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The Mighty Mentor: Activating your supervisor superpowers!

Jennifer Pratt, MS, CCC-SLP

Moderated by:
Amy Hansen, MA, CCC-SLP, Managing Editor, SpeechPathology.com

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THE MIGHTY MENTOR:
ACTIVATING YOUR SUPERVISOR SUPERPOWERS!

Jennifer Pratt, MS, CCC-SLP
Clinical Associate Professor, Missouri State University
Our Mission (Learner Outcomes)

1) compare and contrast characteristics of a mentor and a supervisor based on research and supervisee perspectives.
2) After this course, participants will be able to identify important aspects of self-evaluation needed prior to taking on the role of supervisor/mentor.
3) After this course, participants will be able to identify each element of the ASSURE model and corresponding techniques to apply toward clinical education and supervision.

Part I

- BRIEF History Lesson
- Defining Supervisor vs. Mentor
- Tasks and Competencies
- Mentor Traits
A long time ago...

- “Clinical supervision is a part of the earliest history of ASHA. It is an integral part of the initial training of speech-language pathologists and audiologists, as well as their continued professional development at all levels and in all work settings.”

- “A prevailing philosophy suggests that competency in clinical service delivery translates into effective clinical supervision. However, leaders in education have long argued that this is a flawed assumption and that effective supervision requires a unique set of knowledge and skills.”

1970s - Surveys revealed need for training
1978 – ASHA Committee on Supervision addressed specific roles and responsibilities of supervisors
1985 – Supervision “legitimized as a distinct area of expertise and practice” needing “special preparation to enable individuals to function competently…”
1991 - ASHA Div 11 (SIG 11) Administration and Supervision
2008 – ASHA advised that supervisors should “seek training…about different supervisory styles and develop competence.”
2010 - Credentialing survey indicated overwhelming recognition of importance for formal training
2017 – Application for ASHA Specialty Certification in Supervision
Jan 1, 2020 - Supervision of students must be provided by a clinical educator who holds ASHA certification in the appropriate profession, who has the equivalent of a minimum of 9 months of full-time clinical experience, and who has completed a minimum of 2 hours of professional development in clinical instruction/supervision after being awarded ASHA certification.
Evolving Definition

- Anderson's (1988) *Continuum of Supervision* is a conceptual model of supervision often referred to in the communication sciences and disorders (CSD) literature.

> “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. 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)

- ASHA noted that definition lacked attention toward self analysis, self-evaluation and problem solving skills. “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.”

### ASHA Tasks and Competencies

**Examples of Tasks:**
- Effective working relationship
- Develop clinical goals
- Assessment skills
- Clinical management skills
- Observe and analyze assessment and treatment sessions
- Supervisory conferences
- Evaluating clinical performance
- Professional conduct
- Verbal reporting, writing editing

**Competencies - Several listed under each task**

**Task: Establishing and maintaining an effective working relationship with the supervisee.**
- facilitate an understanding of the clinical and supervisory processes.
- organize and provide information regarding the logical sequences of supervisory interaction, that is, joint setting of goals and objectives, data collection and analysis, evaluation.
- interact from a contemporary perspective with the supervisee in both the clinical and supervisory process.
- apply learning principles in the supervisory process.
- apply skills of interpersonal communication in the supervisory process.
- facilitate independent thinking and problem solving by the supervisee.
- maintain a professional and supportive relationship that allows supervisor and supervisee growth.
- interact with the supervisee objectively.
- establish joint communications regarding expectations and responsibilities in the clinical and supervisory processes.
- evaluate, with the supervisee, the effectiveness of the ongoing supervisory relationship.

About 80 unique competencies listed as necessary to accomplish the 13 tasks.
Clinical Education is no small matter!

Clinic as Classroom
- “Only teaching environment in which skill sets such as history taking, behavioral observation and assessment, clinical reasoning and decision-making, empathy and professionalism can be integrated by the student”

Knowledge and Skills:
- Establishing effective relationship
- Interpersonal Communication
- Experiences to develop critical thinking
- Questions to foster reasoning skills
- Feedback
- Diversity

Clinical supervisors do more than oversee the work of the aspiring clinician. They teach specific skills, clarify concepts, assist with critical thinking, conduct performance evaluations, mentor, advise, and model professional behavior.

“Clinical Educators”
How this webinar came to be...

What do we know about the evidence for effective supervision?

- Little empirical evidence as it relates to client outcomes
- We are learning more about how knowledge and skills are being acquired by supervisees
  - Descriptive studies
  - Shared experiences
  - Research literature of social work, nursing, psychology, business, substance abuse
Recurring theme in research across disciplines:

The quality of the interpersonal relationship is probably the single most important factor for the effectiveness of supervision, more important than the supervisory methods used.

