapiro & Carlson, 2009; Stone-Goldman, 2011b):

1. At low-stress times, practice asking yourself, “What am I thinking? What am I feeling?” Practice awareness without attempting to think or feel something different. Don’t wait for a crisis to practice.
2. Remember to breathe. When anxious or upset, we are likely to become more tense. We might hold our breath or breathe more shallowly, which can increase anxiety.
3. Stay alert to moments when you are feeling triggered. Pay attention to the feeling of being triggered even if you cannot alter your response right then.
4. When you notice yourself responding too intensely or having an uncomfortable reaction, look for a way you can change some small part of your reaction. For example, relax your face or your body posture, give yourself more time to listen, or slow your speech rate.

Conclusion: Beyond Supervision
In this article we have focused on the importance and value of reflection for the clinical supervisor dealing with disruptions to balance. In reality, any supervisor who commits to reflective practice will discover how quickly the reflection extends beyond the immediate supervisory concerns—to other professional matters and then to general life issues. In daily life, the interplay between the personal and the professional is frequent and complex, sometimes subtle and sometimes obvious (Katz & Johnson, 2006; Stone-Goldman, 2011a). For example, we might find ourselves distressed when a client’s problems remind us of those of our own aging parent; we might have uncomfortable memories of being a novice when a graduate student struggles; we might experience anxiety and sadness when students’ or clients’ losses resonate with losses we anticipate or have suffered.
We may begin reflection with an eye towards supervisory issues, only to find ourselves turning toward a deeply personal matter. Even if we are surprised by what we stumble upon, we need not worry or block the path of reflection. Our professional life is rich with stories and emotions that inevitably connect to personal realms, and we must be open to following whatever winding road our reflection takes. We can best understand the whole of ourselves by receiving and examining all the pieces that come to our awareness.

Our goal becomes to appreciate the importance of our internal lives, to understand our intersecting personal and professional experiences, and to parse out what is real and immediate versus what is an echo of our personal story. In the short term we restore as much balance as possible and tuck away our unfinished business until we have more time for exploration. In the long-term we practice moving towards balance as often as possible and leaving ourselves open to new levels of insight. We continually strive to bring our most balanced self to our professional interactions, and to approach challenges with dignity, compassion, and acceptance. ♦

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Facilitating Clinical Success for Students with Accents

Jessica R. Bonner

Abstract
Students with accents face unique challenges in communication sciences and disorders (CSD) programs, especially in transition to and through clinical practicum. Yet their clinical success is essential if speech-language pathologists are to meet demands of linguistically diverse patients on their caseloads. In this article, the role of CSD programs, clinical supervisors, and students is discussed with emphasis on strategies the clinical supervisor may use to assist the student with an accent develop competencies required for effective service delivery.

Learning Objectives:
1. Describe historical and current challenges of students with accents in the field of communication sciences and disorders.
2. Discuss current literature related to the impact of accents on service delivery in communication sciences and disorders.
3. List ways clinical supervisors can assist students with accents transition through clinical practicum.

Over the past few decades, there has been a shift toward a more linguistically diverse student population in communication sciences and disorders (CSD) programs. Changes in United States (U.S.) demographics, increases in the number of U.S. residents whose first language is not English, and program initiatives aimed at recruitment and retention of ethnic/racial minority students have contributed to this trend (ASHA, 2011b, 2014). According to the Council of Academic Programs in Communication Sciences and Disorders (CAPCSD) 2000-2001 Survey of Undergraduate and Graduate Programs, masters level racial/ethnic minority students comprised 11% of students enrolled during that time compared to 14.3% in 2011-2012 (CAPCSD, 2002, 2013). In a recent survey of thirty-three CSD programs, non-native English students accounted for 18% of the total number of student respondents (Levy & Crowley, 2011). Sudler (2012) reported even higher numbers of non-native English speakers with 21% survey respondents. Although racial/ethnic minorities continue to be underrepresented in the communication disorders field, students’ cultural and linguistic backgrounds are increasingly more varied.

Students in CSD programs in the U.S. come from linguistic backgrounds that mirror immigrant and foreign languages of the general population. In the U.S., English is spoken by the majority of the population (82%) and Spanish is the second most common language (12%) (U.S. Census, 2011). According to the U.S. Census (2011), French, German, Russian, Italian, Polish, and Arabic are widely used, in addition to Chinese languages, Korean, and more recent immigrant languages such as Tagalog and Vietnamese. Bilingual speech-language pathologists (SLP) who speak these and other languages make up a small proportion of SLPs in the workforce. The proportion of Hispanic/Latino certified SLPs, for example, is approximately 3.5% in contrast to 20% of school-aged Hispanic/Latino children receiving services (Project BEST, 2009). Thus, a growing mismatch exists between SLPs and their clients who are increasingly linguistically diverse (Centeno, 2009; Levy & Crowley, 2012; Riquelme, 2014). The need for students to be trained to serve individuals from these varied linguistic backgrounds is great; their inclusion will allow speech-language services to be provided to a broader population and help address concerns over the paucity of bilingual SLPs (Uffen, 2002).

CSD students from diverse linguistic backgrounds may speak with an accent that developed on the basis of being 1) born in another country and learning their native language before English, 2) born in the U.S. and learning their native language then English (or both simultaneously), or 3) born in the U.S. or other English
speaking country and using regional accents (ASHA, 1998). An accent refers to “the unique way that speech is pronounced by a group of people” (ASHA, 2012, p. 1). Differences in pronunciation of consonants and vowels, and differences in prosodic features such as duration, rhythm, stress, pitch, intonation, and loudness make individual accents distinctive (Barb, 2005). These traits, which are segmental and suprasegmental in nature, carry over from the original language to the second language and influence the speaker’s message (Wolfram & Fasold, 1975). As a result, there are many versions of the English language including French-influenced (or French-accented) English or Cantonese-influenced English in which individual patterns (e.g., tonal patterns) influence English use (Battle, 2012).

Whether an individual uses a foreign accent or a regional one (as in the case of speakers of Southern or Appalachian English) everyone speaks with an accent. There is considerable variation, however, across individual accents by their degree or strength (i.e., the extent to which a person’s production pattern sounds different from what you expect) (Munro, Derwing, & Morton, 2006). The terms heavy, strong, thick, or mild are often used to describe the perceived difference. Individual accents are also often judged by level of “intelligibility” which is the ability of the listener to recognize individual words or utterances or their “actual understanding” (Munro, Derwing, & Morton, 2006; Smith & Nelson, 1985 as cited in Pickering, 2006) as well as by level of “comprehensibility” which is the listener’s ability to understand the meaning of the word or utterance based on context (Smith & Nelson, 1985 as cited in Pickering, 2006). Even though it is possible to have high levels of intelligibility and comprehensibility with accented speech, a general correlation exists between stronger accents and both lower intelligibility and comprehensibility (Rogers, Dalby, & Nishi, 2004). Students with accents who have reduced intelligibility may struggle to be understood by listeners and asked to repeat themselves frequently, may avoid speaking in the classroom and be reluctant to ask questions or for clarification, and may find it hard to get their point across as the listener keys in on the accent rather than the content of their message (ASHA, 2012; Omeri, Malcolm, Ahern & Wellington, 2003).

Because of the importance of oral communication in the field of communication sciences and disorders students with accents have traditionally faced exceptional challenges in CSD programs. The literature is replete with case scenarios and situations that document difficulties students with accents have encountered because of their accents and issues with intelligibility. Examples suggest that students with accents have been discouraged from pursing a degree in CSD, have had their potential as speech-language pathologists (SLP) questioned (especially by clinical supervisors or employers), and have been limited in clinical practicum opportunities (ASHA, 1998; ASHA, 2011b; Hegde & Davis, 2010; Sudler, 2012; Uffen, 2002;). ASHA’s Office of Multicultural Affairs reportedly fields numerous calls each year regarding whether to permit a student with an accent entry to clinical practicum as well as from students after they have been denied clinical opportunities due to concerns over their accents (ASHA, 2011b). The ability of the student with accented English to model target phonemes, grammatical features, or other aspects of speech and language, or to be understood by a client (i.e., intelligibility) has been a lingering concern of many programs (ASHA, 2011b).

ASHA’s (1998, 2011b) technical papers on accents have been useful in preventing students from being unfairly excluded from clinical education because of an accent. Both documents emphasize that use of non-traditional options (e.g., computer applications, software, and audio-recordings) (ASHA, 2011b) for providing a model is appropriate to meet client/patient needs. However, programs, although well intentioned, may struggle with how to be inclusive (or expand the net of opportunities) and value bilingual skills versus viewing the accent as “something that has to be dealt with” (Mosheim, 2013, p. 1). Most programs address issues of intelligibility on a case by case basis and often do not have policies and procedures in place when student issues arise. Levy and Crowley (2011) found, for example, that of thirty-three programs surveyed, 32% of CSD program directors responded that they had a policy, whereas 64% indicated their institution had no policy. In addition, when asked to specify their policy, five of the nine programs with a policy referred to ASHA’s (1998) statement on students who speak English with accents. As students with accents enter CSD programs with greater frequency, programs must have a plan in place and develop resources to address the needs of these students.
CSD programs and clinic directors have important decisions to make regarding a student with an accent when placing the student into a clinical setting. Often decisions regarding entry into practicum are based on the student’s level of intelligibility. Although strong accents as judged by the listener may be less intelligible, other factors including language pairings, listener familiarity and attitude toward the speaker’s language also likely influence intelligibility. For example, Major, Fitzmaurice, Bunta and Balasubramanian (2002) measured comprehension of a brief lecture presented in English by Chinese, Japanese, Spanish, and Standard American English (SAE) speakers. The results indicated that Chinese and Japanese speakers understood Spanish-accented English as well as SAE. It was speculated that prosodic rhythms shared by these languages facilitated intelligibility in the same way that similar phonological forms across languages allow for an “intelligibility benefit” (Bent & Bradlow, 2003). Similarly, Bent and Bradlow (2003) found that Chinese listeners perceive Korean-accented English as more intelligible than they find North American English speakers when listening to recordings of English sentences. Chen (2011) asked five groups of listeners to dictate recorded passages and judge the intelligibility of Cantonese and Mandarin-influenced English speakers. The results indicated that all listeners (e.g., native English speakers, Filipino and Pakistani, and Japanese speakers) achieved at least 70% intelligibility with both accents, Mandarin-accented English was easier to understand than Cantonese-accented English, and both Mandarin and Cantonese groups more readily understood English influenced accents from their respective languages. Thus, some English-accented languages will be perceived more intelligibly than others on the basis of the languages paired and/or features shared.

Listener attitudes or perceptions of non-native accents have been studied with regard to their impact on intelligibility. Chen (2011) examined the impact of language background on listener perceptions of Chinese accents. Results indicated that when listeners from five different language backgrounds (e.g., native English speakers, Filipino and Pakistani, and Japanese) rated speakers according to their “feelings toward foreign accents,” listeners did not perceive any of the accents favorably (i.e., ratings averaged 3.5 points on 7 point scale). Also, in an investigation of monolingual (American English speaking) SLP students’ perceptions of non-native speakers, Meyer, Dunajski, and Menz (2007) found that familiar accents (i.e., those accents perceived as being more similar to the listener’s own or those accents heard more frequently) were rated more positively than unfamiliar. Familiar accents were identified by the authors as Spanish and British English whereas Cantonese and Russian were considered unfamiliar.

A speaker’s grammar may also influence the perception of one’s accent. However, very little data exists on the relationship between grammar and intelligibility. Meierkord (2004) examined conversations of “outer and expanding circle speakers” and found that grammatical differences did not hinder comprehension. Rather, Meierkord indicated that lexical variations (e.g., idioms) and vocabulary were more likely to impact comprehension. In contrast, Oladosu (2000) examined the intelligibility of student’s grammatical and lexical errors in their sentences written in Arabic. Findings suggested that the student’s sentences were generally intelligible, but not acceptable to native and proficient Arabic speakers. According to these and other findings, an accented speaker may be understood, but the accent may be perceived as less comprehensible if the grammar is different from the native speaker (Abdelal, Ciocci, & Abdelal, 2008). A multitude of factors such as language pairings, familiarity and attitude toward the student’s language, and grammar, in addition to the intelligibility level of the student’s accent may need to be considered when placing a student in clinical practicum. CSD programs must be aware of available research to clarify the influence of these factors on clinical outcomes and to help guide placement decisions.

The research needed to guide decisions for placing students is limited and often conflicting. For example, research suggests that listeners expend more effort to comprehend accented speech than native (Derwing & Munro, 1997), familiar and less accented speech is perceived with greater intelligibility (Bent & Bradlow, 2003; Rogers, Dalby, & Nishi, 2004) and individuals with communication disorders including those with dementia (Mahendra, Bayles, & Tomoeda, 1999), aphasia (Burda, Brace, & Hosch, 2007) and children with articulation disorders (Wilkinson & Payne, 2005) have difficulty understanding accented speech. Alternatively, investigators have indicated that some speakers with heavily accented speech are more intelligible than other
speakers with less noticeable accents (Derwing & Monro, 1997). Studies also suggest that listeners, even older listeners, may be able to acclimate to accented speech (Bent & Bradlow, 2003; Gordon-Salant, 2010). Therefore, it is unclear to what extent a listener with a communication disorder might be able to adjust to the student with accented speech during practicum.

As students with accents enter clinical practicum with greater frequency, clinical supervisors have the responsibility of assisting students in the development of skills that will allow critical evaluation and use of knowledge gained from various diagnostic and treatment experiences (Newman, 2013). It is the supervisor’s role to arrange client assignments across disorder types/ages, provide feedback for each client, and guide the student toward clinical independence. Without empirical data and program policies to guide the decisions or clinical input, Levy & Crowley (2012) suggest that clinical judgments pertaining to the student with an accent are likely based on “supervisor beliefs about the impact of a student’s accent on service delivery rather than on evidence or stated policies” (p. 49). To support their claim, Levy and Crowley (2012) cite a study in which an Asian speaker was perceived as having a heavier accent and being a less adequate instructor than a Caucasian counterpart based solely on a photograph (Rubin & Smith, 1990). In a study of clinical educators’ experiences and expectations of a diverse group of South African audiology students, researchers found that supervisors were “unsure of how to manage and assess students where language barriers occurred in clinic” (Keeton, Singh, & Kathard, 2012). Others have found familiar accents to be rated as more intelligent, competent, and fluent than unfamiliar accents (Meyer, et al., 2007). Thus, attitude toward the student’s accent may cause the supervisor to perceive the student with an accent to be less proficient, cause the supervisor to be less focused on clinical implementation (as he/she focuses on the accent versus the clinical interaction), and less willing to consider more appropriate/alternative options pertaining to treatment strategies or client assignments.

Given the importance of the decisions that clinic directors and supervisors have to make for the student with the accent (and for the client), recent studies have attempted to better understand the impact of accent on the provision of services. Sudler (2012), for example, was interested in the minimum level of intelligibility needed for the SLP and student with an accent to be effective when working with various clinical populations. The results indicated that the majority of participants agreed that the accented speech of the SLP and student needs to be fully intelligible (but not near native proficiency). The results support the belief that because accents are persistent and difficult to change (Lippi-Green, 2011) near native proficiency is not a reasonable or attainable objective for many speakers (SFSU, 2011). In another study, Levy and Crowley (2012) examined clinic directors’ and students’ beliefs regarding which practice areas an SLP with an accent is able to conduct appropriate treatment. Results suggested that clinic directors felt that clinicians with accents could not appropriately treat those with phonological disorders or individuals requiring accent modification. However, directors felt that those clinicians could provide treatment appropriately in those individuals with voice disorders and dysphagia. Although directors were more accepting of accents in areas where pronunciation and language were less of a factor, clinic directors did not perceive adults with language disorders as requiring the most native-like productions. Levy and Crowley’s results have been supported by other investigators with SLP ratings indicating that accent would have the greatest effect on clients with auditory difficulties, least effect on augmentative and alternative communication (AAC) users and those with dysphagia, and inconsistent results for neurogenic disorders (Burda, Scherz, Hageman, & Edwards, 2003; Sudler, 2012).

All students seeking a master’s degree in communication disorders are retained and progress through CSD programs based upon their academic and clinical performance, and professional attributes deemed essential for entry into the profession. Given that students must be able to acquire, develop, and attain skills that relate to oral communication and intelligibility (i.e., essential functions), students with accented speech must be keenly aware of their own capabilities in relation to those specified functions. Formative assessments in oral and written communication present an opportunity for CSD programs and the student to learn about any concerns. In the academic and clinical components of the program, students have a responsibility to be engaged and proactive in addressing issues with intelligibility, and to follow up with program and supervisor
recommendations to give them the greatest chance for success in clinical practicum.

Amid concerns from CSD programs regarding how best to manage or resolve issues that may arise with students with accented speech, ASHA (2011) put forth a series of strategies to help guide University programs and students through the clinical education process. ASHA identified nine strategies for supporting students when there are concerns including:

- Provide early support
- Provide an accent modification enhancement plan
- Avoid communicating inferiority
- Be respectful of what the individual offers to the profession
- Focus on the client’s perception of the accent
- Address any client concerns
- Choose external sites carefully
- Acquisition of self-awareness by the student
- Seek outside support

ASHA’s (2011b) position statement focused on strategies for the CSD program and student. The following highlights the clinical supervisor’s role and strategies he/she may use in supporting the student with an accent during clinical practicum in external sites. ASHA’s (2011b) strategies, current literature, and actual student case scenarios provide a backdrop for the discussion. Specific recommendations and strategies for clinical supervisors are presented in bold.

Provide support early.
ASHA (2011b) recommends that the student’s program put mechanisms in place to support the student with accented speech (where there are concerns) as early as possible. External clinical settings represent a new environment for the student, with their own potential challenges pertaining to the student’s accent. As soon as the clinical supervisor becomes aware that there is an issue with the student’s accent that may impact service delivery, he/she should discuss concerns with the student and the clinic director of the student’s program—don’t wait. Delaying discussion may allow negative circumstances to build or valuable time to pass that might have been used addressing concerns. Supervisors should be aware that the student’s accent may or may not have been a factor during the student’s academic preparation. Requirements for the student’s intelligibility are somewhat different in the classroom or academic setting versus the therapy setting and may not predict the student’s clinical performance.

At the CSD program level, students may pass screenings or formative assessments that were in place to identify issues with the student’s accent. Students may enter practicum without apparent “red flags” concerning their accent. Consider the following scenario:
The student was an active participant in class and was an “A” student. The student passed several important milestones in the graduate program including a formative writing assessment, candidacy requirements, and comprehensive examinations. The student’s accent was readily perceived, but was not of concern based upon classroom and one-on-one interactions. Early in the program there was mention of improvement needed in written language and that continued support through university writing services to address grammatical errors was indicated. Otherwise, there was no documented difficulty with speech intelligibility. The student entered the clinical practicum sequence without apparent “red flags” or concerns that might signal difficulty communicating with clients.

A few weeks into practicum, the student’s clinical supervisor expressed concerns about grammar, word choices, sound errors, and intelligibility. It was believed that the student could not be an effective clinician given the perceived deficiencies in oral communication. Attempts were made to have the student modify her speech, but ultimately such attempts failed and the student was asked to leave the practicum.

The clinical supervisor should communicate specific characteristics about the student’s accent to the student and clinic director early (even if observations of the student are limited to a few sessions). The supervisor can make note of pronunciation, vocabulary, or grammatical differences and encourage the student to keep a notebook of changes that need to be made. The supervisor should discuss with student and director any accent modification plan that may have been in place before entry to practicum and determine whether the concerns in practicum are ongoing issues or new ones. Consider that issues that weren’t
apparent before practicum may be related to other factors (e.g., anxiety). Affective issues such as anxiety can result in a “mental block” and prevent student learning (Roseberry-McKibbin, 2008, p.226).

The supervisor should identify resources for the student and him/herself early as soon as issues are raised. ASHA (2011b) recommends that programs provide website resources, mentors, etc., for students. In addition, the clinical supervisor, together with the student, should identify any resources that may meet specific needs for those clients/patients that the student is working with.

A committee that includes the supervisor, CSD program director or other faculty/staff, and student may be formed as a resource for the student and the supervisor. The committee can work to put a plan in place to meet the student’s needs and to ensure the efficacy of the services (Levy & Crowley, 2012). Accent modification, a tutor to address grammar specifically, or a mentor who speaks the student’s native language may be beneficial resources. It may also be helpful to consider a more substantial role for the clinic director in the student’s supervision (e.g., more frequent visits and other clinical support for the student, and possibly serve as a mentor for the supervisor). There is evidence that monolingual clinicians feel inadequately prepared to manage clients and students when the language is not shared (Munoz, Watson, Yarbrough, & Flahive, 2011). This may also be the case when the supervisor shares the same language as the client but is culturally/linguistically different from the student. The supervisor should seek support for him/herself early and in some cases may consider switching the student to a supervisor with greater confidence or experience in managing the student.

The student has a role as well. Students with accents must work to demonstrate strong, albeit developing, clinical skills. Being prepared for sessions, anticipating communication breakdowns with clients, continuous self-evaluation and reflection, and open communication with the supervisor pertaining to issues with pronunciation, vocabulary, or grammar are important to clinical success. This will assist the supervisor in providing early support through examining the impact of intelligibility on the client, determining appropriate clients, recommending strategies and resources, or eliminating factors other than the student’s accent (e.g., weak knowledge and skills) as the cause of difficult client and student interactions.

Provide an accent modification enhancement plan
As ASHA (2011b) indicates, not all students with accents require accent modification plans. However, if the supervisor has concerns, it is possible that the student had one in place prior to entering practicum. Depending on the circumstances, the program may or may not alert the supervisor of issues pertaining to the student’s accent.

ASHA (2011b) recommends that the student have accent modification at some point during their program (as appropriate) with short-term/long-term goals specified. If the student has completed an accent modification plan but is struggling with a client, the supervisor and program should consider if additional goals should be addressed that focus on carry-over of skills, higher level or more contextualized communication (e.g., discourse), or production practice under more stressful conditions (e.g., time pressure, distractions, etc.). The supervisor should provide input regarding students’ needs related to their accent beyond the goals identified in the accent modification plan.

If the student with accented speech has difficulty with grammar, encourage the student to continue work to improve those skills. Consider the following student scenario:

Upon reflection, a student noted that monolingual English speakers are more tolerant of intonation and pitch differences than differences or errors in grammar. The student indicated that intonation and pitch are second, grammar is first, and that the perception of the monolingual speaker is that the student with the accent “can’t speak English,” if their grammar is different from native English speakers’ grammar.

Sudler (2012) provided evidence that supports the student’s comments in the above scenario. In response to the survey question “Should professionals provide services because of their accent?” participants indicated that “the problem is not the accent but competency and knowledge of the English language…I have a hard time understanding her” (Sudler, 2012, p. 57). Continuing to make changes in spoken and written grammar may be
an essential piece of the student’s modification plan and critical to making changes in perceived intelligibility, comprehensibility, and acceptability for working with clients.

As part of the modification plan, the supervisor might consider videotaping or audiotaping the student (or have the student record him/herself) to allow review of the student/client interaction. Recording the student would give the supervisor the freedom during the session to examine the student’s knowledge, skill, and implementation as well as the student’s accent. The supervisor can go back and review the recorded session with the student and provide feedback regarding the accent and interaction with the client. The supervisor should not expect native production from the student even after accent modification. Unless the student chooses, native production is not the goal.

Consider that the client may adapt with exposure to the student’s accent and difficulty perceiving the accent decreased (Bent & Bradlow, 2003; Levy & Crowley, 2012). In addition, there may be clients who are less impacted by the student’s accent or tasks (e.g., assessment which tends to be more scripted) (ASHA, 2011b). Consider highlighting accent changes that are needed to work with an individual client/patient (based upon the client’s goals or lesson plan for an individual session) versus discussing a broad range of modification strategies. The student may then include those suggestions on the lesson plan (e.g., During J.B’s session, use the word “shovel” vs “spade” when reviewing target vocabulary ”). Thus, it may be possible to help the student develop a “lingua franca,” a contact language or core set of changes specific to clients (Pickering, 2006) rather than relying on a generalized approach to modify the student’s accent.

Avoid communicating inferiority
ASHA (2011b) maintains that CSD programs must show sensitivity towards the students’ accented speech in order that their peers perceive the accents positively. In the academic setting, ASHA suggests that peers not provide services to students with accents or observe them in clinic during accent modification sessions. However, ASHA notes that a peer may be used if he/she is in a different cohort from the student with the accent. Similarly, a supervisor would not want to enlist the aid of one student clinician to help the other with an accent. The supervisor may, however, recommend that the student identify a peer outside the practicum setting who might provide informal modeling or skill practice. Consider the following scenario:
The student identified a peer who was another student in CSD and began brief weekly phone conversations. The purpose was to get feedback regarding grammar, intonation/pitch, and use of expressions from a native English speaker during casual conversation.

Clinical supervisors must avoid communicating to the student that the student’s accented speech is inferior to his/her own as this may impact the student’s self-esteem and confidence. Diminishing the student’s self-esteem and confidence will result in even greater difficulty with intelligibility as production gives way to nerves! In addition, learning is maximized when students have a positive self-concept and positive attitude about their language (Roseberry-McKinnin, 2008).

Supervisors must also explore and evaluate their own beliefs about their students’ accents in the same way that clinicians are to become aware of cultural differences among themselves and their clients (Battle, 2012). The supervisor’s beliefs will guide the student’s clinical experiences and may impact decisions regarding the effectiveness of the student. Most clinicians believe themselves to be “very” or “moderately” qualified to interact appropriately with clients, their families, and students from diverse culturally and linguistic backgrounds (ASHA, 2010a, 2011a). However, supervisors sometimes unknowingly present themselves as less than culturally sensitive (Torres, Rodriguez, & Payne, 2011). For example, using a word such as “atrocious” to describe an accented student’s grammar may convey a need to reflect on one’s cultural competence. Supervisors who “catch themselves” in these situations, however can use them as “aha” moments to become more culturally aware (Torres, et al., 2011, p.1) and in doing so, minimize any suggestion of inferiority.

Battle (2012) contends that becoming culturally competent is a continuous process rather than a discrete one. Moreover, she suggests that “the culturally competent clinician seeks continuous self-assessment regarding cultural differences” (Battle, 2012, p. 16). These statements reflect a standard that should be considered not only in reference to cross-
cultural clinical services, but should also be applied to cross-cultural supervision. ASHA provides several resources to help SLPs become more aware of their own cultural competence including the Cultural Competence Checklist (ASHA, 2010b), the Multicultural IQ Quiz (Moxley, 2003), and the Cultural Competence Awareness tool (ASHA, 2013).

Another consideration for supervisors regarding the issue of inferiority is to focus on the student’s knowledge, skills, and implementation versus showing undue attention toward the student’s accent. Thus, it is important to hear what the student is saying during interactions with the client/patient and not just how. Having this awareness will help distinguish between issues with poor intelligibility and/or incomprehensibility versus the student’s lack of knowledge and skills. It will also assist in being able to provide feedback to the student regarding treatment as well as feedback pertaining to changes needed in speech or grammar.

ASHA (2011b) suggests that supervisors have knowledge of current methods for enhancing intelligibility and adopt a philosophy that the purpose of accent modification is to “maximize communicative effectiveness” rather than eradicating the person’s accent.

Be respectful of what the individual offers to the profession
ASHA (2011b) suggests that students from diverse cultural and linguistic backgrounds are important to the field of communication disorders and are needed especially to offer services to bilingual and multilingual clients who speak the same languages. ASHA (2011b) recommends that programs support students as they address accent-related issues and recognize that students’ skills will develop overtime. The clinical supervisor can help by acknowledging how vital the accented student’s skills are and by seeking out opportunities for the student to use his/her skills. For example, the supervisor might identify specific clients for the student to work with to highlight the student’s strengths (Levy & Crowley, 2012).

Although most students with accents want to work with bilingual clients, not all do. Those students with accents who opt not to work with bilingual populations have a lot to contribute and should be afforded the opportunity to optimize skills needed to work competently with clients who are not the same linguistically. Although students with accents are sorely needed to address the shortage of bilingual clinicians, it is important to understand that these students can meet the needs of non-bilingual populations as well.

Whatever the student’s issues are with regard to accent, supervisors should be positive and supportive. Because of the shortage of bilingual clinicians many of these students will not have supervisors or mentors with similar cultural and linguistic experiences. Be willing to learn about and from the student. Ask the student to present an inservice on a topic pertaining to current research involving accent and intelligibility, or culturally and linguistically diverse populations in the community, and/or other topics that may enhance cultural awareness and sensitivity for SLPs in the student’s practicum setting.

Programs also have a role. Programs might encourage students to participate in multicultural research, serve on program or university-wide committees related to diversity issues, volunteer in state and national conventions to promote student involvement in the profession. Bilingual students in CSD programs with strong linguistic skills might consider working in the university’s writing center; students with accents with difficulty in grammar have had success getting feedback on written assignments from a fellow student when that was the student’s role. A number of Communication Disorders departments have initiated bilingual programs to actively engage, recruit, and train students from diverse cultural and linguistic backgrounds, and to respond to the shortage of bilingual SLPs. Although programs vary, Brice, Kester, and Brice (2013) found a trend in programs offering bilingual practicums and research opportunities.

Focus on the client’s perception of the accent
Based upon current research the client’s ability to perceive accented speech is crucial to language comprehension especially among adults with aphasia (Burda et al., 2007). Therefore, ASHA (2011b) suggests that it is important to note whether the client understands the accented student’s speech, but equally critical to determine whether the patient is able to learn from the student. At the program level, a student may shadow an SLP or ASHA (2011b) recommends having the student volunteer, or serve as an assistant as
a way to ease the student into practicum. It is recommended that students seek out these opportunities before their clinical practicum begins to gauge the impact of their intelligibility on patients with communication deficits.

The clinical supervisor must also observe the client’s response to the student. If the client has trouble, he/she can suggest strategies that can help the student minimize comprehension failure such as “repeat, rephrase, vary rate/loudness, and provide comprehension checks” (ASHA, 2011b, p. 9). In addition, scripting information to the client or family may be another way to assist the student with a means of communicating their ideas effectively (Newman, 2013). Scripting would allow the student with an accent to practice articulation and model correct grammar, and practice responses to questions before interacting with the client and thereby increase intelligibility. The supervisor should encourage use of strategies and resources that the student can use to positively impact the client/patient.

The supervisor should also observe whether there are certain clients that the student is more comfortable with and clients that are more comfortable with the student. The supervisor might pair the student with a client who might acclimate more readily to the client’s accent, a client where the accent may impact the client less, or a client who is from a similar cultural and linguistic background so that the student’s strengths might be utilized (ASHA, 2011b). A monolingual English speaking client, for example, may be motivated by a student who uses Polish-influenced English if it is familiar and/or reminds them of a family member.

The student may benefit from volunteer opportunities to allow them to practice skills. They may or may not have done so prior to practicum. Although studies suggest that accented clinicians may not be best suited to provide accent modification (Levy & Crowley, 2012; Sudler, 2012), students may have success volunteering in community programs that focus on improving residents’ second language skills when those individuals are from the same language backgrounds. Consider the following scenario:

The volunteer activity involved weekly one-on-one interactions with an English as a Second Language (ESL) speaker with accented speech who had been living in the U.S. for approximately one year. The sessions included basic review of grammar and production practice. This activity helped the student further understand her own grammatical differences—i.e., helped her distinguish between errors made because she didn’t know a rule versus where the rule is familiar but not applied. The sessions also provided practice using standard grammar, intonation and pitch, etc. (e.g., changes made during accent reduction with the SLP during activities). The one-on-one interaction with the ESL speaker gave the student an opportunity to develop, modify, and carry-out plans, develop activities, and provide corrective feedback. Because the sessions, in many ways, mimicked therapeutic interactions they allowed the student to continue to develop skills needed to be successful in practicum.

The opportunity to teach a second language learner with less skill in the second language than the student can be a valuable experience as the student teaches that individual what they have learned and consolidates the skill. Encourage the student to engage in community-based experiences that may facilitate intelligibility and in turn, improve the client’s perception of the student’s accent.

Address any client concerns
If the client or client’s family expresses concerns regarding the student’s accent, the supervisor should discuss the purpose and importance of clinical education of students to them. The supervisor should explain to the family that the student is supervised directly and that the quality of services is maintained. It is important to address client/family concerns whether they are legitimate or not (ASHA, 2011b). The supervisor should also be aware of program policies, stated policies in the university/site contract, and policies within their own facility related to discrimination. Ultimately, the supervisor is responsible for the client/patient.

Choose external sites carefully
ASHA (2011b) recommends that supervisors become aware of the program’s philosophy and their approach to ensuring the success of students with accents. More specifically, supervisors should take advantage of any continuing education opportunities and have an ongoing dialogue with the student’s program...
Supervisors should determine if the student’s program offers online continuing education opportunities on topics related to supervision in general or course offerings related to supervision or cultural and linguistic diversity. Some programs have such offerings at no cost to supervisors.

ASHA (2011b) recommends that programs select clinical sites for students where the caseloads are more conducive to student success (i.e., bilingual placements or those sites where the clients/patients are linguistically similar to the student). Identifying placements for students with accents that are culturally and linguistically compatible is the same as placing any other student who requests a placement based upon specific interests (e.g., the student wants to work with a particular clinical population) or desire for certain experiences (e.g., the student wants an acute care medical site). However, it is important for programs to keep in mind that not all students with accents want/request bilingual placements, and for students with accents to keep in mind that bilingual placements and supervisors in most areas are limited and may not be available.

Programs and clinical supervisors must consider whether the external site is a good fit for the student based on the supervisor’s cultural competence as well as the student’s limitations concerning patient outcomes. Supervisors might consider having the student re-assigned ideally after strategies have been exhausted (e.g., strategies to facilitate patient comprehension, or modifying caseload, etc.). Supervisors must avoid allowing the student’s accent related concerns to mask other issues that may be influencing their clinical performance (such as poor ability to carry out goals/lesson plan, poor interpersonal skills, etc.). It may be easy to lose sight of these skills if the student’s accent gets the better of the supervisor’s attention. In some students with accents, inability to perform a host of essential functions may be more of a problem than the accent.

Student clinicians are also likely to have a higher level of anxiety with an external site compared to on-campus placement and also in their first practicum. Supervisors should allow the student sufficient time to adjust to the site and note any change in the student’s intelligibility as the student’s comfort increases.

**Acquisition of student self-awareness**

A student may be completely unaware of the potential impact or impact of their accent on a peer, client, or colleague. A student may have heard only positive feedback regarding their accent (e.g., “I love your accent”), or when given critical feedback may indicate, “no one has ever mentioned my accent in that way before.” Some students have experienced primarily negative feedback and discrimination regarding their accent. These students may be particularly anxious and lacking confidence as they enter practicum worried about the reaction of their supervisor, peer, or the client to their accent. As a culturally competent supervisor it is important to develop awareness and understanding of what the student is going through as it relates to their cultural background.