- Is this emphasized sufficiently in our definition, tasks and competencies?
- Sounds more like a mentor -- I’d rather see myself as and aim to be a mentor!

**Supervision** can be broadly defined as overseeing and directing the work of others.

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).

**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).

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.
1st Year Graduate Clinician Videos (sup v mentor)

2nd Year Graduate Clinician Videos (sup v mentor)
Mentor vs. Supervisor – Videos

First Year:
- **Supervisor**: Stern, critique, authority, responsibility, formal, could become a mentor, assigned to you
- **Mentor**: Encouraging, look up to, friend, look up to, advice, casual

2nd year:
- **Supervisor**: Spread thin, detached, reduced priority on learner, expectations come from past work experiences; power differential; assigned; need to seek out mentoring skills to foster growth, formal.
- **Mentor**: Can be dual roles in one leader; advice that can generalize, lasting relationship; Truly cares about growth and education; productive; 1:1; informal; can be sought out

There is a difference.
- One may argue that one can be an effective mentor w/o being a supervisor, but not as effective a supervisor without being a mentor.
- “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” (ASHA)
- Should mentor characteristics be the bar we set?
- How can we integrate deliberate and appropriate mentorship into clinical education?
- Let’s go to the source…
Characteristics of the Ideal Clinical Supervisor: 1st Year Clinicians

Characteristics of the Ideal Clinical Supervisor: 2nd Year Clinicians
Characteristics of the Ideal Clinical Supervisor:

First Year
- Feedback, critiques, encourages while critiquing, be sensitive to fear, be specific and detailed, resourceful, helpful

Second Year
- Open, organized, straightforward, honest, supporting growth, (less fear), coaching, sectioned and specific feedback, understanding and personable/flexible, working yet personal relationship
- Advanced students have more experiences to draw upon to formulate opinions, make comparisons, etc.

Desirable Mentor Traits
- Assertive
- Confident
- Approachable
- Empathic
- Experienced
- Patient
- Creative
- Inspiring
- Consistent and Specific
- Non-judgmental
- Honest / Trustworthy
- Kind
- Fair
- Respected in field
- Active Listening
- Set a high bar

The most valued mentoring skill is giving encouragement (Phillips-Jones 2003) Needs to be sincere, consistent, not over-done.

R: 21, 28, 29, 34
Positive Mentor Roles

- **Role model**: Well respected by peers and students hold in high regard. “Influencer.”
- **Energizer**: Motivating, inspiring, enthusiastic
- **Envisioner**: Embraces change; works to improve care and encourage student
- **Investor**: Gives freely of their time and experience
- **Supporter**: Approachable, available, empathic, addresses student anxiety
- **Standard prodder**: Questioning, seeks improvement, up-to-date knowledge
- **Eye-opener**: Shows student the wider picture beyond the single patient, caseload
- **Challenger**: Helps student develop critical thinking and encourages questions and challenges; case building

Toxic Mentor Roles

- **Avoiders** – Unavailable for variety of reasons. “Too busy”. Shortened meetings, limited alternatives for meetings and consults
- **Dumpers** – Expect students to manage difficult situations w/o appropriate training or education. Impacts student confidence. Expects student to initiate all meetings, all questions, and to guide learning experience
- **Blockers** – Actively refuse or ignore requests for help or resources. May also over-supervise and not allow any independent skill development and execution. Sabotage.
- **Destroyers** – Negative and focus on only corrective feedback. Quick to point out faults. May do this in shared spaces. Arrogant and may see self as superior with nothing to learn from student themselves

R: (Gopee and Darling as cited in 34)
Specific Toxic Traits

- Works with student less than 40% of the time (including direct and indirect)
- Unapproachable
- Cancels meetings frequently
- Does not care or inquire about learning level and needs
- Puts student in difficult situation; sets up for failure
- Does not engage student in self reflection and analysis
- Does not participate in mentor training
- Does not incorporate EBP
- Reluctant to change; defensive; rigid
- Unprofessional
- Does not play well with others – talks negatively about peers, coworkers, team members

R: (Darling as cited in) 34

Part II:
Becoming a More Self-ASSURed Mentor and Clinical Educator
Me First! Self-Evaluation

“Off-Label” Exercises:
- What qualities did my best/worst instructors possess? What skills? What environments were most conducive to my learning? Did anyone ever ask me how I learned best or what was important to me?
- Last time you were coached, critiqued? put yourself in a new situation that afford yourself the opportunity to respect the knowledge of someone and be humbled, be impressed and be even frustrated and hopefully proud. What went well? What could have gone better? How did you feel when you were corrected?

Evidence supports that supervisees appreciate mentor-like qualities in their supervisors.

Evaluate Situation, Motivation and Intent.