The supervisor should assist the student in developing clinical self-awareness which for students with accents should include their accented speech. Supervisors should not be fearful of alerting the student to concerns regarding their accent nor view alerting the student as being culturally insensitive. Although it is not the supervisor’s responsibility to serve as the student’s “accent modification therapist,” the supervisor might consider “role play” as a means of helping the student develop awareness of their accent as it relates to providing optimal services for the client. To encourage increased self-awareness, provide the student with regular opportunities to evaluate sessions with clients and identify instances where their accent influenced patient behavior. The supervisor might also engage the student in brief role plays to practice skills, encourage the student to write self-cues on lesson plans (e.g., as a reminder to use strategies to facilitate pronunciation, semantics, intonation, etc.), or strategies to facilitate comprehension in adult neurogenic clients.

Upon entry into the academic program, some programs use a self-evaluation tool to get a sense of the student’s perception of his/her own speech, language, and pragmatic skills.

**Seek outside support**

ASHA recommends that programs assess their own policies and practices for supporting students with accents. Use of exit interviews from those students with accents who completed the program and feedback from those students regarding what the program can do
to improve was suggested. Programs might also form a standing committee whose purpose is to develop, expand, and/or revise policies and procedures and update faculty on current research. Clinical supervisors might develop a library of resources for clinicians in the work setting. The local or regional SLP associations may have resources to offer or loan. Many state associations have multicultural committees that “house” resources. The supervisor might also get feedback from the program regarding supervision of the student and discuss with the program any changes that might be made to improve policies and procedures for subsequent students.

Conclusion
Communication Disorders programs and clinical supervisors play a major role in facilitating accented students’ transition to and through clinical practicum. Strategies to guide and support clinical supervisors in their efforts to train students have been emphasized and are offered to supplement ASHA’s 2011 strategies for programs and students with accents. Use of these strategies will ease challenges for linguistically and culturally diverse students entering the profession and lead to clinical success.

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Supervision: Issues Related to Race and Culture

Shelly Victor

Abstract
The topic of racial differences in the supervisory relationship has not been well-examined in the professions of speech-language pathology and audiology. Other disciplines such as counseling and family therapy have explored these issues to discover that racial issues need to be discussed within the supervisory dyad. A summary of challenges in the discussion of cross racial supervision and approaches to addressing the topic in the supervisory relationship is discussed.

Learning Objectives:
1. Discuss the literature on the influence of race on the supervisory relationship.
2. Explain the challenges of cross-racial supervision.
3. Discuss strategies to improve the cross-racial supervisory relationship.

If you listen to and read the news, you will likely hear about topics and issues related to race. Most recently, the incident with Trayvon Martin and Stand your Ground has brought the discussion of race to the forefront (Shooting, n.d.). Thus, race and race relations are part of our sociopolitical fabric. On a smaller scale, we can view the supervisory relationship as social and interpersonal thus the issue of race should be explored within the supervisory dyad.

You may reject the fact that issues related to race exist within the supervisory relationship. However, an exploration of research from other healthcare professions suggests otherwise (Chang, Hays, & Shoffner, 2013). Listening to the stories of supervisees as described below, we can decipher what the issues are.

- “I feel that my supervisor and I did not acknowledge and honor our different assumptions, beliefs, and values, nor did we explore how these factors informed the way that we conceptualized clients” (Hird, Cavaleri, Dulko, Felice, & Ho, 2001, p. 118)

- “My supervisor was visibly uncomfortable as we discussed my client’s experience of racism. He expended considerable energy trying to reframe the issue for me and my client” (Hird et al., 2001, p. 122).

- “When I eventually broached the topic of unintentional racism with my supervisor (which I believed played an insidious role in our supervision), I heard a slight gasp of discomfort.” (Hird et al., 2001, pp. 120-121).

No doubt, racism is an uncomfortable topic to discuss. People would deny that they think about race; however, racism may be subtle; occurring below the surface with acts of aggression which people are not aware of committing (Parker & Lynn, 2002). These microaggressions, which are covert, can take the form of spoken or behavioral slights and insults which are not recognized by the person responsible for them (Hall & Fields, 2012; Sue et al., 2007). A microaggression may occur through under-respect, a put down, a tone of voice, or exclusion in a conversation or group. This microaggression of “color-blindness” occurs when a person’s race may be invalidated if a supervisor comments “I don’t see color differences.”

Race as a Social Construct
A body of research exists on the topic of supervision and race. According to Parker and Lynn (2002), critical race theory is a sociopolitical theory with implications for society and education. The theory attempts to explain how race and racism are part of our social fabric. In addition to racial issues, a power differential in supervision exists where the supervisor holds the power.
Race and the supervisory relationship

The American-Speech-Language-Hearing Association (ASHA) has developed a technical report for supervisors as a guideline to best practice in supervision. One of the tasks of supervision is developing supervisory relationships with those who are culturally and linguistically diverse (American Speech-Language-Hearing Association, 2008). ASHA’s technical report on supervision acknowledges the importance of the interpersonal relationship on the effectiveness of the supervisory dyad. Communication skills of active listening, honesty in communication, and openness to ideas are critical to a successful relationship (American Speech-Language-Hearing Association, 2008).

Researchers in disciplines such as counseling, social work, and psychology have examined the influence of race on the supervisory relationship. Jernigan, Green, Helms, Perez-Gualdron, and Henze (2010) conducted a qualitative study of multiracial supervisory dyads using semi-structured interviews. They found that when supervisees initiated the discussion of race some supervisors were unsure why the topic had been raised. If the supervisor was receptive, then the supervisee became more secure in the supervisory relationship. These supervisees reported that they then withdrew from the supervisory process. An interesting finding from the interviews was that it cannot be assumed that a person of color better understands issues related to race and culture.

Burkhard et al. (2006), using semi-structured interviews, examined culturally responsive and culturally unresponsive supervisors. Thirteen supervisees of color and 13 supervisees who were European-American participated in this qualitative study. The researchers found that cultural issues were discussed in both groups. The relationship with the supervisor improved after a culturally responsive event but if the supervisor did not want to discuss culture then supervisees viewed this negatively which then affected the supervisory relationship.

McDowell (2004) conducted a qualitative study with students in marriage and family therapy program which was Euro-centered. Eight participants participated in interviews and were asked to comment about themes related to race. The participants of color reported that they experienced racism through lack of racial awareness or inattention paid to race and some reported their treatment in the program was different. Some felt marginalized since the program was Euro-centered. Their solutions to these issues were that those of color supported each other, some students developed inner strength, and some had to make sense of the situation and tried to understand the supervisor’s perspective.

Differences in racial competence

Issues related to race and perceptions of competence have been explored. Hird, Tso, and Gloria (2004) surveyed supervisors regarding the amount of time devoted to discussing racial issues. Supervisors who were racially and ethnically mixed were reported to have more multicultural competence in supervision and discussed racial issues more than White supervisors. Constantine and Sue (2007) found that Black supervisees felt that their White supervisors avoided discussion of racial issues.

Challenges to cross-racial supervision

Heffron, Grunstein, and Tilmont (2007) discussed the barriers to discussing the topic of race. A fear exists of not discussing the topic properly and feeling ignorant about the subject. Hird et al. (2001) agree and state that “Conversations about multiculturalism may initially be awkward or uncomfortable” (p. 122).

Estrada, Wiggins Frame, and Williams (2004) believe that “Color blind” reasoning is used to not discuss the issue. This microaggression is one where the supervisor believes that everyone is alike and there are no racial differences. The literature shows that this is a denial of other people’s racial identities.
Another challenge is the limited percentage of time devoted to racial issues in the supervisory relationship. The focus may be on the client and the supervisee’s ability to treat the client with limited time devoted to the supervisory process and the relationship between the supervisor and supervisee. In some cases, supervisees may be more developed in their ability to discuss racial issues than the supervisor which may put the supervisor on the defensive. A review of the literature shows that much of the focus in speech-language pathology and audiology related to race and culture has been on the client and not the supervisory relationship. Thus, supervisors may discuss with supervisees interaction with clients who are culturally or racially different from their own but do not address racial and cultural issues between themselves.

Approaches to race in supervision
Based on quantitative and qualitative research studies, issues of racism can occur in the supervisory relationship. It would be naïve to think that the supervisory relationship would be immune to the same social issues that affect nonsupervisory relationships. Acknowledging this is the first step in exploring and understanding other viewpoints. Developing a relationship which is based on open communication, a feeling of safety, honesty, and respect is critical in the supervisory relationship (Stroud, 2010).

Acknowledging that there may be a racial issue is the first step. Based on a review of research, the following suggestions are provided. Chang et al. (2003) believe that the supervisor is responsible for addressing the issue of race and culture. Given the power differential which exists between the supervisor and supervisee, it is reasonable that supervisees would be reluctant to raise the issue of race. Thus the supervisor needs to be willing to discuss race even though the topic may be uncomfortable (Jernigan et al., 2010). Certainly, barriers may exist which deter the discussion. Fear of not discussing the topic properly or feeling ignorant about discussing race are common themes (Heffron et al., 2007). Sommer et al. (2009) suggest using stories about culture to enhance awareness. Supervisors and supervisees can share stories about family, holidays, and food which relate to race and culture. After a discussion of race, it would not be unusual to find more similarities than differences. Storytelling is another venue so that the other person can develop empathy and begin to understand someone else’s experiences (Sommer et al., 2009).

Active disclosure of one’s knowledge and misunderstandings of the other’s race is a first step in the process (Ancis & Marshall, 2010; Sommer et al., 2009). This active disclosure requires an environment of respect and open communication. Additionally, the conversation should occur early so miscommunication does not occur (Hird et al., 2001).

The goal is for supervisors as well as supervisees to develop racial competence (Ancis & Marshall, 2010). Supervisors must understand their racial biases, and the perceptions of their clients and supervisees who are culturally diverse.

As a supervisor you may not understand your supervisees’ perspectives of their race. Their stories and life experiences may sounds strange to the supervisor. However, the supervisor needs to accept the supervisees’ perception of their truth as they live it (Stroud, 2010).

Suthakaran (2011) suggested using analogies to develop empathy. An example of this is story about two people who are after the same carrot dangling from the ceiling. One person is standing on a table, realizes he has an unfair advantage and then gives the other person a stool so they are on equal footing.

Lastly, Hird et al. (2001) provide a script which can be used by a supervisor in discussing the issue of race. An important component of my supervision model includes developing a strong trusting relationship with my supervisee. I notice that there are differences that exist between the two of us, such as gender, race, ethnicity, and age. I’m wondering how that might affect our ability to develop a strong working relationship. Let me tell you some of my thoughts. I would like to hear yours as well (p.124).

Conclusion
The topic of cross racial supervision should be addressed in the speech-language pathology and audiology supervisory dyad. Other professions, such as counseling and marriage therapy, have conducted research on this topic and found that race is an issue within the supervisory relationship which needs to be
addressed. Although the topic of race may be difficult to discuss, approaches to this discussion such as developing honest and open communication should occur. It is essential to the supervisory relationship that differences in race be acknowledged and valued.

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References
Commentary:

3 Things Great Speech-Language Pathologists Never Do

Erik X. Raj

I'm one of the luckiest speech-language pathologists out there because I have some of the best colleagues. These clinicians, who I very affectionately call my friends, possess marvelous qualities that make them stand out amongst the crowd. They truly shine, but not necessarily because of what they DO do, it's because of what they DON'T do. That sentence might sound a bit confusing, but bare with me, it'll make sense once you keep reading. Here's a collection of 3 things that great SLPs never do. It's my hope that by highlighting the things they NEVER do, you will have the opportunity to evaluate yourself in a helpful manner that will allow you to stay on track towards becoming the best possible SLP that YOU can be.

1. Great SLPs never hide their mistakes.
The most effective of SLPs will always be the first to tell you about the past speech therapy mistakes that they've made. They never try to hide their mistakes by acting as if they've never made errors before. Once a great SLP realizes that a mistake has been made, he/she takes full responsibility for the given action or decision, corrects course, embraces that learning experience, and then confidently moves on.

2. Great SLPs never resist learning new things.
The most effective of SLPs will always be the first to exclaim that they're life-long learners who simply can't get enough of new knowledge. They don't believe in only "doing it the old way," they actively seek out new approaches and ideas that could potentially change the lives of those that they work together with. These types of great clinicians understand that by taking the opportunity to learn new things, they're showing those around them that they wish to keep growing as communication professionals.

3. Great SLPs never avoid seeking help.
The most effective of SLPs will always be the first to ask for help or seek out advice if he/she seems to be stuck. They don't feel as if they're failures when they search for support because they recognize that asking for help is a sign of educational maturity and it shows a clear commitment to the field of speech-language pathology. They want to be the best that they can be, so they never hesitate to reach out to a colleague to set up a brain storming session in hopes of better understanding the given problem.

In closing . . .

Great SLPs were not born great. Like everyone, they've had their fair share of ups and downs, but they keep moving forward, never falling behind. It takes a lot of learning, mistake making, and support to become great. So go on, keep makin' mistakes, keep learnin' new stuff, and always remember to ask for help whenever you feel you need it. Because, that's exactly how you become a great SLP. Cool? Cool!

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Commentary:

A Question of Race: The elephant in the room

Janice M. Wright

"Race matters, for reasons that really are only skin deep, that cannot be discussed any other way and that cannot be washed away." Justice Sonia Sotomayor

Race is just one aspect of our cultural identity; it is an aspect that often is not addressed or considered when discussing issues in clinical supervision. It may be that clinical supervisors adapt the attitude of cultural blindness, “we are all alike” but that negates the rich cultural heritage that someone from a different race or ethnic background can bring to the supervisor/supervisee relationship. It is important to recognize that while some aspects of our cultural identity can be easily overlooked, because such things as socio-economic status, educational level or even at times religion cannot be easily identified, race is visible and cannot be easily manipulated or changed. The topic of racial or ethnic differences becomes the elephant in the room when looking at the relationship between a supervisor who is from a majority culture and a student from a minority culture.

Over my career as a student and a professional there have been quite a few instances of what I would call unconscious incompetent remarks made by a supervisor. Unconscious incompetence occurs when an individual makes a remark or performs an action which can be perceived by another individual as culturally insensitive. It is unconscious incompetence because the individual is unaware of how insensitive the remark or the action may be. One of my first supervisors would pepper me with questions about my family and when I would provide an answer she would say “oh that can’t be right”, as if she did not believe my answers to her questions about my family. The next comment would be “I don’t know of any other Black families like that”. After a few days of this type of question and response I stopped answering her, the end result was a written evaluation that said “Janice does an excellent job working with clients but she is not very sociable and may have a difficult time in any work environment”. Although this occurred in 1975, I still remember the feeling of “not belonging” in this profession.

It would be wonderful to be able to say that this type of behavior does not occur in this day and age; however conversations with students and professionals of color indicate that this is not a true statement. One individual was told that she was not going to be sent to a certain off-campus site because this location does not “see many people of color and we don’t know how they will react.” The student wondered why the university would still use this location for any student if this was such a racist facility. A professional of color with a unique name is often asked “where are you from” and when she states Cleveland, the response is “no really, where are you from?” The professional stopped trying to explain and made up some exotic sounding country that is totally fictitious just so she would stop being questioned.
Just recently I heard about a meeting where there was an intense discussion about where to send a student who wore a hijab (a headscarf that covers most of the hair and neck, and sometimes the shoulders of some women who are Muslim) as if she was not aware of the hijab she wore. The supervisors stated that they were trying to protect her from the racist comments that she may hear. Again, if this is a facility that was so racist, why are we sending any students there?

Our code of ethics states that it is important to strive for increased cultural sensitivity toward students and professionals who are culturally different. With 94.6% of audiologists and 96.2% of speech language pathologists in Ohio self-identifying as White there is a significant racial/ethnic disparity between student clinicians and supervisors. As supervisors it is important for us to engage in self-scrutiny with respect to race and cultural competencies to identify possible areas of dissonance between the supervisee from an underrepresented racial population with a supervisor from the majority culture.

So how do you begin to eat the elephant in the room. . . one bite at a time. The literature of diversity often uses the term competence in terms of being a culturally competent professional. I prefer to use the term humility as in being a culturally humble professional. The term ‘competent’ implies that a person will eventually understand everything that they need to know about every culture and aspects of cultural identity that a supervisee may bring to the supervisor/supervisee interaction; this is impossible. Instead if the person strives to become culturally humble they can take the first bite of the elephant by identifying and addressing the systematic biases at the institutional and individual level that may ultimately undermine the ability to successfully mentor a student of color through a program. So why talk about race in the context of supervisor/supervisee interactions? I will end as I began with the words of Chief Justice Sonia Sotomayor- “Race matters because of the slights, the snickers, the silent judgments that reinforce that most crippling of thoughts: “I do not belong here.”
Supplementary Appendix
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The American Speech-Language Hearing Association (ASHA) has granted permission to OSLHA to reprint the following from the ASHA Website:

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*Not available for Continuing Education Credits
Clinical Supervision in Speech-Language Pathology

Position Statement

American Speech-Language-Hearing Association

The position statement Clinical Supervision in Speech-Language Pathology and Audiology was approved in 1985. This new position statement updates that document with respect to the profession of speech-language pathology. Although the principles of supervision are common to both professions, this position statement addresses only speech-language pathology because of differences in pre-service education and practice between the two professions.

It is the position of the American Speech-Language-Hearing Association that clinical supervision (also called clinical teaching or clinical education) is a distinct area of practice in speech-language pathology and that it is an essential component in the education of students and the continual professional growth of speech-language pathologists. The supervisory process consists of a variety of activities and behaviors specific to the needs, competencies, and expectations of the supervisor and supervisee, and the requirements of the practice setting. The highly complex nature of supervision makes it critically important that supervisors obtain education in the supervisory process. Engaging in ongoing self-analysis and self-evaluation to facilitate the continuous development of supervisory skills and behaviors is fundamental to this process. Effective supervision facilitates the development of clinical competence in supervisees at all levels of practice, from students to certified clinicians. Clinical supervision is a collaborative process with shared responsibility for many of the activities involved in the supervisory experience. The supervisory relationship should be based on a foundation of mutual respect and effective interpersonal communication. Clinical supervisors have an obligation to fulfill the legal requirements and ethical responsibilities associated with state, national, and professional standards for supervision.

Clinical Supervision in Speech-Language Pathology

Ad Hoc Committee on Supervision in Speech-Language Pathology
American Speech-Language-Hearing Association

Abstract:
This technical report was developed by the Ad Hoc Committee on Supervision in Speech-Language Pathology of the American Speech-Language-Hearing Association (ASHA). Members of the committee were Lisa O’Connor (chair), Christine Baron, Thalia Coleman, Barbara Conrad, Wren Newman, Kathy Panther, and Janet E. Brown (ex officio). Brian B. Shulman, vice president for professional practices in speech-language pathology (2006–2008), served as the monitoring officer. This document was approved by the Board of Directors on March 12, 2008.

Because of increasing amounts of data from studies on supervision, advances in technology, and a greater understanding of the value of interpersonal factors in the supervisory process, there was a need to update ASHA's 1985 position statement Clinical Supervision in Speech-Language Pathology and Audiology (ASHA, 1985b). This 2008 technical report accompanies an updated position statement and knowledge and skills document for the profession of speech-language pathology (ASHA 2008a, 2008b). Although the principles of supervision (also called clinical teaching or clinical education) are common to both professions, the updated documents address only speech-language pathology because of differences in pre-service education and practice between the two professions.

The 1985 position statement identified specified competencies for supervisors, with an emphasis on clinical supervision of students. This 2008 technical report addresses supervision across the spectrum of supervisees, with the exception of speech-language pathology assistants. Professionals looking for guidance in supervising support personnel should refer to the ASHA position statement, guidelines, and knowledge and skills documents on this topic (ASHA, 2002, 2004b, 2004e).

As stated in ASHA’s position statement on clinical supervision in speech-language pathology (ASHA, 2008a), “clinical supervision (also called clinical teaching or clinical education) is a distinct area of practice in speech-language pathology and ... is an essential component in the education of students and the continual professional growth of speech-language pathologists” (p. 1). Clinical supervision is also a collaborative process, with shared responsibility for many of the activities throughout the supervisory experience.

At some point in their career, many speech-language pathologists (SLPs) will be involved in a role that involves supervising students, clinical fellows, practicing SLPs, and/or paraprofessionals. Many of these SLPs do not have formal training or preparation in supervision. Recognizing the importance and complexity involved in the supervisory process, it is critical that increased focus be devoted to knowledge of the issues and skills in providing clinical supervision across the spectrum of a professional career in speech-language pathology. The purpose of this technical report is to highlight key principles and issues that reflect the importance and the highly skilled nature of providing exemplary supervision. It is not intended to provide a comprehensive text on how to become a supervisor. The companion document Knowledge
and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision (ASHA, 2008b) delineates areas of competence, and the position statement Clinical Supervision in Speech-Language Pathology (ASHA, 2008a) affirms the role of supervision within the profession.

**Background Information**

In 1978, the ASHA Committee on Supervision indicated that there was little knowledge of the critical factors in supervision methodology (American Speech and Hearing Association, 1978). During the three decades since that report was written, a body of work has been published that has helped to identify some of the critical factors in supervision methodology and their relationship to the effectiveness of supervision.

Jean Anderson’s *The Supervisory Process in Speech-Language Pathology and Audiology* (1988) played a significant role in helping professionals understand the critical factors in supervision methodology and their contribution to the effectiveness of supervision. Her continuum of supervision is the most widely recognized supervision model in speech-language pathology (see Figure 1). This model is based on a developmental continuum that spans a professional career.

![Figure 1. Continuum of supervision](image)

The continuum mandates a change over time in the amount and type of involvement of both the supervisor and the supervisee in the supervisory process. As the amount of direction by the supervisor decreases, the amount of participation by the supervisee increases across the continuum (J. L. Anderson, 1988). The stages (evaluation-feedback, transitional, self-supervision) should not be viewed as time-bound, as any individual supervisee may be found at any point on the continuum depending on situational variables as well as the knowledge and skill of the supervisee. The model stresses the importance of modifying the supervisor’s style in response to the needs, knowledge, and skills of the supervisee at each stage of clinical development. This model also fosters professional growth on the part of both the supervisor and the supervisee.

In addition to the publications from acknowledged experts in the profession, ASHA has provided guidance in the area of supervision through standards, the Code of Ethics, and Issues in Ethics statements. These documents are described below in the sections Standards, Regulations, and Legal Issues and Ethical Considerations in Supervision.
Research on Supervision
As the profession of speech-language pathology has advanced, evidence-based knowledge about practice in clinical disorders has developed through experimental and descriptive research. However, there is little empirical evidence in the area of supervision (Spence, Wilson, Kavanagh, Strong, & Worrall, 2001), especially as it relates to client outcomes. Knowledge about supervision in speech-language pathology has primarily come from descriptive studies documented in texts by acknowledged experts, conference proceedings, and personal and shared experience. The results of descriptive studies have led to the identification of some of the behaviors that supervisors need to modify in order to be less directive and to facilitate high levels of critical thinking in supervisees (Dowling, 1995; Strike-Roussos, 1988, 1995, as cited in McCrea and Brasseur, 2003). Another major source of information about supervision comes from the research literature from other professions. McCrea and Brasseur (2003) examined the work of Rogers (1951), Carkhuff (1967, 1969), Leddick and Barnard (1980), and Hart (1982) in psychology; Fiedler (1967) in business management; Kagan (1970) in social work; and Cogan (1973) and Goldhammer (1969; Goldhammer, Anderson, & Kajewski, 1980) in education to show the extent to which other disciplines have contributed to our knowledge of effective supervision, and to emphasize the shared core principles of supervision regardless of the discipline and/or service delivery setting (Dowling, 2001).

Definition of Supervision
In 1988 Jean Anderson offered the following definition of the supervisory process:

Supervision is a process that consists of a variety of patterns of behavior, the appropriateness of which depends on the needs, competencies, expectations and philosophies of the supervisor and the supervisee and the specifics of the situation (tasks, client, setting and other variables). The goals of the supervisory process are the professional growth and development of the supervisee and the supervisor, which it is assumed will result ultimately in optimal service to clients. (p. 12)

Anderson's definition is still consistent with the goals of the process but needs some expansion. ASHA's position statement (1985b) noted that “effective clinical teaching” involves the development of self-analysis, self-evaluation, and problem-solving skills on the part of the individual being supervised. Self-analysis and self-evaluation are important activities for the supervisor as well. Therefore, Anderson's definition may be expanded to include the following:

Professional growth and development of the supervisee and the supervisor are enhanced when supervision or clinical teaching involves self-analysis and self-evaluation. Effective clinical teaching also promotes the use of critical thinking and problem-solving skills on the part of the individual being supervised.

Critical thinking is based on building hypotheses, collecting data, and analyzing outcomes. A supervisor can facilitate the critical thinking abilities of supervisees through collecting data and facilitating problem solving. Engaging in this process will also help supervisees assess the quality of their service delivery. The Data Collection in Supervision section that follows provides further information on this topic.

The following sections discuss key issues that affect supervision or influence the supervisory process.

Supervision across Settings
Professional, clinical, and operational demands across practice settings vary; however, the supervisory process can be viewed as basically the same wherever speech-language pathology services are delivered. Client populations as well as
equipment, tools, and techniques used to provide clinical services can differ across the practice settings. Nevertheless, the dynamics of the supervisory relationship and the components of the supervisory process are similar regardless of work setting.

Often the supervisor is also responsible for day-to-day operations and program management. These supervisors with management responsibilities are accountable to multiple stakeholders (e.g., administrators, regulatory agencies, consumers, employees, and payers). These supervisors also have an obligation to provide clinical teaching to supervisees at all levels of their career. Clinical education may be managed directly by the supervisor, facilitated as a collaborative activity by the supervisor, or delivered in peer training formats (e.g., through literature review and discussion, or continuing education). Methods may vary according to the needs of the clinical population, developmental level of the supervisee, supervisor and supervisee teaching/learning styles and preferences, economics, and practice setting. The basic objective of professional growth and development for both the supervisor and supervisee remains at the core of the supervisory process.

**Technology in Supervision**

Although technology is not a new concept in supervision, the ways in which technology may be used have changed immensely. It can allow one message to be received by many at one time (through an e-mail list) or it can provide support to just one supervisee through the use of two-way videoconferencing (i.e., “e-supervision”). Through the use of technology, information can be delivered at a distance in real time or be archived for users to retrieve at their convenience. Many forms of technology can be used to support communication and clinical teaching, particularly the Internet, which facilitates the use of e-mail, e-mail lists, instant messaging, Web sites/pages, videoconferencing, video software, Weblogs (or “blogs”), and podcasting. The Appendix provides examples of current uses of technology for supervision. When one uses technology in supervision (e.g., videoconferencing) it is important to be aware of and follow regulatory guidelines involving confidentiality.

**The Influence of Power in Supervision**

Power has been defined as the ability of one party to change or control the behavior, attitudes, opinions, objectives, needs, and values of another party (Rahim, 1989). Although different models and descriptions of power are described in the literature, some researchers have acknowledged the importance of modifying supervisees' behavior using social and interpersonal influence processes. One form of social influence is power (Wagner & Hess, 1999). According to Robyak, Goodyear, and Prange (1987), supervisors' power influences trainees to change their clinical behaviors. Other disciplines have extensively investigated social power because of the influence that power has on subordinates' compliance, motivation, satisfaction, task commitment, job performance, and interpersonal conflicts (Wagner & Hess, 1999).

Understanding the influence of social power on the supervisory relationship is important. Supervisors hold the power of grading, signing off on clinical hours, conducting performance evaluations, and making promotion decisions. Lack of awareness of the influence of power can result in intimidation and a reluctance on the part of the supervisee to participate actively in the supervisory experience.

Individuals from diverse cultural and/or linguistic backgrounds may respond differently to the power dynamic (e.g., to people they perceive to be in roles of authority). They may behave in ways that may be interpreted as inappropriate by those who are unfamiliar with their culture and/or background (Coleman, 2000). Therefore, it is important for
supervisors to know when to consult someone who can serve as a cultural mediator or advisor concerning effective strategies for culturally appropriate interactions with individuals (clients and supervisees) from specific backgrounds.

**Mentoring in Supervision**

The terms mentoring and supervision are not synonymous but are often used interchangeably (Urish, 2004). Mentoring is typically defined as a relationship between two people in which one person (the mentor) is dedicated to the personal and professional growth of the other (the mentee) (Robertson, 1992). While this definition may sound similar to the relationship of the supervisor and the supervisee, the primary focus of supervision is accountability for the supervisee’s performance (e.g., providing grades or conducting performance evaluations; documenting professional behavior and clinical performance). In contrast, mentoring focuses on creating effective ways to build skills, influence attitudes, and cultivate aspirations. Mentors advise, tutor, sponsor, and instill a professional identity in mentees. Mentoring is an intense interaction between two people, where the mentor has authority and power based on experience. To highlight the importance of the mentoring role, the 2005 ASHA Standards for Clinical Certification references mentoring. In some sections the terminology has been changed from supervision to mentoring and from clinical fellowship supervisor to clinical fellowship mentor (Council for Clinical Certification in Audiology and Speech-Language Pathology [CFCC], 2005).

Some aspect of mentoring should be involved in all supervisory relationships, the degree being dependent on supervisory style, the amount of experience and skill level of the supervisee, and factors associated with the practice setting. Supervisors who maintain a “direct-active” style of supervision as described by J. L. Anderson (1988) are less likely to address the mentoring aspect of supervision. The “direct-active” style focuses mainly on growth in performance rather than on the personal growth of the supervisee. “Collaborative” or “consultative” styles, as described by J. L. Anderson (1988), better facilitate the ability to address the mentoring aspect of supervision. Mentoring is most appropriate when supervisees have moved into the advanced level of the “transitional stage” and/or the self-supervision stage on the Anderson continuum.

**Training in Supervision**

Many professionals are thrust into the role of supervisor or clinical educator without adequate preparation or training (J. L. Anderson, 1988; Dowling, 2001; McCrea & Brasseur, 2003; Spence et al., 2001). They become “overnight supervisors” and are forced to draw on their own past experiences as supervisees, positive or negative, as a source for their own techniques and methodologies. Supervisors in all practice settings may also have unrealistic expectations concerning the academic and clinical preparation of supervisees, particularly students.

Dowling (2001) and McCrea and Brasseur (2003) discussed research in speech-language pathology by Culatta and Seltzer (1976), Irwin (1975, 1976), McCrea (1980), Roberts and Smith (1982), and Strike-Roussos (1988, 1995) indicating that supervisors who engage in supervisory conferences/meetings without formal supervisory training tend to dominate talk time, problem solving, and strategy development. These supervisors tend to use the same direct style of supervision with all supervisees regardless of their knowledge or skill levels, and without regard for the supervisee’s learning style, which can lead to passive supervisee involvement and dependence on the supervisor (J. L. Anderson, 1988). Further, a direct style of supervision diminishes the need for the supervisee to use critical thinking and problem-solving skills. Supervisors should seek training on the supervisory process so that they can learn about differing supervisory styles and develop competence in supervision. This will help ensure the use of strategies and behaviors that promote supervisee learning and development. ASHA’s Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision (ASHA, 2008b) lists competencies for effective supervision. Training in supervision can be obtained through
course work, continuing education programs, self-study, peer mentoring, and resources from ASHA (e.g., products and/or continuing education offerings) and from Special Interest Division 11, Administration and Supervision.

**Supervisor Accountability**

Quite often, the effectiveness of a supervisor is determined by asking the supervisee to evaluate the clinical instructor. While such evaluations do have some importance, few supervisees have sufficient understanding of the supervisory process to know what to expect of a supervisor. Further, unless complete anonymity is ensured, the likelihood of receiving honest feedback may be questioned. Therefore, supervisors should also evaluate their own behaviors relative to the supervisory process. Given the lack of validated guidelines for accomplishing such self-evaluation, supervisors must devise their own methods of data collection (McCrea & Brasseur, 2003) or turn to resources from other fields. Casey (1985) and colleagues (Casey, Smith, & Ulrich, 1988) developed a self-assessment guide to assist supervisors in determining their effectiveness in acquiring the 13 tasks and 81 associated competencies contained in the 1985 position statement (ASHA, 1985b). Analyzing the results allows the supervisor to identify supervisory objectives, decide on certain procedures, and determine whether goals were accomplished.

Studying the supervisory process in relation to one's own behavior is an opportunity for the supervisor to develop a personalized quality assurance mechanism, and a way to ensure accountability. Making a decision to improve as a supervisor also promotes job satisfaction, self-fulfillment, and ethical behavior, and prevents burnout (Dowling, 2001).

**Data Collection in Supervision**

Objective data about the supervisee's performance adds credibility and facilitates the supervisory process (J. L. Anderson, 1988; Shapiro, 1994). According to J. L. Anderson (1988) and Shapiro (1994), data collection methods can include rating scales, tallying behaviors, verbatim recording, interaction analysis, and individually designed methods. A number of tools have also been developed for analysis of behaviors and self-assessment (J. L. Anderson, 1988; Casey et al., 1988; Dowling, 2001; McCreary & Brasseur, 2003; Shapiro, 1994). Results from the analysis of this data can be applied both to the supervisee's clinical interactions with clients as well as to behaviors of the supervisor and supervisee during supervisory conferences. Analysis of both the supervisee and supervisor's behaviors during supervisory conferences can yield valuable insights to improve the interactions and outcomes of the supervisory experience for both individuals.

To be effective at their job, supervisors must be concerned about their own learning and development. Studying one's own behavior in supervisory process not only facilitates accountability in clinical teaching, but also is an opportunity for supervisors to examine their own behavior in order to improve their effectiveness in supervision.

**Communication Skills in Supervision**

Although supervisors may collect data and analyze the behaviors of supervisees, success in facilitating a supervisee's development may ultimately rest on the supervisor's skill in communicating effectively about these behaviors. While there are many resources that discuss interpersonal communication, McCrea and Brasseur (2003) briefly reviewed the literature in speech-language pathology on the interpersonal aspects of the supervisory process, citing Pickering (1979, 1984, 1987, 1990), Caracciolo and colleagues (1978), Crago (1987), Hagler, Casey, and DesRochers (1989), McCrea (1980), McCreary and colleagues (1987, 1996), and Ghitter (1987). All of these researchers found a relationship between the interpersonal skills of supervisors and the clinical effectiveness of the supervisees. In their review of the literature, McCrea and Brasseur noted the importance of a supervisor's skill in communication. Adopting an effective communication style for each supervisee was shown to affect the supervisees' willingness to participate in conferences,
share ideas and feelings, and positively change clinical behaviors. Ghitter (1987, as cited in McCrea & Brasseur, 2003) reported that when supervisees perceive high levels of unconditional positive regard, genuineness, empathic understanding, and concreteness, their clinical behaviors change in positive directions.

The ability to communicate effectively is viewed by many as an aptitude or an innate skill that people possess without any training. However, many professionals operate at a level of effectiveness far below their potential (Adler, Rosenfeld, & Proctor, 2001). There are also potential barriers to clear and accurate communication (e.g., age, gender, social and economic status, and cultural/linguistic background). Further information addressing such barriers is included in the sections Generational Differences and Cultural and Linguistic Considerations in Supervision). Training in interpersonal communication is an important component of supervisory training. Growth in the interpersonal domain will enhance supervisors' proficiencies in interacting with clinicians in a helpful manner.

**Standards, Regulations, and Legal Issues**

Various external groups provide guidance for or regulation of supervision in speech-language pathology, particularly with respect to students and clinical fellows. ASHA's standards for certification and accreditation, state licensure laws, and federal/state reimbursement programs set minimum standards for the amount of supervision provided to individuals who are not certified SLPs.