Self Awareness and Planning

- Adjunct: Mentor needs and skills self-inventory – See My Mentoring Skills Inventory handout

Readiness Inventory

- Is supervision voluntary for me?
- Do I want to do this? Why?
  - What is my intended outcome? Me as better instructor, keeping skills sharp, imparting knowledge, training future professionals – what is my motivation.
- Do I have time and motivation to embark on my own learning?
- Do I have a supervision style?
- How much time can I dedicate toward being an effective clinical educator/ supervisor?
- Do I have access to resources to support learning?
- Do I like collaborating?
- Do I find students energizing?
- Do I have administrative support?
- How will logistics and physical space impact my role?
- Do I have a clinical education plan in place?
- Am I winging it?
What is your supervisor kryptonite?

**Barriers to teaching** –
- What is changeable vs. what is not?
- Time, Priority Status, Confidence, Documentation/Productivity standards, space/noise/privacy, low motivation/skill.
- Personal Biases
- Must I always be in a good mood?

**Intentions are good, BUT….complex contextual issues impede efforts toward effective instruction**
(Derosa, et al):

1. **Educational**: Unclear learning needs (What the heck are they doing in the university? What level can I expect of this supervisee?)

2. **Culture-based**: Attitudes, lack of support for instructors to receive training, lack of training for cultural competence, lack of award system

3. **Environmental**: time, setting, physical space. “Clinical preceptors do not typically have specific institutional financial support for the time they spend teaching in the clinical curriculum” (DeRosa)

R: 13

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What if my supervisee and me are very different people?

- “It is unclear whether likeness or difference is associated with positive outcomes. No significance was found between similarity or difference in style and the quality of the supervisory relationship or the degree of satisfaction with supervision. Likeness in style was found to be related to the tendency of the supervisor to positively evaluate supervisees’ performance.”

R: 36
Designing your Master Plan

**ASSURE** (Rega, 1993; Bastable, et al 2011)

- Analyze, State, Select, Use, Require, Evaluate
- A model to organize the approach for patient and clinical education by clinical nurse educators ([Health Professional as Educator, Bastable and Gramet, Ch 1])
  - “forging a relationship between educator and learner”

- Transferrable framework to organize tasks and competencies needed for supervision as outlined by ASHA
- Can weave in mentor qualities to advance goal of fostering a quality relationship

**Analyze the Learner**

Learning = active process during interaction with environment; integrate new knowledge with previously acquired experiences. Requires ATTENTION!

Considerations:
- Affected by society/culture, structure of stimuli, effectiveness of role models, pattern and type of reinforcement (feedback) and practice opportunities (generalization)
- Who is your learner? Grad Student – Intern – CF – SLPA?
- Did you select them? Were they assigned?

**Building your Knowledge Pre-meeting:**
- Get some info – do some recon!
  - Hypotheses based on Generational Characteristics
  - Learning Theories
Pre-meeting: Generational Info

Millennial Fast Facts:
- Born 1982-2000 (US Census Bureau)
- Largest and most diverse generation ever to attend college
- Sheltered and appreciate rewards for participation
- Lack of professional boundaries influenced by socialization
- Need for frequent and immediate feedback
- Surface thinkers; lack critical thinking skills
- Generous and Team Oriented
- Dependent on “how to” specific guidelines
- Pressured to perform
- Desire to Achieve; Confident; Optimistic
- Technologically savvy
- Respectful of cultural differences

Tools and Tips:
- Provide praise for work
- Be explicit about “self-rewards”
- Clear instructions and expectation written out – provide a contract
- Daily or weekly learning outcomes/ highlights
- Collaborative and cooperative learning – experiential learning with peers, OT, PT, dietary
- Be consistent with feedback, including why you may be pulling back on it
- Provide feedback in various forms
- Incorporate technology – give them a job!
- Exposure to problem solving how to deliver service and get “buy in” from people of different backgrounds

Generation Z:
- Digital Natives
- 24/7 contact via social media
- Believe tech can solve problems and is most relevant means of accessing information (watch a video vs read)
- Find info but don’t evaluate it
- Appreciate diversity
- Email is their snail mail

- Fast delivery of context with graphics
- Kinesthetic, experiential, hands on learners – poor tolerance and attention for “watching”
- Instant gratification – immediate attention “Instant Feedback”
- Clear goals, consistent rewards, but do like to be challenged
- Need learning delivered in smaller chunks due to short attention span – are not used to doing one thing at a time
- Problem solving is long, tedious, and boring – want quick fix
- Team work, small groups – want options
- Want a voice in how they learn – will be more reflective this way and independent

From: A Tsunami of Learners Called Generation Z by Darla Rothman, Ph.D
Learning Theories and Styles

- The most commonly held conclusion from works on learning styles in supervision states unequivocally that conscious awareness and explicit knowledge of the learning style of the supervisee as well as the supervisory style of the supervisor is important in the promotion of learning in the practice setting (Bogo & Vayda, 1998; Epstein, 1996; Tennant, 1997 as cited in ref 20 and 36).