At the preprofessional level, the Standards for Accreditation of Graduate Education Programs in Audiology and Speech-Language Pathology (Council on Academic Accreditation in Audiology and Speech-Language Pathology [CAA], 2004) require competent and ethical conduct of faculty, including on-site and off-site faculty. The standards also require programs to demonstrate that “Clinical supervision is commensurate with the clinical knowledge and skills of each student...” (Standard 3.5B; CAA, 2004).

Standards and Implementation Procedures for the Certificate of Clinical Competence address the requirements for direct and indirect supervision of students (CFCC, 2005). The standards require that student supervision be provided by a certified SLP, and that at least 25% of a student's total contact with each client be directly observed. The amount of supervision “should be adjusted upward if the student's level of knowledge, experience, and competence warrants” (CFCC, 2005). Standards for clinical fellows require 36 mentoring activities, including 18 hours of on-site direct client contact observation. Both sets of standards may be updated periodically.

Regulation by state licensure boards is separate from ASHA requirements; therefore, all students, clinical fellows, and certified clinical practitioners must be aware of and adhere to ASHA certification requirements as well as their state’s requirements. Licensure laws regulate the provision of SLP services within the state; for SLPs practicing in schools, different or additional standards may also be required. States' requirements for student supervision may in some cases exceed ASHA's requirements.

Supervisors also must be aware of regulations for student supervision issued by payers such as the Centers for Medicare and Medicaid Services (CMS). For services delivered to Medicare beneficiaries under Part B, Medicare guidance explicitly states that the qualified SLP must be in the room at all times and be actively engaged in directing the treatment provided by the student (CMS, 2003, chapter 15, section 230B.1). There is an exception for services to Part A beneficiaries residing in a skilled nursing facility where “line of sight” supervision of the student by the qualified SLP is required instead of “in the room.”
The nature of the supervisory relationship includes a vicarious liability for the actions of the supervisee. Supervisors hold full responsibility for the behavior, clinical services, and documentation of the student clinician. For their own protection as well as to foster the growth of students and protect the welfare of clients, supervisors must be fully involved and aware of the performance of the student and address any issues that could affect patient outcomes or satisfaction.

**Ethical Considerations in Supervision**

ASHA’s Code of Ethics (2003) provides a framework for ethical behavior of supervisors across supervisory responsibilities. Principle of Ethics I states that client welfare must always be held paramount. Accordingly, the supervisor must provide appropriate supervision and adjust the amount and type of supervision based on the supervisee's performance. The supervisor ensures that the supervisee fulfills professional responsibilities such as maintaining confidentiality of client information, documenting client records in an accurate and timely manner, and completing other professional activities. In addition, the supervisor has an obligation to inform the client of the name and credentials of individuals (such as students) involved in their treatment.

Principle of Ethics II addresses issues of professional competence, and its rules state that professionals should only engage in those aspects of the profession that are within their scope of competence. Accordingly, supervisors should seek training in the area of effective supervisory practices to develop their competence in this area. Supervisors also have the responsibility to ensure that client services are provided competently by supervisees whether they are students, clinical fellows, or practicing clinicians. In addition, the rules state that treatment delegated to clinical fellows, students, and other nonprofessionals must be supervised by a certified speech-language pathologist.

Principle of Ethics IV addresses the ethical responsibility to maintain “harmonious interprofessional and intraprofessional relationships” and not abuse their authority over students (ASHA, 2003). See the section The Influence of Power in Supervision for further discussion of this issue.

Issues in Ethics statements are developed by ASHA's Board of Ethics to provide guidance on specific issues of ethical conduct. Statements related to supervision include Fees for Clinical Service Provided by Students and Clinical Fellows (ASHA, 2004a), Supervision of Student Clinicians (ASHA, 2004d), and Responsibilities of Individuals Who Mentor Clinical Fellows (2007).

Supervisors should also be cognizant of the problems that may arise from developing a social relationship with a supervisee in addition to their supervisory relationship. Although working together may provide opportunities for socialization beyond professional activities, supervisors must be comfortable in addressing a supervisee's performance without being influenced by their relationship outside the work setting.

King (2003) identified situations where ethical misconduct in the area of supervision may occur. Although King’s comments were directed to the supervision of students, these concerns can be applied to all supervisory relationships. According to King, situations of potential misconduct can include, but are not limited to, failure to provide a sufficient amount of supervision based on the performance of the supervisee, failure to educate and monitor the supervisee’s protection of patient confidentiality, failure to verify appropriate competencies before delegating tasks to supervisees, failure to demonstrate benefit to the patient based on outcomes, and failure to provide self-assessment tools and opportunities to supervisees.
Supervision by Other Professionals

Increasingly, ASHA-certified SLPs and clinical fellows may work in settings where their direct supervisor may be an administrator or an individual from another profession. Evaluation of clinical skills by that individual is not appropriate, according to ASHA’s position statement on Professional Performance Appraisal by Individuals Outside the Professions of Speech-Language Pathology and Audiology (ASHA, 1993). Peer appraisal and/or self-evaluation are recommended as alternatives. In addition, guidelines on the Professional Performance Review Process for the School-Based Speech-Language Pathologist (ASHA, 2006) were recently developed to help address this frequently occurring situation in schools.

Access to Clinical Externships

Practicing SLPs participate in the training and development of those who are entering the profession. However, pressures within the workplace have created challenges to students gaining access to externship sites (McAllister, 2005). Students are considered by some clinicians and administrators to be a drain on existing resources. The pace of the work, productivity demands, complexity of clients, and program specialization can limit an organization's willingness to embrace the task of student training (McAllister, 2005). In some cases, an externship supervisor's expectations of a student's knowledge and skills may be unrealistic and/or not met. Requirements for specified levels of supervision imposed by regulatory agencies (e.g., CMS) have also been identified as barriers to accepting students.

Staffing shortages can also limit student placement opportunities. Student training is often one of the casualties of inadequate staffing in the workplace. Veteran SLPs have much to offer students and other supervisees, but these individuals may work on a part-time or as-needed basis. Organizations that implement flexible work schedules to retain seasoned employees may refuse student placements because they believe they cannot accommodate the students' scheduling needs (McAllister, 2005). An unfortunate irony exists because sites that do not offer student externship placements are less likely to successfully recruit qualified SLPs.

McAllister (2005) posited the need for innovative solutions in the following areas. A shift in training models may be necessary in some cases to provide more opportunities for student placements. Ingenuity and collaboration between universities and work sites can ultimately produce innovative scheduling, supervisory incentives, and exploration of new supervisory models that may allow for excellent training opportunities. Cooperative partnerships between the universities, work sites, and clinicians are needed to develop collaborative training models appropriate to work site demands and pressures. Universities can play a key role in assisting work sites in experimenting with and evaluating innovative training models and in educating potential and existing supervisors on best practices in clinical education.

Cultural and Linguistic Considerations in Supervision

The population of the United States is becoming increasingly diverse. Supervisors will interact more frequently with individuals from backgrounds that are different from their own. As they interact with others, supervisors will have to take into account culturally based behaviors, values, and belief systems to be successful in their interactions. No universal communication, learning, or behavioral style is used by all people. Many cultural values have a significant impact on how and when individuals choose to communicate, how they behave in various settings, and how they prefer to learn. Differences in cultural values have an impact on the nature and effectiveness of all aspects of clinical interactions, including supervisor-supervisee relationships. Supervisors must take into consideration culturally based behaviors and learning styles of supervisees if their interactions with them are to be successful (Coleman, 2000).
Shapiro, Ogletree, and Brotherton (2002) reported research findings that most faculty were viewed as not being prepared for engaging in the supervisory process even with students from mainstream backgrounds. This problem is even more widespread in view of previous findings that most SLPs do not believe they are prepared to work effectively with clients from culturally and linguistically diverse backgrounds (ASHA, 1985a; Carey, 1992; Coleman & Lieberman, 1995; Keough, 1990). The lack of understanding and/or appreciation for culturally and linguistically diverse clients could also have a significant impact on the nature of interactions these professionals have with other nontraditional students, such as older students or returning students (McAllister, 2005).

Supervisors who supervise individuals from culturally and linguistically diverse backgrounds should develop competencies that will help them engage in appropriate clinical education practices (ASHA, 1998a, 1998b, 2004c, 2005). Many researchers across disciplines have addressed the issue of culturally appropriate clinical intervention strategies (Adler, 1993; N. B. Anderson, 1992, Battle, 1993, Cheng, 1987, Langdon & Cheng, 1992). One of the first suggestions in most of these sources is that the service provider conduct a self-inventory of his or her cultural awareness and sensitivity. Resources for cultural competence awareness assessment may be obtained through ASHA and/or literature review. Recognizing that behavior may be influenced by culture allows supervisors to develop a better understanding of variations among people.

Generational Differences
The coexistence of multiple generations in the workforce presents unique challenges in supervision. Differences in values and expectations of one generation versus another can result in misinterpretations and misunderstandings during supervisor–supervisee interactions. McCready (2007) noted that various authors (Kersten, 2002; Lancaster & Stillman, 2002; and Raines, 2002, 2003) have mentioned that the disparities among generations today are deeper and more complex than in the past. According to Lancaster and Stillman (2002), there are four separate and distinct generations working together today: the Traditionalists (born between 1900 and 1945), the Baby Boomers (born 1946–1964), the Generation Xers (born 1965–1980), and the Millennials (1981–1999). People, places, events, and symbols not only define each of these generational cohorts but profoundly influence their values and expectations. Supervisors therefore need to be prepared to understand and accommodate attitudes and behaviors that may differ from their own.

McCready (2007) described ways in which supervisors across work settings can bridge the generation gap and facilitate improved communication. One suggestion is to form study groups to investigate the research in this area; the group could then present their findings to a larger group within the work setting (McCready, 2007). The supervisor can also engage in discussions about the generations represented in the work setting and how generational characteristics may and may not apply to specific individuals (McCready, 2007). Such discussion might include generational characteristics that can lead to miscommunication and misunderstandings in interactions with clients and supervisors.

Supervising Challenging Supervisees
Students who are admitted to graduate programs in communication sciences and disorders have successfully passed through a very competitive screening process using a variety of selection criteria such as Graduate Record Examination scores, undergraduate grade point averages, and letters of recommendation. Most of these students perform well in their academic courses and clinical assignments. However, most training programs periodically encounter students who present special challenges during the supervisory process (Shapiro et al., 2002) and are often referred to as “marginal” students. Dowling (1985, as cited in Dowling, 2001) described marginal students as individuals who “cannot work
independently, are unable to formulate goals and procedures, have basic gaps in conceptual understanding, and cannot follow through with suggestions” (p. 162). Given the impact on students, programs, clients, and the professions, working effectively with marginal students deserves serious and systematic consideration (Shapiro et al., 2002). These same issues may apply to supervisees of varying experience levels and in all practice settings.

One characteristic that is frequently reported about these challenging supervisees is their lack of ability to accurately evaluate their skill level (Kruger & Dunning, 1999, as cited in McCrea & Brasseur, 2003). Using the supervisory conference/meeting can be critically important in assisting them in evaluating their own performance (Dowling, 2001). During these meetings, supervisors need to give specific feedback based on data collected about the supervisee’s performance and provide concrete assistance in planning and strategy development (Dowling, 2001). Eventually, however, the supervisee must learn to engage in self-analysis and self-evaluation to develop an understanding of his or her own performance.

Summary
This document defines supervision and highlights key issues that reflect the complexity of providing exemplary supervision. Acquiring competency as a supervisor is essential to developing supervisory behaviors and activities that are critical to the training of professionals. Such supervisory training may not be provided as part of graduate education programs; therefore, SLPs must look to continuing education opportunities, peer learning and mentoring, and self-study using literature that focuses on the supervisory process (J. L. Anderson, 1988; Casey et al., 1988; Dowling, 2001; McCrea & Brasseur, 2003; Shapiro, 1994; Shapiro & Anderson, 1989). Although there may be opportunities to learn from other disciplines that also use supervisory practices, preparation in the supervisory process specific to speech-language pathology is critically important. McCrea and Brasseur (2003) and Dowling (2001) discussed ways in which preparation in the supervisory process can be implemented. The models discussed in these texts range from inclusion of information in early clinical management courses to doctoral level preparation. Training that is included as part of academic and clinical training of professionals and extended to supervisors at off-campus practicum sites will enhance the supervisors' effectiveness (Dowling, 1992; and Dowling, 1993, 1994, as cited in McCrea & Brasseur, 2003). ASHA’s Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision (ASHA, 2008b) delineates specific areas of competence deemed necessary to the provision of effective supervision.

Research Directions
Systematic study and investigation of the supervisory process is necessary to expand the evidence base from which increased knowledge about supervision and the supervisory process will emerge. Topics for further research may include the following:

- exploring different supervisory approaches that promote problem solving, self-analysis, and self-evaluation to develop clinical effectiveness;
- identifying essential components of training effective supervisors;
- examining the efficacy of supervisory training on supervisor/supervisee satisfaction and competence;
- identifying the basic behaviors/skills that supervisors should use in their interactions with supervisees that are essential to an effective working relationship;
- examining how supervisory style affects the development of clinical competence;
- examining different methods to develop more efficient models of supervision;
- examining supervisor behaviors that enhance supervisee growth (e.g., examining the process for negotiating and mutually agreeing on targets for change and measuring the impact that supervisor change has on the
supervisee’s professional growth) or training supervisors to use specific interpersonal skills (e.g., empathy, active listening) and then measuring how such skills enhance supervisee growth (McCrea & Brasseur, 2003);  
• examining the effectiveness and efficiency of technology in delivering supervision;  
• examining the impact of supervision on client outcomes;  
• examining supervisory approaches and communication styles with supervisees in consideration of gender, age, cultural, and linguistic diversity;  
• examining aspects of the supervisory process (i.e., understanding, planning, observing, analyzing, and integrating) and the relationship of each to the success of the supervisory experience (McCrea & Brasseur, 2003).

References


Knowledge and Skills Needed by Speech-Language Pathologists
Providing Clinical Supervision

American Speech-Language Hearing Association

Abstract
This knowledge and skills document is an official statement of the American Speech-Language-Hearing Association (ASHA). This knowledge and skills statement was developed by the Ad Hoc Committee on Supervision. Members of the committee were Lisa O'Connor (chair), Christine Baron, Thalia Coleman, Barbara Conrad, Wren Newman, Kathy Panther, and Janet E. Brown (ex officio). Brian B. Shulman, vice president for professional practices in speech-language pathology (2006–2008), served as the monitoring officer. This document was approved by the Board of Directors on March 12, 2008.

Knowledge and Skills
This document accompanies ASHA's policy documents Clinical Supervision in Speech-Language Pathology: Position Statement and Technical Report (ASHA, 2008a, 2008b). ASHA's position statement affirms that clinical supervision (also called clinical teaching or clinical education) is a distinct area of expertise and practice, and that it is critically important that individuals who engage in supervision obtain education in the supervisory process. The role of supervisor may include administrative responsibilities in some settings, and, should this be the case, the supervisor will have two major responsibilities: clinical teaching and program management tasks. However, the knowledge and skills addressed in this document are focused on the essential elements of being a clinical educator in any service delivery setting with students, clinical fellows, and professionals.

Professionals looking for guidance in supervising support personnel should refer to the ASHA position statement and knowledge and skills documents on that topic (ASHA, 2002, 2004a, 2004b).

ASHA's technical report on clinical supervision in speech-language pathology (2008b) cites Jean Anderson's (1988) definition of supervision:

Supervision is a process that consists of a variety of patterns of behavior, the appropriateness of which depends on the needs, competencies, expectations and philosophies of the supervisor and the supervisee and the specifics of the situation (tasks, client, setting and other variables). The goals of the supervisory process are the professional growth and development of the supervisee and the supervisor, which it is assumed will result ultimately in optimal service to clients. (p. 12)

The ASHA technical report (2008b) adds the following elements to the above definition:

Professional growth and development of the supervisee and the supervisor are enhanced when supervision or clinical teaching involves self-analysis and self-evaluation. Effective clinical teaching also promotes the use of critical thinking and problem-solving skills on the part of the individual being supervised. (p. 3)
This expanded definition was used as a basis for the following knowledge and skills statements.

**Developing Knowledge and Skills**

All certified SLPs have received supervision during their student practica and clinical fellowship; however, this by itself does not ensure competence as a supervisor. Furthermore, achieving clinical competence does not imply that one has the special skills required to be an effective supervisor. ASHA does not have specific requirements for coursework or credentials to serve as a supervisor; however, some states or settings may require coursework and/or years of experience to serve as a supervisor. Knowledge and skills may be developed in a variety of ways: participating in courses or workshops on supervision, engaging in self-study, participating in Division 11 (Administration and Supervision), and gaining mentored experiences under the guidance of an experienced clinical educator.

The following 11 items represent core areas of knowledge and skills. The supervisee is an essential partner in the supervisory process; however, these areas are presented from the perspective of knowledge and skills that should be acquired by the supervisor.

I. **Preparation for the Supervisory Experience**
   a. **Knowledge Required**
      i. Be familiar with the literature on supervision and the impact of supervisor behaviors on the growth and development of the supervisee.
      ii. 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.
      iii. Understand the value of different observation formats to benefit supervisee growth and development.
      iv. Understand the importance of implementing a supervisory style that corresponds to the knowledge and skill level of the supervisee.
      v. Understand the basic principles and dynamics of effective collaboration.
      vi. Be familiar with data collection methods and tools for analysis of clinical behaviors.
      vii. Understand types and uses of technology and their application in supervision.
   b. **Skills Required**
      i. 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.
      ii. Assist the supervisee in formulating goals for the clinical and supervisory processes, as needed.
      iii. Assess the supervisee's knowledge, skills, and prior experiences in relationship to the clients served.
      iv. Adapt or develop observational formats that facilitate objective data collection.
      v. 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.
      vi. Model effective collaboration and communication skills in interdisciplinary teams.
      vii. Be able to analyze the data collected to facilitate the supervisee’s clinical skill development and professional growth.
      viii. Use technology as appropriate to enhance communication effectiveness and efficiency in the supervisory process.