Pre-meeting: Learning Theories Primer

Principles and constructs that predict and describe how people learn

- Behaviorism – Active educator manipulates stimuli and reinforcement to direct learning and change. Giving immediate feedback, whether positive or negative, should enable your learners to behave in a certain way.
- Cognitive – Active educator structures meaningful experiences to encourage thinking and problem solving. Active participation is essential.
- Social – Active educator models behavior, evaluates learning materials, influences learner’s self-regulation.
- Psychodynamic – Educator as “reflective interpreter” who makes sense of learner’s motivation by listening and posing questions to simulate awareness and insight.
- Humanistic – Educator encourages positive self growth; actively listens, is empathic, allows freedom of choice.
Experiential Learning

Kolb (1984) proposed a four stage experiential learning cycle. Way by which people can understand their experiences and modify their behavior. The more often a learner reflects on a task, the more often they have the opportunity to modify and refine their efforts. Learning can begin at any stage and is continuous.

1. **Concrete experience**: experience or immerse yourself in the task; simply carry out the task assigned. *Doing* stage.
2. **Observation and reflection**: step back from the task and review what has been done and experienced. Values, attitudes and beliefs can influence thinking. *Thinking* about what you have done.
3. **Abstract conceptualization**: interpreting the events that have been carried out and making sense of them. *Planning* how you will do it differently.
4. **Active experimentation**: take the new learning and predict what is likely to happen next or what actions should be taken to refine the way the task is done again. *Redoing* stage based upon experience and reflection.


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**EL Styles (Learning Types)**

<table>
<thead>
<tr>
<th>Accommodator:</th>
<th>Converger:</th>
</tr>
</thead>
<tbody>
<tr>
<td>get things done, take the lead, takes risks, initiates, adaptable and practical</td>
<td>defines goals, makes decisions, responds deductively, defines problems, is logical</td>
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<table>
<thead>
<tr>
<th>Diverger:</th>
<th>Assimilator:</th>
</tr>
</thead>
<tbody>
<tr>
<td>imaginative, understands people, recognizes problems, brainstorms, open minded</td>
<td>plans, defines problems, creates models, develops theories, is patient</td>
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According to this framework, individuals have personal learning preferences and tend to favor different cognitive activities. Preferences form four different learning types.

- Type and complexity of experience may determine what type of stage is needed or expected.

- Can experience different needs/stages/styles within same overarching experience (e.g., aphasia eval vs. trach/vent; treating child with artic delay versus severe autism).

More Recon...

Let’s look at expectations for the initial meeting and responses to “What is your worst nightmare?”
1st year clinician first meeting:

Worst Nightmare…
2nd year clinician first meetings:

Worst Nightmare...
Themes:

Meeting Expectations
- **1st** year – specific, have a plan, fearful
- **2nd** year – specific list of CE expectations before first meeting, resources

“What is your worst nightmare?”
- **1st** year – feeling dumb, stupid questions, belittled, not approachable, apathetic, not relationship oriented
- **2nd** year – being belittled, negative feedback, not clicking, apathetic or dismissive

Initial Meeting

Gather specifics:
- Evaluate their situation, motivation and intent
- Who is this person? What is important to them? Prepare to make them feel welcome
- In 3 years time, you would like to be doing __________
- Your passions are ________________
- Preferred mode for taking in information (visual, auditory, motor, combo).
- What skills they want to achieve
- What are some challenges you are trying to overcome related to your skills and clinical growth?
- Describe your ideal supervisor / mentor

- Deal with any initial anxieties
  - Barriers to learning/processing: time, stress, learning readiness, compliance, complexity of material, denial of learning needs, poor or disorganized support system (includes ineffective mentor), behavior, environment, slow to adapt.
  - What can they change? What can we help change?
  - Larson’s Supervisory Expectations Rating Scale

Initial Meeting

Motivation – Critical Influence in Learning, Retaining and Applying Knowledge

- **Have to want to gain something** – rewards and pleasure, meeting a goal or a need, mastery of skill, meeting expectations, self-growth, conflict resolution

- Arouses tension/imbalance (I don’t have something I want or need) and acts as the catalyst to act to change behavior.


Analyze the Learner
State the Objectives

- What will supervisee be able to do following your instruction and by what time?

- Are we trying to get the them job ready? Ready for next level in practicum? Remediation or focusing on a specific skill?

- Tools to organize the learning process: measurable and attainable goals – What is the Cooperative Mission? The individual mission?