II. **Interpersonal Communication and the Supervisor-Supervisee Relationship**
   a. **Knowledge Required**
      i. Understand the basic principles and dynamics of effective interpersonal communication.
ii. Understand different learning styles and how to work most effectively with each style in the supervisory relationship.

iii. Understand how differences in age, gender, culture, social roles, and self-concept can present challenges to effective interpersonal communication.

iv. Understand the importance of effective listening skills. Understand differences in communication styles, including cultural/linguistic, generational, and gender differences, and how this may have an impact on the working relationship with the supervisee.

v. Be familiar with research on supervision in terms of developing supervisory relationships and in analyzing supervisor and supervisee behaviors.

vi. Understand key principles of conflict resolution.

b. Skills Required

i. Demonstrate the use of effective interpersonal skills.

ii. Facilitate the supervisee’s use of interpersonal communication skills that will maximize communication effectiveness.

iii. Recognize and accommodate differences in learning styles as part of the supervisory process.

iv. Recognize and be able to address the challenges to successful communication interactions (e.g., generational and/or gender differences and cultural/linguistic factors).

v. Recognize and accommodate differences in communication styles.

vi. Demonstrate behaviors that facilitate effective listening (e.g., silent listening, questioning, paraphrasing, empathizing, and supporting).

vii. Maintain a professional and supportive relationship that allows for both supervisee and supervisor growth.

viii. Apply research on supervision in developing supervisory relationships and in analyzing supervisor and supervisee behaviors.

ix. Conduct a supervisor self-assessment to identify strengths as well as areas that need improvement (e.g., interpersonal communication).

x. Use appropriate conflict resolution strategies.

III. Development of the Supervisee’s Critical Thinking and Problem-Solving Skills

a. Knowledge Required

i. Understand methods of collecting data to analyze the clinical and supervisory processes.

ii. Understand how data can be used to facilitate change in client, clinician, and/or supervisory behaviors.

iii. Understand how communication style influences the supervisee’s development of critical thinking and problem-solving skills.

iv. Understand the use of self-evaluation to promote supervisee growth.

b. Skills Required

i. Assist the supervisee in using a variety of data collection procedures.

ii. Assist the supervisee in objectively analyzing and interpreting the data obtained and in understanding how to use it for modification of intervention plans.

iii. Assist the supervisee in identifying salient patterns in either clinician or client behavior that facilitate or hinder learning.

iv. Use language that fosters independent thinking and assists the supervisee in recognizing and defining problems, and in developing solutions.

v. Assist the supervisee in determining whether the objectives for the client and/or the supervisory experience have been met.

IV. Development of the Supervisee’s Clinical Competence in Assessment

a. Knowledge Required

i. Understand and demonstrate best practices, including the application of current research in speech-language pathology, for assessing clients with specific communication and swallowing disorders.
ii. Understand principles and techniques for establishing an effective client–clinician relationship.
iii. Understand assessment tools and techniques specific to the clients served.
iv. Understand the principles of counseling when providing assessment results.
v. Understand and demonstrate alternative assessment procedures for linguistically diverse clients, including the use of interpreters and culture brokers.

b. Skills Required
   i. Facilitate the supervisee's use of best practices in assessment, including the application of current research to the assessment process.
   ii. Facilitate the supervisee's use of verbal and nonverbal behaviors to establish an effective client–clinician relationship.
   iii. Assist the supervisee in selecting and using assessment tools and techniques specific to the clients served.
   iv. Assist the supervisee in providing rationales for the selected procedures.
   v. Demonstrate how to integrate assessment findings and observations to diagnose and develop appropriate recommendations for intervention and/or management.
   vi. Provide instruction, modeling, and/or feedback in counseling clients and/or caregivers about assessment results and recommendations in a respectful and sensitive manner. Facilitate the supervisee's ability to use alternative assessment procedures for linguistically diverse clients.

V. Development of the Supervisee's Clinical Competence in Intervention
   a. Knowledge Required
      i. Understand best practices, including the application of current research in speech-language pathology, for developing a treatment plan for and providing intervention to clients with specific communication and swallowing disorders.
      ii. Be familiar with intervention materials, procedures, and techniques that are evidence based.
      iii. Be familiar with methods of data collection to analyze client behaviors and performance.
      iv. Understand the role of counseling in the therapeutic process.
      v. Know when and how to identify and use resources for intervention with linguistically diverse clients.
   b. Skills Required
      i. Assist the supervisee in developing and prioritizing appropriate treatment goals.
      ii. Facilitate the supervisee's consideration of evidence in selecting materials, procedures, and techniques, and in providing a rationale for their use.
      iii. Assist the supervisee in selecting and using a variety of clinical materials and techniques appropriate to the clients served, and in providing a rationale for their use.
      iv. Demonstrate the use of a variety of data collection procedures appropriate to the specific clinical situation.
      v. Assist the supervisee in analyzing the data collected in order to reformulate goals, treatment plans, procedures, and techniques.
      vi. Facilitate supervisee's effective use of counseling to promote and facilitate change in client and/or caregiver behavior.
      vii. Facilitate the supervisee's use of alternative intervention materials or techniques for linguistically diverse clients.

VI. Supervisory Conferences or Meetings of Clinical Teaching Teams
   a. Knowledge Required
      i. Understand the importance of scheduling regular supervisory conferences and/or team meetings.
      ii. Understand the use of supervisory conferences to address salient issues relevant to the professional growth of both the supervisor and the supervisee.
      iii. Understand the need to involve the supervisee in jointly establishing the conference agenda (e.g., purpose, content, timing, and rationale).
iv. Understand how to facilitate a joint discussion of clinical or supervisory issues.

v. Understand the characteristics of constructive feedback and the strategies for providing such feedback.

vi. Understand the importance of data collection and analysis for evaluating the effectiveness of conferences and/or team meetings.

vii. Demonstrate collaborative behaviors when functioning as part of a service delivery team.

b. **Skills Required**
   
i. Regularly schedule supervisory conferences and/or team meetings.

ii. Facilitate planning of supervisory conference agendas in collaboration with the supervisee.

iii. Select items for the conference based on saliency, accessibility of patterns for treatment, and the use of data that are appropriate for measuring the accomplishment of clinical and supervisory objectives.

iv. Use active listening as well as verbal and nonverbal response behaviors that facilitate the supervisee's active participation in the conference.

v. Ability to use the type of questions that stimulate thinking and promote problem solving by the supervisee.

vi. Provide feedback that is descriptive and objective rather than evaluative.

vii. Use data collection to analyze the extent to which the content and dynamics of the conference are facilitating goal achievement, desired outcomes, and planned changes.

viii. Assist the supervisee in collaborating and functioning effectively as a member of a service delivery team.

VII. **Evaluating the Growth of the Supervisee Both as a Clinician and as a Professional**

a. **Knowledge Required**
   
i. Recognize the significance of the supervisory role in clinical accountability to the clients served and to the growth of the supervisee.

ii. Understand the evaluation process as a collaborative activity and facilitate the involvement of the supervisee in this process.

iii. Understand the purposes and use of evaluation tools to measure the clinical and professional growth of the supervisee. Understand the differences between subjective and objective aspects of evaluation. Understand strategies that foster self-evaluation.

b. **Skills Required**
   
i. Use data collection methods that will assist in analyzing the relationship between client/supervisee behaviors and specific clinical outcomes.

ii. Identify and/or develop and appropriately use evaluation tools that measure the clinical and professional growth of the supervisee.

iii. Analyze data collected prior to formulating conclusions and evaluating the supervisee's clinical skills.

iv. Provide verbal and written feedback that is descriptive and objective in a timely manner.

v. Assist the supervisee in describing and measuring his or her own progress and achievement.

VIII. **Diversity (Ability, Race, Ethnicity, Gender, Age, Culture, Language, Class, Experience, and Education)**

a. **Knowledge Required**
   
i. Understand how differences (e.g., race, culture, gender, age) may influence learning and behavioral styles and how to adjust supervisory style to meet the supervisee's needs.

ii. Understand the role culture plays in the way individuals interact with those in positions of authority.

iii. Consider cross-cultural differences in determining appropriate feedback mechanisms and modes.

iv. Understand impact of assimilation and/or acculturation processes on a person's behavioral response style.
v. Understand impact of culture and language differences on clinician interactions with clients and/or family members.

b. Skills Required
   i. Create a learning and work environment that uses the strengths and expertise of all participants.
   ii. Demonstrate empathy and concern for others as evidenced by behaviors such as active listening, asking questions, and facilitating open and honest communication.
   iii. Apply culturally appropriate methods for providing feedback to supervisees.
   iv. Know when to consult someone who can serve as a cultural mediator or advisor concerning effective strategies for culturally appropriate interactions with individuals (clients and supervisees) from specific backgrounds.
   v. Demonstrate the effective use of interpreters, translators, and/or culture brokers as appropriate for clients from diverse backgrounds.

IX. The Development and Maintenance of Clinical and Supervisory Documentation
   a. Knowledge Required
      i. Understand the value of accurate and timely documentation.
      ii. Understand effective record-keeping systems and practices for clinically related interactions.
      iii. Understand current regulatory requirements for clinical documentation in different settings (e.g., health care, schools).
      iv. Be familiar with documentation formats used in different settings.
   b. Skills Required
      i. Facilitate the supervisee’s ability to complete clinical documentation accurately and effectively, and in compliance with accrediting and regulatory agencies and third party funding sources.
      ii. Assist the supervisee in sharing information collaboratively while adhering to requirements for confidentiality (e.g., HIPAA, FERPA).
      iii. Assist the supervisee in maintaining documentation regarding supervisory interactions (e.g., Clinical Fellowship requirements).

X. Ethical, Regulatory, and Legal Requirements
   a. Knowledge Required
      i. Understand current standards for student supervision (Council on Academic Accreditation in Audiology and Speech-Language Pathology, 2004)
      ii. Understand current standards for mentoring clinical fellows (Council for Clinical Certification in Audiology and Speech-Language Pathology, 2005).
      iii. Understand current ASHA Code of Ethics rules, particularly regarding supervision, competence, delegation, representation of credentials, and interprofessional and intraprofessional relationships.
      iv. Understand current state licensure board requirements for supervision.
      v. Understand state, national, and setting-specific requirements for confidentiality and privacy, billing, and documentation policies.
   b. Skills Required
      i. Adhere to all ASHA, state, and facility standards, regulations, and requirements for supervision.
      ii. Assist the supervisee in adhering to standards, regulations, and setting-specific requirements for documentation, billing, and protection of privacy and confidentiality.
      iii. Demonstrate ethical behaviors in both interprofessional and intraprofessional relationships.
      iv. Assist the supervisee in conforming with standards and regulations for professional conduct.
      v. Assist the supervisee in developing strategies to remain current with standards and regulations throughout their professional careers.

XI. Principles of Mentoring
   a. Knowledge Required
b. Skills Required

i. Model professional and personal behaviors necessary for maintenance and life-long development of professional competency.
ii. Foster a mutually trusting relationship with the supervisee.
iii. Communicate in a manner that provides support and encouragement.
iv. Provide professional growth opportunities to the supervisee.

References


The "Ethics Roundtable" grew out of the work of the Council on Professional Ethics (which subsequently merged with the Ethical Practice Board to form the Board of Ethics). The goal of the Ethics Roundtable is to respond to the ethics questions and educational needs of the members of ASHA. This column originally appeared in Asha magazine and later on the website.

The use of several commentaries on a case is intended to illustrate that there are many ways in which these issues can be approached. Readers may find that one opinion "rings true" for them, and as a professional that can be reassuring. However, this format may also give readers an opportunity to consider other perspectives and to ponder the beliefs and opinions which influence clinical practice.

Only the following selected case studies were chosen for inclusion in this issue of e-Hearsay. For additional case studies, go to http://www.asha.org/practice/ethics/roundtable/

When Student and Supervisor Disagree

Case Study:
Ms. Robertson, a 78-year-old is hospitalized after a hip fracture. A speech-language consultation is requested because her physician is concerned about her cognitive abilities. The evaluation is conducted by Scott, a student clinician. He observes mild cognitive deficits, but also notes that Ms. Robertson coughs immediately after taking sips of water and that she has a wet voice quality for several minutes after drinking. From the medical record, Scott notes that she had pneumonia on admission to the hospital and has been treated for pneumonia at least three times in the past nine months.

Scott discusses his observations with his supervisor. He recommends a "bedside" swallowing evaluation and possible videofluoroscopic swallow examination. His supervisor suggests that she coughs because she is recovering from pneumonia. Furthermore, they were consulted for a cognitive assessment, thus his observations about her swallowing are inappropriate to include in his report. Scott is concerned about the patient, but unsure of his role as a student and questions how to interpret his own observations.

Questions to Consider
- Does the Code of Ethics provide guidance in this case?
- What is the role of a student in advocating for patients and handling disagreements with a supervisor?
- What approaches could Scott take to continue the discussion with the supervisor?
Responses

1. **Julia Ferre' Shuler Assistant Professor/Clinical Supervisor** University of Redlands, Redlands, CA
   This situation is an example of the importance of a mediated learning experience between a supervisor and student. In the mediated learning experience the supervisor provides information and opportunities in which a student can gain independence in clinical decision making. This type of learning experience requires constant dialogue between the supervisor and student. These dialogues facilitate an interchange of information and opportunity for development of critical thinking skills. Dialogues benefit supervisors as much as students and can make clinical supervision a rewarding experience.
   In Scott’s situation, if he and his supervisor were involved in such a learning relationship, decision-making conversations could help both he and his supervisor with this clinical case. Unfortunately it appears that there is more of an authoritarian relationship, which precludes productive discussions. In a case such as this, the ASHA Code of Ethics could be used to help Scott initiate a discussion with his supervisor. The following is an example: Principle of Ethics I, B: Individuals shall use every resource, including referral when appropriate, to ensure that high-quality service is provided. A discussion could be initiated in regards to requesting follow-up referral of a bedside swallow evaluation for Ms. Robertson. The bedside swallow evaluation could then determine the necessity of the Modified Barium Swallow procedure.

   Scott should feel that he can advocate for Ms. Robertson, however, he is limited to what he can do independently as a student clinician (ASHA Code of Ethics: Principle of Ethics II; A&B). Scott would need to view this experience as a test of his interpersonal skills, challenging his ability to enter into a productive discussion with a superior for the sake of client advocacy. This type of discussion with his supervisor would benefit him in the future when engaging in similar conflict situations with colleagues in the professional setting. In making the assumption that Scott is at an externship clinical placement, if he has difficulty engaging his supervisor in a productive dialogue, he should contact his University for guidance.

   A discussion that could arise from a case such as Scott’s is if he is at an externship placement, it is his University’s responsibility to assure that his placement is a quality learning experience. His case then highlights the need for Universities to provide clinical supervision training for external practicum placements. With the ASHA requirement of completion of 300 supervised clinical hours in a minimum of three clinical practicum sites, Universities must send their students to quality externship experiences. This places the responsibility of training students on Speech-Language Pathologist professionals. Typically, Speech-Language Pathologist professionals have expansive technical training in regards to treatment of speech and language disorders, but have not had the opportunity for training in clinical supervision methods. Clinical Supervisors must be trained in methodology of student learning and teaching. It is a University’s responsibility to provide such training. This type of training will improve the richness of the clinical experience for the student, as well as the supervisor.

2. **Sara Gambs Clinical Fellow-Speech-Language Pathology**, Audiology/Speech Pathology Services Ann Arbor VA Health System. Ann Arbor, Michigan
   As a student in speech language pathology, Scott should be bound by the same code of ethics that guided his supervisor’s conduct, and his responsibility as a patient advocate and clinician is stated therein. The code instructs Scott to hold the welfare of the patient paramount, and states that "Individuals shall not provide professional services without exercising independent professional judgment..." Scott is therefore obligated to
pursue his concern about Ms. Robertson’s swallowing, despite the delicate nature of the student-supervisor relationship.

Unfortunately, ASHA’s code of ethics provides Scott little guidance as to how to resolve this conflict. It confers a profound responsibility upon him, that of Ms. Robertson’s welfare, but offers little instruction in how to approach his supervisor and ask her to reconsider her opinion. Scott’s best plan of action may be to re-open the issue as a teaching case. Scott could explain that he has not seen many swallowing cases, and that he was unable to distinguish between "getting over pneumonia" and aspiration. He could ask his supervisor how to discriminate between the two groups, and what criteria she uses to decide when a patient should be assessed for swallowing problems. During this discussion, Scott can bring out points specific to Ms. Robertson, and ask the supervisor to explain the differences between aspiration and this patient’s behavior. Presenting the topic in this manner is non-threatening and should not cause the supervisor to feel that she is being challenged. At the same time, the information that she provides may help clarify the situation. It is possible that Scott may learn something about the patient’s condition that leads him to understand the supervisor’s viewpoint. He may discover that there is a difference between this case and others that logically precludes a swallowing assessment for this patient. Another possible outcome is that the supervisor will provide an unsatisfactory response to Scott’s query, and he remains concerned that this issue is being managed improperly. In this case, it is difficult to press the issue much further. The student is in a uniquely precarious situation, and whether or not the conversation should continue will have to be determined by the student’s individual judgment.

Obviously, some supervisors are more approachable than others, and would not feel as though they were being contradicted by continued discussion. Others may interpret this persistence very negatively, which could impact their view of the student’s performance as a clinician or as part of a team. A logical next step might be for Scott to consult with his university. The clinic director or other advisor may be able to put the issue in perspective and help Scott recognize his responsibility. However, taking further action with the supervisor or other hospital personnel is ill advised. The bottom line in this scenario is that the student must approach the supervisor and ask for clarification about this situation. If the supervisor does not see the need for swallowing intervention after the discussion, then the student has little recourse.