- Establish achievable objectives to increase confidence. Do the objectives align with motivations and expectations expressed in the interview? If not, problem solve why this is.

- Considering generational learning styles:
  - Provide rationales for objectives; Objectives should be in writing and should be signed (contract!)
  - Aim to make objectives a collaborative endeavor
  - Timelines for exposure to experiences, skill acquisition
  - Assume capability; offer exposure to unique experiences

- The 13 tasks outlined by ASHA provide a comprehensive checklist of objectives BUT tailor them to your setting.

Ref: 7, 34
Learning Objectives examples

1. Understand the organization and structure of rehabilitation and/or educational agencies, including the budgetary and reporting processes.
   - Change to: *Explain how reimbursement systems determine eligibility and payment for services for clients in skilled nursing facilities under Medicare Part A (by…)*.
   - List 2 methods of documentation that are needed to support evidence for medical necessity (by…)

2. To demonstrate methods of managing environments to maximize appropriate use of instructional techniques, materials, equipment, and computer technology
   *Provide a 10 minute instructional inservice to rehab support staff that emphasizes how to best implement safe swallowing strategies in the presence of environmental distractions (by…)*

Objectives – Change these to be measurable and specific

- The student clinician will compose professionally written documentation
- The student clinician will engage in professional oral communication and interaction
- The student clinician will evidence independence with critical thinking skills
- The supervisee will demonstrate independence with rounding and FIMS scoring.
- The supervisee will demonstrate independent execution of MBS.
Analyze the Learner
State the Objectives
Select Instructional Methods

• The Instructional Bridge between your supervisee’s current knowledge and the stated objectives

• How will you foster critical thinking and decision making?

Ref: 7, 17

Instructional Strategies

Inquiry based learning:
- Research supports these methods as being highly effective in stimulating critical thinking skills
- Student centered; instructor as “guide”; Students acquire and analyze knowledge versus being passive recipient

1. Problem-based learning
2. Concept Mapping

Instructor Driven
1. Role-play
2. Questioning

Ref: 30, 32, 35
Problem based learning

- Uses real problems as context to learn (versus lecture or reading material). Typically small group work supported by facilitator. Promotes knowledge and skill acquisition, confidence, improved attitude, communication, flexibility, self-directedness, intrinsic motivation and team work.

- Intentionally complex and/or ill-defined. Often may not have a single answer.

- Whitehill, Bridges and Chan proposed a curricular approach comprised of a problem cycle:
  1. Problem
  2. Generate Learning Issues (questions, current knowledge)
  3. Independent study
  4. Critically evaluate and discuss readings
  5. Synthesize Information (concept map or written report)
  6. Reflections on own performance, peers, facilitator

The following is an example of a case taken from the Year 1 curriculum in Problem-based learning (PBL) and speech-language pathology: A tutorial (Whitehill, Bridges, & Chan, 2013).

- Mrs. Huang, a 75-year-old woman, was referred to a speech therapist for drooling, swallowing problems and a speech problem. The speech therapist found that Mrs. Huang had a left unilateral weakness of the oral-facial muscles, slurred speech but no language problems and showed signs of aspiration on thin liquids. Mrs. Huang’s daughter would like to know why only the left side of the face is affected and would this affect her mother’s speech and swallowing ability.

- Students are expected to generate learning issues similar to those below:
  - What is drooling?
  - What is a swallowing problem?
  - What causes unilateral weakness of the oral-facial muscles?
  - What will be the impact on swallowing and speech?
  - What do we mean by “slurred speech”?
  - Why is Mrs. Huang’s speech slurred?
  - What is aspiration in this context?
  - What are possible causes of speech and swallowing problems in the elderly?
Maria, a 52-year-old female was admitted to the hospital yesterday due to delirium and physical illness from ETOH abuse. She was found down, barely audible and responsive by a neighbor around 2:00pm. Nursing now reports that Maria is awake and talking, though still very weak. The hospitalist ordered SLP services for a clinical swallow evaluation. Evaluation results indicated Maria was safe to initiate a regular textured diet and thin liquids. During the evaluation, the SLP observed that Maria periodically produced paraphasias and nonsense words of which she was unaware. She had frequent episodes of clear speech, presenting as lucid and intelligible as well.

- What is delirium?
- Why may someone with a history of ETOH abuse experience delirium?
- What are the implications of being “found down?”
- What possible explanations are there for Maria to demonstrate intact swallowing and impaired speech/language that seems transient in nature?
- What should the SLP do next?