3. Susan MacRae, RN Research and Development Associate The Picker Institute Boston, Massachusetts

The case of Ms. Robertson raises three important questions in my mind. The first is whether the case raises a clinical issue or an ethical issue. The second is the question of --at what point do students have the clinical skills necessary to independently advocate for certain treatments on a patient’s behalf? And thirdly is the question of how to manage professional disagreements.

As a general rule, it is essential that we ground our clinical work in the best medical outcomes research that is available. Our goal should be to estimate the probability of occurrences for all outcomes that matter to the patient, taking into consideration in as great a detail as possible, both the patient preferences as well as the patients’ medical situation e.g., age, sex and severity of illness. Only recently, are we starting to recognize the importance of such data and information to support better treatment decisions. If we have clear medical evidence for a treatment decision and it coincides with a patient’s values, rarely do conflicts seem to emerge. And if they do, it is often between the professional preferences based on the medical evidence, and the patient values. But that is not the case here. Much more often, conflict seems to emerge in cases where the science is unclear and for a number of reasons, the patient is unable to contribute any preferences. This may leave us in a
situation very similar to the one we have with Ms. R, where two clinicians disagree about what is "best" for her. How can decisions be made in this case?

There are no clear rules about whose opinion should take precedence in cases where there is no definitive guidance from science or from the patient (which I take to be the case here). But it is surely the case that this becomes further complicated in cases involving students and their supervisors. Students are not blank tablets. There is literature that suggests that beginning nursing students think critically and act ethically during their first clinical nursing course. The same is surely true across professions. But it is also the case that beginning students are early on in their journey. When each student has the skills necessary to independently advocate for a certain treatment on a patient's behalf is unique to the student.

But what if a student disagrees with their supervisor? Students will disagree with their supervisors and their peers throughout their careers. Hopefully some of that will be minimized by relying more on outcomes data and patient preferences but there will always be this dilemma. I think in cases where a student has evidence (either data or patient preferences information) to suggest a different treatment plan, other than the one that is being proposed, I believe that student has an obligation to do his/her best to advocate for that patient. Ideally this would be done by approaching the supervisor directly with the evidence in hand. In other cases, it may be necessary to invite another perspective, from another clinician or an ethics committee for example.

In many other cases however, what is "right" is unknown. This may be because for example, there is a fundamental difference of opinion about goals (e.g., length of life vs. quality of life), or a difference of opinion about limits of professional responsibility (e.g., should these clinicians be making recommendations about Ms. R's swallowing disorder?), or a difference regarding a clinicians understanding of community's health versus individuals health. In cases such as these, it is often difficult to come up with one "right" answer. In these circumstances, often the best thing a student can do is seek support from others who understand the complexity inherent in the clinical environment, and seek opportunities to hear other perspectives on complex issues. One approach I have seen very useful in dealing with these issues is the use of an informal student discussion group. If students from a variety of perspectives and levels of experience can be brought together in a non-threatening environment, the students seem to learn to embrace these multiple perspectives through a process of growth, as they simultaneously learn to identify more clearly with their own voice.


When a Student Fails to Make the Grade

Case Study
Sarah is a graduate student clinician in speech-language pathology, assigned to an off-site placement in an acute care rehabilitation setting. She expects to complete her graduate program at the end of the current term and has accepted a CF position in a rehabilitation program. Throughout the 5-day/week, 10-week placement, Sarah has had a number of problems. Her on-site supervisor observes that Sarah is often late for appointments, fails to complete paperwork, shows poor documentation skills, has difficulty relating to patients and families, and struggles to make clinical decisions and to master clinical assessment tools. During conferences the supervisor has given Sarah constructive suggestions and they
have agreed on specific goals, such as being on-time for all clients, completing daily paperwork before leaving the facility, and preparing for sessions ahead of time.

Over the past few weeks, Sarah has shown some improvement but continues to need direction to select therapy materials, to set daily goals for patients she has been managing for several weeks, and to administer familiar assessment tools accurately.

The supervisor consults with the university practicum coordinator to outline her concerns. The university coordinator notes that Sarah's performance has been uneven throughout her enrollment in the program and that other supervisors have expressed similar concerns. The university coordinator points out that Sarah is scheduled to graduate this term and that a less-than-satisfactory grade could create problems.

Questions to Consider

- What is the appropriate action for the off-site supervisor?
- What is the appropriate action for the university coordinator?
- What guidance is available from ASHA's Code of Ethics?
- What are the implications of passing or failing Sarah? What options are available to the off-site supervisor? The university coordinator? To the student?

Responses

1. Ken Bleile Ph.D. CCC-SLP Associate Professor and Head Department of Communicative Disorders University of Northern Iowa

   Thankfully, cases such as Sarah's do not occur frequently. Unfortunately, what such cases lack in frequency they more than make up in intensity and potential for divisiveness. Most often, the off-site supervisor comes away muttering about why he or she should provide supervision when the university does not appear to value the report. As in the case of Sarah, the fact that others have noticed similar problems may further convince the off-site supervisor of the accuracy of his or her observations. The university practicum coordinator, on the other hand, may grumble that the off-site supervisor does not fully understand the importance of graduating students in a timely manner.

   Which position represents the best ethical standard-- that of the off-site supervisor or that of the practicum coordinator? I believe the off-site supervisor comes closest to the ethical standards set forth in our profession's Code of Ethics. The off-site supervisor is concerned about Sarah's lack of clinical abilities, while the practicum coordinator's major concern seems with the student. Students are a mechanism through which faculty in universities provide service to the community. Hard as it sometimes is for those of us in universities to remember, a student's well-being cannot be paramount in all situations.

   It seems to me that the responsibility of the off-site supervisor is to speak with Sarah and the practicum coordinator, explain her concerns, listen to feedback, and then give Sarah the evaluation and grade that most accurately reflects her performance. Sarah has an opportunity to appeal the grade. Determination of a final grade is likely to lie with the university, the organization in which Sarah is enrolled as a student. If the off-site supervisor disagrees with the final grade given to Sarah, she may wish to write a letter of concern to the practicum coordinator, sending copies to the department's Clinic Director and its Department Head.
2. Sandra R. Ulrich M.A., CCC-SLP TFG, Inc., Gales Ferry, Connecticut Former Director (Retired), Speech and Hearing Clinic The University of Connecticut, Storrs, CT

Sarah, the site supervisor, and the university coordinator face a number of questions and challenges. Fortunately, the Code of Ethics, Principle I, provides explicit guidance: "Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally" (ASHA, 1994). Although ASHA does not apply the Code to individuals who have not yet applied for membership and/or certification, universities must provide opportunity for students to learn about the Code and most require that practicum students ascribe to the Code.

Sarah's performance can be considered from three perspectives:

1. For the on-site supervisor, the patients, and the facility, any student should be allowed to proceed with client management only when able to do so at a pre-determined and operationally defined level of competence. Clock hours are earned for satisfactory completion of clinical activity; the supervisor's signature on clock hours indicates her judgment that the hours shown represent satisfactory performance. The supervisor should be able to show that she has provided specific, direct feedback to this student throughout the 10-week placement, with opportunity and support for making necessary changes. She also must show that she has kept the university coordinator informed about the nature of Sarah's difficulties.

2. For the campus coordinator, Sarah's performance indicates that she should not earn clock hours or a satisfactory grade. As presented, the situation suggests that it is unlikely that she will be eligible to graduate this term. The program should be able to demonstrate that it maintained systematic and periodic contact with the off-campus facility, and with Sarah, regarding her performance. Steps taken to assist the facility and the student in modifying her clinical behaviors should be documented. The university's policy regarding unsatisfactory clinical activity should be reviewed with Sarah, the site supervisor, and others as appropriate (e.g., the academic advisor).

3. For Sarah, serious questions are raised about her basic sense of clinical responsibility and about her skills of self-analysis, problem-solving, and self-direction. Her difficulties in selecting materials, setting goals, and accurately administering routine assessment instruments indicate that her knowledge and clinical skills are not yet adequate for entry-level practice as a speech-language pathologist. Meeting clients on time, completing paperwork, and establishing appropriate relationships with clients and their families are competencies expected of students and professionals at all levels. It is particularly troubling that these areas have been problematic "throughout" the placement, and even more so that Sarah apparently has failed to engage in the kind of self-analysis that could lead to problem-solving.

Although action must be taken, some information that is critical to appropriate resolution of the situation is, unfortunately, not available. Specifically, what were the expectations of the facility, the supervisor, the university, and Sarah for this assignment? Does Sarah agree with the supervisor's evaluation? Are there external reasons contributing to her difficulties (e.g., illness, other responsibilities)? What analysis of her own performance has Sarah provided? What data has she collected relative to her work with clients and her general professional behavior? What plans did she present for modifying her performance? What were the objectives, the procedures to achieve them, the plans for their measurement, and the criteria for their evaluation? Has at least one other supervisor observed Sarah's sessions and reviewed her written work?
Available options: Any options at this point in time will depend on the university's policy and on Sarah's history. For example, does the university allow students to repeat unsatisfactory clinical assignments? Has Sarah already had a "second" chance? What will be necessary in another setting to assure Sarah’s progress? How will Sarah be accountable for change?

At least three options exist:

1. Jointly develop and implement an action plan for additional practicum, with objectives, procedures, time lines, criteria, and so on. The plan must be precise in its operational definitions, and all parties must agree that there is a reasonable expectation of positive change.
2. Alter the practicum to a job-shadowing experience for a certain time period, with gradual introduction of clinical responsibilities. Again, objectives for the job-shadowing should be precise, and Sarah should be expected to participate with her supervisor in jointly writing chart notes, discussing patient plans and procedures, assisting in preparation of documentation, and so on.
3. Dismiss the student from the program on the basis of failure to complete an expected component of the curriculum satisfactorily.

The first two options may be implemented in the current site or in a different site that provides a similar population and experiences. With the permission of her program, Sarah may find it helpful to take some time for reflection before resuming additional practicum.

Better strategies for managing a student's observed problems in practicum can be employed if difficulties are identified earlier in the placement. This would allow joint efforts by the student, the on-site supervisor, and the university coordinator to develop better description of the situation to explore reasons for the difficulty, and to design problem-solving action. For example, can Sarah function satisfactorily if she is responsible for a smaller number of patients or a different type of patient (disorder area, age, severity, complexity)? Will a different amount or type of supervision make a difference? Are there external reasons for her behavior (e.g., illness, financial problems)? Is Sarah familiar with the philosophy of care and with the general procedures of the facility (i.e., parking, security, charting, available resources)?

The answers to these and other questions can determine possible action, which may include a better statement of the expectations, job shadowing, observation of other clinicians, co-treatment and co-assessment, reduced number or type of patients, a leave of absence to resolve external problems, and so on. Regarding Sarah's problems in administering assessment tools, there should be a clear plan regarding what tools she is expected to manage skillfully. She should help to develop procedures for attaining and demonstrating skill with those tools, including resources, time lines, and a functional statement of what constitutes "appropriate" administration (e.g., amount of time, completeness, accurate directions, accurate scoring).

Additional Issues to Consider
Sharing information with the off-campus supervisor about Sarah's past difficulties is helpful only if it assists in understanding the current situation or in knowing strategies that are useful in working with Sarah to modify her behavior. A better strategy would be for Sarah to discuss her strengths and her needs with the off-campus supervisor, including those objectives she has selected for her own growth in the current placement, supervisory strategies that she finds helpful, and her concerns for the affiliation.
Similarly, if the site could provide Sarah with information regarding tasks and tools she will be expected to know and use within the first two weeks of the affiliation, she could begin preparing in advance of the assignment. Examples of charting, reports, and other expected documentation could also be provided in advance. Some negotiation of expectations and discussion of realistic constraints may be necessary and typically should include the university coordinator.

A mutual understanding of expectations and needs, and careful planning for the experience often can avoid the sad and non-productive circumstances described in Sarah's story.

3. Marcy Rosenbaum Ph.D. Assistant Professor, Department of Family Medicine and Office of Consultation and Research in Medical Education University of Iowa College of Medicine Iowa City, Iowa

The case of a student who is due for graduation and displays less than satisfactory clinical and/or professional behavior during clinical rotations is not a new one in clinical educational settings. Recently, we faced a very similar situation with a fourth year medical student. I queried many colleagues for advice on how to approach this issue and most suggested that some form of remediation would be most appropriate and was commonly used. In our case, we required that the student participate in intensive remediation focused specifically on her weak areas during a one-month rotation. Her graduation was made contingent upon successful completion of this program. This effort was labor intensive and tailored specifically for the student. Other institutions have well-established structured remediation programs for just this sort of situation. These remediation efforts give the message to students that clinical weaknesses are not to be taken lightly and may significantly delay graduation or require a change in the student's life circumstances.

This case points to much more critical issues regarding the ability of evaluation systems to catch and correct student behaviors and weaknesses of application before it is almost too late to take any action. The rigor of evaluation is especially important when students receive much of their training in clinical sites. If clinical and professional skills are important areas to master as part of the training program, these aspects of clinical practice need to be given as much importance as other issues in the evaluation system.

If the university coordinator noted others also having had problems with Sarah, what actions were taken to correct these problems earlier? It is the responsibility of the university coordinator to make sure both student and preceptor know what is expected of students and the recourse available if students do not meet these expectations. If Sarah was able to "pass" previous rotations in which she had problems, she has no reason to believe this current rotation should be any different. Thus during each of Sarah's previous rotation expectations should have been laid out clearly and enforced through the provision of a non-passing grade or the recommendation for remediation.

This case also raises questions about the reasons for Sarah's inconsistent behaviors and her seeming inability to reproduce the basic skills required of her. Certainly further explanation for the causes of these behaviors is warranted. I think our first reaction is that Sarah has not applied herself and does not care about such things as time or professionalism. A second reaction could be that she "just doesn't get it", perhaps Sarah is "not too bright." However, behaviors such as these can be red flags that point to more complex explanations for these behaviors. Mark Quirk, Assistant Dean for Academic Achievement at University of Massachusetts Medical Center, might argue that Sarah may have a learning disability that explains her performance difficulties. He
writes eloquently about his experiences in discovering learning disabilities as being at the root of many "difficult student" encounters in his 1994 book, "How to Learn and Teach in Medical School." Or perhaps Sarah has an unstable home environment that contributes to her tardiness and seeming lack of attentiveness during her work.

In sum, this case raises several issues and suggests several potential actions. First, the potential causes of Sarah's behavior should be thoroughly explored. Second, both supervisor and university coordinator should make sure that behavioral expectations are clear to students, as well as the consequences of not meeting those expectations. Finally, institutions should have remediation opportunities available to students so they can learn to correct their behaviors and proudly go out into the world as new professionals, in a timely manner.


When Supervisor and Supervisee Disagree
Case Submitted by Crystal S. Cooper

Case Study
David is a bright eight-year old student enrolled in third grade in a public school. He has received classroom-based speech-language services for a severe phonological disorder and mild-moderate disfluencies since kindergarten. His phonological disorder has improved significantly, however, his disfluencies have increased. During the past three months, David has refused to answer questions in class, and on one occasion burst into tears while presenting an oral report in front of his class.

David told his speech-language pathologist, Ms. McCoy that he is embarrassed by his stuttering and that some of his classmates laugh and tease him about his speech. David is re-evaluated to determine his continued eligibility for services.

Ms. McCoy recommends continued speech therapy with classroom intervention and adds a direct pull-out component to therapy in order to address the affective and cognitive components of his stuttering syndrome. David, she believes, would be embarrassed by discussing his feelings if his classmates were present.

Ms. McCoy sends her report to her supervisor, who distributes the report to the Eligibility Team. At the eligibility meeting, Ms. McCoy notices that her recommendation for pull-out therapy has been omitted. When she raises her recommendation, her supervisor replies "in an ideal world" the recommendation would be accepted, but the school system has determined that pull-out therapy is not cost-effective and is not an option given the current financial climate. Ms. McCoy is gently reminded that she is up for tenure review this year.

At the Individualized Education Program (IEP) meeting, David's parents express concern about his worsening stuttering and its effect on his academic and social skills. The supervisor takes the lead during the meeting and does not inform the parents that there are other service delivery options. Ms. McCoy signs the IEP, which includes in-class intervention only. When asked about the case, she replies, "I did my job by informing my supervisor of my recommendations."
1. **Barbara Moore-Brown** Director, Pupil Services Murrieta Valley Unified School District Murrieta, CA

There are several troubling issues in this scenario. A few of them are as follows:

(1) Decisions about goals and objectives, services, and where services will occur are a function of the Individualized Education Plan (IEP) team. If the eligibility team tells Ms. McCoy that she cannot serve a student in the manner in which she recommends could be construed as pre-determination, which is a violation of the law.

(2) Failure to inform the parents of their right to due process is also a violation of the law, particular attention is given to notice requirements under the newly adopted Individuals with Disabilities Education Act (IDEA).

(3) The team of teachers, clinicians, and parents are required to design an IEP that will "confer educational benefit." If the IEP team does not do so they may increase the likelihood that the parents would win a due process hearing and would be held responsible for private therapy that the parents obtain.

(4) The threat to Ms. McCoy's job is a violation of federal law.

Having identified these issues, what should Ms. McCoy do? First, she should be aware that informing her supervisor that she recommends more therapy does not "get her off the hook." Courts are now finding damages against educators who do not fulfill their responsibilities to special education students. I would recommend that Ms. McCoy consider the following options:

(1) Recommend a compromise. Often people are willing to try something in the short term, but hesitate to commit to a year long program. Perhaps the team would agree to a trial pull-out therapy for four weeks along with the implementation of a home program. The team could meet again and evaluate his progress in therapy, at home, and in the classroom and determine how best to proceed.

(2) Ms. McCoy could revisit her schedule and see if she can find some way to provide the services to David without reducing services to other students.

(3) She could schedule a meeting with her supervisor to discuss the therapeutic and educational justification for her recommendations. If she feels uncomfortable, she could invite another staff member, perhaps David's classroom teacher, to join her.

(4) Ms. McCoy could write a dissent to the IEP and indicate the services she recommends and why.

(5) Ms. McCoy also has some personnel options to exercise because it appears that her job is being threatened.

Each of these options present a challenge to the therapist, but this is a difficult situation. It is clear that not providing appropriate services to a student with an IEP is a serious situation. Ms. McCoy must evaluate the best way to serve David, keep his parents informed, reach an understanding with her supervisor, and thereby avoid breaking the law.

2. **Monica L. Ferguson** Speech-Language Pathologist Fairbanks Northstar Borough School District Fairbanks, Alaska

The supervisor has placed the speech-language pathologist (SLP) in the difficult position of choosing between legal and ethical responsibility to the child and job security. The SLP has an obligation to provide competent
services; therefore, this is more of a legal than an ethical dilemma. The dilemma faced by this SLP is how to address the blatant abuse of supervisory power.

In this case the student is not making progress on IEP goals delivered in the general classroom which address his stuttering syndrome. The recommendation has been made for pull-out therapy to facilitate progress.

When a student is not making progress on IEP goals and objectives, the multidisciplinary team (parents, teachers, specialists, administrators) must review the IEP for necessary modifications, and then determine if the placement is appropriate to facilitate reasonable progress (IDEA, P.L. 105-17, 1997). It is the legal responsibility of the SLP to recommend changes in student placement, if necessary, to facilitate such progress on IEP goals and objectives. It is the ethical responsibility of the SLP to not misrepresent services delivered by making untrue statements or by failing to state important information that should be considered (ASHA Code of Ethics, 1994). The SLP must, therefore, discuss all relevant information and recommendations with the parents and others present at the IEP meeting.

Although the SLP cannot be fired for acting in the best interests of the student, we all know that one's work situation can be made extremely difficult by a disgruntled supervisor. Despite the complexity of the problem, the SLP has an ethical and legal obligation to act on behalf of the child. In this situation, the SLP has failed to disclose important information to the parents that David requires a more restrictive placement with pull-out therapy in order to achieve progress with fluency goals.

There are legal and professional protections available for the school-based SLP. However, it is advisable in this situation to first address the problem in a straightforward and professional manner with the supervisor.

Ideally, Ms. McCoy should have informed her supervisor prior to the IEP meeting of her legal and ethical responsibility and intentions of reviewing the complete findings of the evaluation and the recommendation for pull-out therapy. Recommendations can then be discussed for an alternative service delivery model which will meet the needs of the child without increasing staffing or district expense. With this alternative model, the general education teacher and SLP share the responsibility for delivering the IEP goals in the general education classroom, thus enabling the SLP to conduct separate pull-out therapy sessions. For example, if the IEP is written for speech-language services 3 times per week, the SLP could provide direct services in a collaborative model with the general education teacher once weekly, and provide consultative services for the additional 2 times per week. The SLP could then conduct pull-out therapy 2 times per week until such time that pull-out therapy is no longer required.

The dilemma faced by the SLP is a difficult one; however, protections are in place if the situation is not resolved by a straightforward communication of the school district’s obligation to the child and the discussion of alternative possibilities for service delivery.

Continuing Education Questions

Directions: Choose the best answer for each question as you read each article. Then log in at http://www.ohioslha.org/membersonly/index.asp to answer the assessment questions. Follow the online directions to earn free ASHA continuing education units (CEUs), while the opportunity is available. Question numbering does begin with 12 due to demographic information required in Survey Monkey.

Using Reflective Practice in Supervision/Mentoring

12. Which is NOT a Reflective Practice (RP) skill?
   a. Entering the realm of feelings
   b. Always providing the right answers
   c. Hearing others’ pain without offering solutions
   d. Using more questions than comments

13. Which is a method of RP?
   a. Group conferencing
   b. Requiring the mentee to self-critique a recording of the therapy session
   c. Journal Writing
   d. All of the Above

14. Integration of RP & Traditional Supervision (TS) allows:
   a. The mentee to engage in problem-solving to make changes, in a safe environment that is geared toward independent professional growth
   b. The supervisor to assume the role as “The Expert”
   c. The supervisor and mentee to hide their vulnerabilities in relation to the case
   d. The mentee to collaborate only for external & observable behaviors

15. Which is true about Transference?
   a. It is mostly a conscious process
   b. It can cause the mentee to have strong feelings of needing to please the supervisor
   c. It is always accompanied by counter-transference
   d. It cannot be analyzed through self-reflective questioning

Conflict Resolution: A Necessary Tool for Supervision

16. The statement “conflict is something I will not tolerate” is an example of which definition of conflict:
   a. Integrated definition
   b. Feminist definition
   c. Unitarian definition
   d. Masculine definition

17. The term that defines the conflict resolution style that should be described as a mini-win and mini-lose with negotiated goals and relationships is:
   a. Controlling Style
   b. Compromising Style
   c. Accommodating Style
   d. Avoidance Style
18. A judicious means to reach consensus between those individuals involved in conflict is called:
   a. An argument
   b. Conflict management
   c. A disagreement
   d. Conflict resolution

19. A supervisor using active listening to recognize and respond to the issues that matter to the supervisee is using:
   a. A healthy response to conflict
   b. A neutral response to conflict
   c. A passive-aggressive response to conflict
   d. An unhealthy response to conflict

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Relativity applies to Physics, not Ethics:

20. The three basic principles of the Belmont Report are:
   a. Respect, Equality and Beneficence
   b. Beneficence, Justice and Right to Expression
   c. Respect, Beneficence, and Justice
   d. None of the above options

21. Research misconduct involves the following:
   a. Fabrication, falsification, and plagiarism
   b. Human subject protection and coercion
   c. Plagiarism
   d. Fabrication or falsification of data

22. A form of courtesy or honorary authorship to a person in authority, although their critical intellectual contribution to the publication is minimal or negligible is called:
   a. Ghost authorship
   b. Authorship by authority
   c. Both a and b
   d. None of the above options

23. One of the main duties of the Institutional Research Board is:
   a. To ensure that all research carried out at the institution is published
   b. To train student researchers
   c. To collaborate with the IRB at other institutions to promote large, multi-center research projects
   d. To prospectively review research proposals and ensure the protection of human subjects prior to, during and after the duration of the study

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Hot Topics in Ethics:

24. Ethics can be defined as:
   a. Moral Principles
   b. Rules of Conduct
   c. Values Relating to Human Conduct
   d. All of the above
25. A professional organization that may be a resource when seeking information on ethics in the practice of Speech-Language Pathology and Audiology is:
   a. The American Medical Association
   b. The American Occupational Therapy Association
   c. The American Speech-Language Hearing Association
   d. All of the above

26. In the State of Ohio, a code of ethics concerning the practice of Speech Pathology and Audiology can be found in:
   a. Ohio Daily Legal News
   b. Ohio Administrative Code Section 4753-09-01
   c. The Federal Register
   d. The ASHA Leader

27. The ASHA Code of Ethics consists of:
   a. Several Chapters
   b. Professional Policies and Procedures
   c. A Preamble, Four Principles and Numerous Rules
   d. Laws and Regulations

Parenting: The Front Line of Bullying Prevention

28. Socioecological models were created to assist with:
   a. An understanding that development is immune to external factors
   b. An understanding of the manner in which various personal and contextual factors are interrelated and influence behaviors
   c. Explaining only the personal factors that influence one’s development
   d. An understanding that one need not take into account one’s entire socioecological system in effort to understand development

29. According to Rose, Monda-Amaya, and Espelage (2011), at greater risk of victimization are those students who:
   a. Come from homes in which parents use an authoritative approach to parenting
   b. Come from homes in which parents use a permissive approach to parenting
   c. Receive services for special needs
   d. Are home-schooled

30. Though research specifically examining bullying in the deaf/hard-of-hearing community is rare, Bauman and Pero (2010) suggest:
   a. Bullying occurs with less frequency among the deaf/hard-of-hearing community
   b. Bullies do not target children with observable disabilities
   c. More frequent victimization is reported among the deaf/hard-of-hearing community compared to those with hearing in the typical range
   d. None of the above

31. The two parenting styles linked to children being perpetrators of bullying behaviors are:
   a. Authoritative and authoritarian
   b. Authoritative and permissive
   c. Authoritarian and permissive
   d. Uninvolved and authoritative
Orofacial Myology – Sharing a Confined Space

32. ASHA’s position on Orofacial Myology
   a. Is provided by any SLP, dental hygienists, dentist or doctor
   b. Is necessary for most sound disorders
   c. Is rejected by swallowing specialists
   d. Requires specialized training and research

33. Orofacial myology is
   a. Not traditional speech therapy
   b. Oral motor exercises
   c. The same as “Tongue Thrust”
   d. A form of dental treatment

34. The IAOM has members from 17 countries. How many members have completed the advanced training?
   a. 17
   b. 250
   c. 193
   d. None

35. Basic treatment for an Orofacial Myology Disorder starts with
   a. Establishing lip closure and tongue positioning
   b. Auditory discrimination exercises
   c. Muscle repatterning
   d. Education to establish motivation and commitment

What’s on Your Side of the Mirror?

36. What would be a characteristic of emotional balance in a supervisor?
   a. Clear, rational thinking
   b. Well-regulated emotions
   c. Ability to focus on the needs of the student without distraction from personal concerns
   d. All of the above would signal emotional balance in a supervisor

37. What is reflective practice?
   a. A strategy of mirroring thoughts and feelings to convey empathy
   b. A process of self-examination and exploration of one’s thoughts and feelings in response to life experiences
   c. A process designed to develop theory of mind
   d. A form of psychotherapy that has been adapted to speech-language pathology

38. How can reflective writing benefit a supervisor?
   a. Suppress emotions and thoughts that are unsuitable for clinical work
   b. Improve speed and accuracy of professional writing
   c. Increase awareness of internal reactions that might get in the way of effective relationships
   d. None of the above

39. What is the purpose of anticipatory reflection?
   a. Restore emotional balance after a triggering event
   b. Control emotions at the time of a stressful interaction
   c. Create a plan to implement reflective practice into work life
   d. Identify and understand potential triggers before an event
**Facilitating Clinical Success for Students with Accents**

40. The strength of a student’s accent
   a. Has no relationship to their speech intelligibility
   b. Clearly determines level of their speech intelligibility
   c. Is one factor in determining level of their speech intelligibility
   d. None of the above

41. According to ASHA’s 1998 position statement on accents
   a. Non-speech options are appropriate to use as models to meet client needs
   b. Non-speech options are inappropriate to use as models to meet client needs
   c. An accented student may use non-speech options only if he/she can model target sounds 50% of the time
   d. If non-speech options are required the student should be excluded from working with the client

42. Clinical supervisors should alert the clinical program director of any concerns regarding the student’s accent
   a. At the time of the student’s midterm evaluation
   b. As soon as the supervisor observes concerns that influence client performance
   c. Only in a written statement to the clinic director at the end of the student’s clinical practicum
   d. When the clinic director visits the student at the external site to observe and discuss how the student is performing in the clinical practicum

43. Which of the following strategies might the clinical supervisor consider when placing a student with an accent with an appropriate client? The supervisor should
   a. Consider a client likely to or motivated to adapt to the student’s speech
   b. Teach the student strategies to support client comprehension (e.g., repeat, rephrase, etc.)
   c. Select clients that best suit the student’s strengths and skills
   d. All of the above

**Supervision: Issues Related to Race and Culture**

44. An example of a microaggression would be:
   a. Put down
   b. Compliment
   c. Praise
   d. Overt racial slur

45. Supervisors who discuss racial issues with their supervisees are viewed:
   a. Negatively
   b. Positively
   c. With concern
   d. Adversely

46. Colorblind according to this article means:
   a. That everyone is not equal and there are racial differences
   b. Race is an issue in today’s society
   c. Culture is an issue in today’s society
   d. That everyone is equal and there are no racial differences

47. Which is not a strategy in developing racial and cultural competence:
   a. Tell stories about your culture
   b. Use analogies to highlight culture and race
   c. Develop color blindness
   d. Develop a relationship built on honesty and openness
Guidelines for Submission to eHearsay

eHEARSAY, the electronic journal of the Ohio Speech-Language Hearing Association, is designed to address the professional development needs of the members of the state association.


Types of Manuscripts

Contributed manuscripts may take any of the following forms:

- **Research Article**: Full-length articles presenting important new research results. Research articles include an abstract, introduction, methods and results sections, discussion, and relevant citations. These are typically limited to 40 manuscript pages including citations, tables, and figures. Large data sets and other supplementary materials are welcome for inclusion in the online publication.

- **Review**: A comprehensive overview of an area of speech, language, or hearing sciences and/or disorders (i.e., systematic review or meta-analysis). Reviews should be accessible to knowledgeable readers not expert in the subject area. They should be prepared with the same rigor as a research article reporting specific results. These are typically limited to 40 manuscript pages including citations, tables, and figures.

- **Tutorial**: Educational expositions covering recent literature on topics of interest to clinicians and other scholars. These are typically limited to 40 manuscript pages including citations, tables, and figures.

- **Research Forum**: The purpose of a research forum (RF) is to provide a concentrated focus on a special topic deemed to be of high interest to the readership. An RF contains a series of empirical studies centering on a key aspect of speech, language, hearing, or swallowing science and/or disorders. RFs may also comprise a set of scholarly papers presented at a scientific conference.
  - A proposal for an RF must be approved for consideration by the journal editor prior to forum development. Pre-approval by an editor does not guarantee that any or all manuscripts submitted will be accepted for publication. The proposal should (1) provide a forum summary, (2) outline the probable manuscript titles and author lists, (3) state whether a prologue and/or epilogue is planned, and (4) designate one person, a forum coordinator, as the point of contact and coordinator of communications with forum authors.

- **Letter to the Editor**: Opinions about material previously published in the journal or views on topics of current relevance. A letter relating to work published in the journal will ordinarily be referred to the author(s) of the original item for a response, which may be published along with the letter. Letters are typically limited to 15 manuscript pages, including citations, tables, and figures.

- **Clinical Focus**: Articles that may be of primary clinical interest but may not have a traditional research format. Case studies, descriptions of clinical programs, and innovative clinical services and activities are among the possibilities.

- **Viewpoint**: Scholarly based opinion(s) on an issue of clinical relevance that currently may be neglected, controversial, related to future legislation, or could serve to update the readership on current thinking in an area.
**Manuscript Style and Requirements**

**Style Manual**
Authors are expected to follow the style specified in the Publication Manual of the American Psychological Association (6th edition).

**Language Policies**
OSLHA policy requires the use of nonsexist and person-first language in preparing manuscripts.

**Page Limit**
A guideline of 40 pages (including title page, abstract, text, acknowledgments, references, appendices, tables, and figures) is suggested as an upper limit for manuscript length. Longer manuscripts, particularly for critical reviews and extended data-based reports, will not be excluded from review, but the author(s) should be prepared to justify the length of the manuscript if requested to do so.

**Peer Review**
All manuscripts are peer reviewed, typically by at least two reviewers with relevant expertise, an issue editor (if applicable), and the journal editor. Correspondence between authors and editors is expected to be professional in tone. If correspondence is not conducted in a professional manner, an editor has the option to bring the matter before the OSLHA Directory of Technology and Publications and/or OSLHA’s Executive Council. After consultation with the Directory of Technology and Publications, the editor may terminate the peer review process for that submission. The author has the right to appeal to the OSLHA Directory of Technology and Publications and/or OSLHA’s Executive Council.

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During manuscript submission, answers to a number of disclosures will be required. The corresponding author:
- Affirms that all of the authors listed in the byline have made contributions appropriate for assumption of authorship, have consented to the byline order, and have agreed to submission of the manuscript in its current form
- Affirms that all applicable research adheres to basic ethical considerations for the protection of human or animal participants in research
- Affirms that there is no copyrighted material in the manuscript or includes a copy of the permission granted to reproduce or adapt any copyrighted material in the paper
- Affirms that the manuscript has not been previously published in the same, or essentially the same, form
- Affirms that the manuscript is not currently under review elsewhere. OSLHA prefers to publish previously unpublished material
- Discloses information about any previous public presentation of the data reported in the submitted manuscript, including at a scientific meeting or in conference proceedings, book chapters, websites, or related media
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Submit your manuscript at any time by sending it to the Journal Editor: Laurie.sheehy@utoledo.edu or the Business Office oslhaoffice@ohioslha.org
I’m excited to announce that Gloriajean Wallace, Ph.D., CCC-SLP, BC-ANCDS will be the Issue Editor for the next eHearsay journal (due out in December 2014). The theme of the journal will focus on Current Issues in Aphasia.

The opening article will be written by Ellayne Ganzfried, Executive Director of the National Aphasia Association and will focus on current issues relating to lack of awareness about aphasia in the general community and ways that influences research, clinical management and every aspect of life for people with aphasia.

There will also be 7 articles prepared by university students and their faculty mentors from several of Ohio’s speech-language pathology programs. The topics range from increasing awareness of aphasia in the public, quality of life scales, counseling, gesture production, bilingualism, spoken word recognition and the effects of audiobook format on reading comprehension.

Aphasia is an acquired neurogenic language disorder resulting from an injury to the brain, most typically the left hemisphere, that affects all language modalities.

Aphasia is not a single disorder, but instead is a family of disorders that involve varying degrees of impairment in four primary areas:
- spoken language expression
- spoken language comprehension,
- written expression, and
- reading comprehension

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