### Concept Maps:

- A visual map (diagram) that connects concepts that are related to a main idea
- Time consuming and highly visual (not best choice for auditory learner; could be a turn off to a millennial).
- Add components as knowledge grows; is a dynamic document
- Can be an excellent tool for remediation (for a visual learner)
- Can be an excellent tool for interdisciplinary collaboration - separate maps that come together – edit into one large map (autism, Left brain MCA CVA)
- Could be replaced with a simplified version – traditional graphic organizer comparing disorders, treatment methods, etc.

Ref: 30, 32, 35
Ideas for Additional Application:

- Develop clinical pathways (decision trees) for specific treatments for patients with neuro degenerative disease

- Design evidenced-based rationales for specific type of service delivery for pre-school children with articulation delays
  - Advance to comparative “branch” off of the map that compares service delivery for artic vs. phonological process of DAOS.
Instructor-Driven Tools

- Valuable as much of our interaction is verbal with supervisees.
- Best to have deliberate time set aside, but can also be implemented during “en route” instruction
- Role Play
  - Dramatize a situation or event. Ideally, one that should expose a difference of opinion
  - Unscripted, let it play out spontaneously but allow recording if possible
  - Ideal for practicing delivery of results, dismissal of services, culturally-relevant issues
  - MUST include debriefing to discuss situation, conclusions, perspectives. Take notes!
  - Could lead to further inquiry based learning – have student draft arguments for / against, concept map an issue, PBL scenario – work it out with a group.
- Strategic Questioning
  - Design questions with intent of helping student stretch and reach beyond surface info.
  - Follow Bloom’s Taxonomy…

Strategic Questioning Examples r/t to Bloom’s

- Knowledge: Wh questions; Describe, Which one; Choose; Define
- Comprehension: In your own words, Give an example, Tell, Select the best; What seems most likely; Classify; Condense this information
- Application: Predict what would happen, Tell me how and why in that order; Discuss the results of; Judge the effects of this treatment
- Analysis: Make assumptions based on X; Differentiate fact from opinion; What is the most relevant info? What is the relationship between…; What findings justify that approach?
- Synthesis: How could you further test? Design a protocol for; How else may you; What’s an alternative to/for?
- Evaluation: Analyze for inconsistencies; compare the two treatment options; Prioritize; Defend; Build your case

Ref: 17, 30

Ref: 6, 33
Analyze the Learner
State the Objectives
Select Instructional Methods

**Use Methods & Materials**

The clinical educator not only exerts significant influence on learning via tool selection, but also via **HOW** the learning experience is structured.

This stage will often determine **if learning will become relatively permanent**

For Learning to Become Permanent:

1. Learning experience must be organized, appropriately paced and pleasurable— use tools in appropriate measure at appropriate time (no concept maps for auditory kinesthetic learners)
2. Practice knowledge and skills under different conditions
3. Provide reinforcement – it signals that learning has occurred
4. Measure performance at later date following conclusion of experience

Ref: 7, 21, 22

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**Facilitating Learning**

Relate learning to the supervisee’s current knowledge and past experience

Inappropriate materials and instruction for ability or stage of expertise will act as obstacle to learning:

- Link learners to information and resources (yet resources you provide and they share with you)
- Encourage and praise enthusiasm, initiative, and creativity
- Can you allow supervisee to look up info digitally in real time (on phones, computer, iPad) to answer questions, prep for caseload?
- Speak to them in their language – Use social media to pose questions, give updates, share relevant information
- Can feedback meetings; consults; use of tools be recorded and reviewed?

Direct instruction will be necessary for specific learning stages, BUT...

Supervisors habitually use a more directive style of supervision with all students, regardless of student experience

Aim to shift from giver of information to process designer and coordinator.

“Sage on the Stage” to
“The Guide on the Side” – enables both partners an active role in the clinical education process”

Ref 7, 33

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**continued**
Analyze the Learner
State the Objectives
Select Instructional Methods
Use Methods & Materials
Require Learner Performance

Feedback
- Data-based (observable), objective appraisal of performance intended to improve clinical skills
- Confirm, reinforce, correct and promote improvement
- Written, verbal, rating scales, narratives
- Factors influencing effectiveness:
  - Timing
  - Frequency
  - Tone
  - Form
  - Specificity

Reflective Practice
- Metacognitive process occurs before, during and after a situation to increase understanding of self and situation
- Critical thinking/self-analysis to solve problems and modify behavior
- Needs to be a guided experience
- Ideally, reviewed but not graded

“Intellectual Engagement” - not just observing and then performing – engage hypothesis formation, prediction, analysis

Ref 7, 8, 11, 12, 16, 18, 33
Feedback

Delivering feedback has been studied extensively but remains challenging. Familiarity with other skills of supervision, does not necessarily translate to giving effective feedback. (Nelson)

Well-given feedback:
- “Should provide the receiver with information on how to improve as well as a rationale as to why the suggested changes would be beneficial.”
- Should be in private when possible
- Begin positively, be clear and specific, convey respect
- Include about 4 praise/positive comments to everyone 1 corrective remark. (Jones 2003)
- Considerate of learning styles and preferences

Corrective feedback is necessary to force change; praise is often insufficient. Manner of delivery is crucial:
Poorly given criticism:
- is likely to evoke negative emotion and may be interpreted as untrue or inaccurate.
- Is judged to be threatening and ill-timed. Emotional Reaction!
- Is seen as ambiguous and confusing

Brain views criticism as threat; we remember criticism strongly but often inaccurately

Ref 7, 8, 10, 18, 27, 31

Words can Change Your

Positive words, such as “peace” and “love,” can strengthen areas in our frontal lobes and promote cognitive functioning. “Propel the motivational centers of the brain into action, and build resiliency.”

Hostile language can disrupt specific genes that play a key part in the production of neurochemicals that protect us from stress.
- at least two regions of the brain -- the amygdala and the medial prefrontal cortex -- work harder when processing criticism, and can keep the brain from doing much else.

Ref 7, 8, 10, 18, 27, 31
A single negative word can increase the activity in our amygdala (the fear center). Releases dozens of stress-producing hormones and neurotransmitters, which in turn interrupts brain functioning, especially with regard to logic, reason, and language.

Servaas found that brain regions involved in emotion processing and social cognition were recruited during the processing of criticism, while default mode activity and higher-order cognitive control functions were attenuated. (Servaas, 2013)

“Angry words send alarm messages through the brain, and they partially shut down the logic-and-reasoning centers located in the frontal lobes” (Newberg and Waldman).

Avoiding the “Shut Down”

- Preference for consistency and structure of feedback has been documented.
  - Written feedback in a timely manner is preferable; can structure verbal as well
  - Set aside time for verbal interactions

- Provide authentic praise first
- Affirm your commitment/concern to supervisee
- Transparency: “This may not be the most comfortable conversation…” “I think highly of you as a person…” “This may be why you are feeling…”
- Reiterate your sense of responsibility for their learning
- Guide/Mentor
  - “I want to support…” “Let’s develop a plan to enhance…” “It is my job to help you....”
Constructing Feedback

- McCready, et al studied kinds of feedback, triggers that were obstacles to receiving feedback and suggestions to manage resistance. Informed on triggers that are elicited when we give feedback and a vehicle of written feedback delivery that was well received by students:

1. Appreciation ➔ Validate, motivate
2. Coaching ➔ Facilitate improvement
3. Evaluation ➔ Measure/rank against standards

- Designed to avoid or minimize triggers ("dismantling distortions" about feedback)
  1. Truth trigger – “That can’t be right!” Receiver feels angry, deflated, confused
  2. Relationship – questionable trustworthiness, motives, credibility
  3. Identity - emanates from how receiver views her future; feedback is seen as threatening and may have nothing to do with the person giving the feedback or the feedback itself

See Handout

- Highlights – Opportunity to use positive words – propel motivation and increase receptiveness to instruction
- Coaching – Suggestions and Compassionate Corrections. Keep this section limited to critical learning points. Avoid overwhelming
- Session eval – An overall impression of the session.

Additional Methods:
- Chronological Feedback
- Debriefings
- Written Framing on Poorly Constructed Documentation
- Dialogue on Feedback
You need to use your time wisely. If one test is consuming most of your allocated time for the eval, make the judgment to move on to another area.

As you are learning, adult tests may not have basal and ceiling criteria, which means they can be time consuming—often we must use our clinical judgement to determine if we have enough data that is representative of performance and then determine to move on to something else. This is a tough call even for experienced SLPs but it does get easier with practice.

Your verbal feedback needs to be more specific.

Remember to keep feedback specific yet with simplified language. For example, with gestures, instead of saying "I like how you did it like that," say, "Your finger for 'toothbrush' was at your mouth"—great! This way, she has a better chance of keying into comprehending main words/ideas of "finger, toothbrush, mouth."

Reflective Practice  ON action and IN action

- **On Action**: Reflect on what has been done and evaluate contribution to outcome; What to do next in a similar situation.
- **In Action**: Thinking on Your Feet. Change behavior in the moment during the task.

- To encourage effective reflection:
  - Be specific. Choose correct method and medium (avoid general “write about your thoughts...”)
    - Focus on a specific area vs. “everything.” E.g., Data collection, verbal cues, engagement.
  - Be supportive and open to questions and opinions
  - Review/assess the reflection but don’t necessarily grade – Can use a rubric ("low stakes")
  - Provide feedback
  - Model reflection –it’s ok to knowing you could do something different/better

Ref 11, 12, 16, 24
Caty, et al in Review of 42 relevant publications re: Reflective Practice in SLP:

1. “While speech-language pathology as a profession appears to have become interested in reflective practice as an important component of clinical education...scholarship on reflection and reflective practice in the field of speech-language pathology is limited.”

2. An analysis of practical approaches to reflection and reflective practice was not suggestive of any more favored approach over another...but written reflection and reflective group discussion were the most reported practical approaches. (e.g. Chabon & Lee-Wilkinson, 2006; Freeman, 2001; Hill, Davidson, & Theodoris, 2012).

3. Needs to be formalized and guided for supervisees. Reflection is a skill that requires support to develop.
   - Interpersonal and intense
   - Observing of self, learning from actions, noticing/feeling, adjusting
   - Must occur with high level of trust and in safe environment
   - Process and work through feelings, recognize emotions, reactions (thermometer vs. thermostat)

Reflective Writing Exercises
- Data free session
- Guided video review (potential areas of focus):
  - Environment
  - Materials
  - Body Posture/Non-verbals
  - Pacing, Instructional methods
  - Productivity
  - Client Responsiveness/Pragmatics/Engagement
- Reflection following SOAP note

Ref 24, 33
Verbal Reflection Exercises

Caty\textsuperscript{12}, et al:

- “Reflective \textit{group discussions} with peers, mentors, critical companions or a supervisor were identified as a predominant approach to foster the reflective process.
  - “Rounding” Meetings
  - Hybrid grand rounds/patient rounding with videos
- Discussions prompted through: case studies, clinical therapy data, feedback on clinical performance, scenarios and work-based dilemmas.

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Analyze the Learner
State the Objectives
Select Instructional Methods
Use Methods & Materials
Require Learner Performance

Evaluate Teaching Plan

- \textbf{Feedback-seeking aids adaptation, performance and learning}
- \textbf{Leave your ego at the door}
- \textbf{Seek verbal and written feedback at critical times – mid point; end of experience.}
- \textbf{Cite previous suggestions for improvement and how you are addressing them with next supervisee (s)}

- \textbf{Keep record of barriers so you may negotiate with admin for specific needs – more time to consult, need for observation of ancillary colleagues, more time for EBP}
- \textbf{Retake ASHA inventory}
- \textbf{Focus group with previous supervisees – value their input and make changes according to feedback}
- \textbf{Assess personal bias - liking the supervisee, negative associations}
- \textbf{Managing of difficult situations: REFLECT REFLECT REFLECT}

Ref 7, 12, 16, 33
To Infinity and Beyond

Looking for a place to start to fortify your fortress? Further exploration?

- Courses on adult learning theory, generational characteristics and styles
- Feedback – well studied and researched!
- ASHA SIG 11

Select one area per season.

“Off Label” recommendations

Mindfulness Practice –
see article handout (Davis and Hayes, 2011):
Benefits of Mindfulness for practitioners of psychotherapists
- “Moment by Moment Awareness”
  - Develops effective emotion regulation in the brain
  - Promotes empathy
  - Compassion
  - Decrease stress and anxiety

Hobbies

- Help structure your time and encourage efficiency – when time is unstructured, we tend to fill it by laboring over unnecessary items (email, tv, social media); if we have a “must do” like book club, choir, tennis – time gets restructured and prioritized
- Promote “flow” – Brain is activated more by active vs. passive leisure. Lose yourself in a project, sport, or game. Immersion works toward increased concentration and focus
- Foster new social connections IRL – interpersonal communication; diplomacy; friendships
- Hobbies make you interesting – something to share, communicate excitement about
- Regardless of the hobby, progressive learning naturally teaches patience. Helps you take alternative perspectives and think about obstacles differently
- Benefits spill over into your work and personal life

http://www.asianefficiency.com/productivity/hobbies-make-you-productive-creative-7-hobbies-take-today/
Wish List

- More research on impact of match/mismatch CE and supervisee learning styles
- Cultural considerations and Diversity issues https://www.asha.org/Practice-Portal/Templates/
- Standardized curriculum / courses
- More evidence on how to fit it all in – how to deliver best practice in CE within work day
- Remediating students; conflict resolution; predictors of success
- More courses on power of mindfulness as it relates to increasing skills needed to be effective instructor
- Ethical situations
- Other?

Thank you to all of the superheroes!

- Students:
  - Appearing in Videos: First Year: Kaitlin Cablish, Sarah Christoff, JoLynn Fairchild, Kelsey Garbee. 2nd Year: Jennifer Badonivac, Audrey Emling, Brittany Knebel, Natalie March, Maddie Schmidt, Julie Shoemake
- Mentors, Teachers, Researchers, ASHA
- Patients/ Clients
- Colleagues and Coworkers
- Family and Friends
References
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