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Coordinator’s Column

Melanie W. Hudson

As I begin my 3-year term as Coordinator, I would like to thank Shelley Victor for her many contributions to Special Interest Group (SIG) 11, Administration and Supervision, during her term as Coordinator. She has left an exciting and challenging legacy for the new Coordinating Committee. I would also like to thank Marva Mount for her years of dedicated work as our Continuing Education (CE) Content Manager. I am happy to welcome Darlene Robke as our new CE Content Manager. I would also like to thank Elissa Zylla-Jones for serving as our Perspectives Editor and welcome her as she begins her term as a member of the Coordinating Committee. Finally, I would like to welcome the members of the Coordinating Committee: Mark DeRuiter (Associate Coordinator), Melissa Passe, Kerri Phillips (as Perspectives Editor), and Elissa Zylla-Jones.

Convention 2011

The 2011 ASHA Convention was most successful for SIG 11. Our short course, “Life Skills of the Well-Rounded Clinician,” was very well-received, with almost 100 in attendance. Evelyn Klein, Marva Mount, and Shari Robertson presented useful strategies that addressed dealing with stress, organization, and time management. Vicki McCready and Shelley Victor, with a panel of National Student Speech Language Hearing Association (NSSLHA) students, presented the SIG invited session, “Supervising and Communicating Across Generations: What’s Up with That?” This session was also very successful.

Shelley Victor, Melissa Passe, and I attended the “Meet the Board of Directors” (BOD) forum at the ASHA Convention as representatives of SIG 11. Our goal was to raise the issue of supervisory experience and education/training. We thanked the Board for actively listening to our concerns and requested that they include this topic on their agenda at the next Board of Directors meeting.

Our Affiliates Meeting at Convention provided an opportunity for members of the Coordinating Committee to meet and greet some of our Convention attendees. It also provided us with the opportunity to discuss the letter that the Coordinating Committee sent to the Council for Clinical Certification (CFCC) in June (see below) on the topic of supervisory experience and training. We enjoyed a lively and productive exchange of ideas and opinions and are looking forward to continued dialogue on the topic with our online community.

Follow-Up on Letter and Requests to CFCC, CAA, and BOD

Affiliates may recall that the Coordinating Committee sent a letter to the CFCC in June 2011, which documented our concerns about the experience and training of supervisors. It included a summary of the results of an earlier survey that we sent to SIG 11 affiliates asking for input on this issue, supporting information from other professional associations regarding their guidelines for supervisors, and the language that we requested the CFCC to include in their revised standards. It is the belief of the SIG 11 Coordinating Committee, as well as many of the affiliates of SIG 11, that supervisors should have at least 2 years of clinical experience following ASHA certification and demonstrate continued learning and competence in the area of supervision.
In addition, during the 2011 peer review process for the Council of Academic Accreditation (CAA), we submitted a request that the topic of supervision be added to the graduate curriculum.

As a follow-up to our meeting with the BOD at Convention, we sent a letter that summarized our concerns regarding supervisors’ qualifications. The letter included the results of the SIG 11 affiliates survey and the supporting information from other professional associations regarding their guidelines for supervisors. Shelly Chabon, 2012 ASHA President, replied, and the topic was discussed by the BOD at its January meeting. After discussing the issue, a Board subcommittee was created to provide greater focus on the issues and develop recommendations for the full BOD to consider. Additional information can be found at http://www.asha.org/About/governance/BOD/BOD-Report-January-2012/ under “2011 Convention Membership Forums.”

**Continuing Education**

The Coordinating Committee will be discussing CE courses to recommend to ASHA Professional Development (APD), which is under the oversight of the Scientific and Professional Education Board (SPEB). Each year, approximately 30 new courses are developed, which are presented as web seminars (webinars), video/DVD self-study programs, or online workshops that combine text, audio, video, and interactive exercises. We are looking forward to promoting the addition of more CE activities for ASHA members in the area of supervision!

Don’t forget that you can earn CEUs with each issue of *Perspectives*. We have excellent articles that can help you maintain your ASHA certification simply by reading and answering the multiple-choice questions. From the Table of Contents screen, click on the CE Questions (PDF) link in the box titled “This Issue.”

**Online Community**

Please consider becoming an active participant in our online community! If you have questions, concerns, or just want to exchange ideas with your fellow SIG 11 affiliates, this is an easy way to do so. You may customize your account, thereby having as little or as much updating sent to your e-mail account as you wish. I am looking forward to seeing heightened activity and thought-provoking discussion from our affiliates in the coming months!
Understanding Personality: A Key to Supervisory Success

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The notion of clinical success has both a narrow and broad perspective. This article explores the idea that the personality of a clinician can impact clinical success from both perspectives. I present a summary of pertinent literature and a discussion of a realistic approach to successful supervision utilizing personality assessment.

After becoming the department director of a rehabilitation hospital, it didn’t take me long to discover that the brightest, most experienced, and best clinician in the department had a problem. In spite of her intelligence and superb clinical skills, her paperwork was significantly delinquent. Short-term strategies to resolve the delinquencies were effective in reducing the backlog but did not produce lasting results. There was no resolution of the underlying issues. At a different facility, a clinician had difficulty with the flexible scheduling necessary for a busy acute care hospital. These two real scenarios suggest that supervisors who primarily focus on behaviors and outcomes may have difficulty understanding the cause of behaviors that influence those outcomes. This lack of understanding may limit outcomes and frustrate both the supervisor and supervisee. Regarding the scenarios, the former clinician was neither lazy nor misunderstood the importance of documentation. But, she had difficulty with processes that were peripheral to direct patient care. The latter clinician demonstrated exceptional clinical skills but required a work environment that was consistent and predictable.

Faced with similar dilemmas, a supervisor can expend considerable mental and physical resources on a situation that may not change significantly. However, the shortage of experienced health professionals suggests that management options to reduce staff turnover are preferred. The manager should consider the underlying cause of the behavior. Is the behavior based on the temperament of the individual? Is there a dissonance between the person’s temperament and the workplace requirements? Representing the cognitive makeup of the therapist, behavior based on temperament is difficult to change without some modification in the context of the work environment. In the scenarios above, the former clinician needed predetermined, inflexible, and permanent blocks of time for paperwork with a certain amount of oversight. The latter clinician was happier when transferred to the more routine environment of the inpatient rehabilitation unit.

These scenarios remind us that there is more to being a successful therapist than just excellent direct patient care. Success is multifaceted and includes meeting the requirements of a complex employment environment. How can a supervisor assist a professional or student in becoming a successful speech-language pathologist? Can the supervisor or manager circumvent potential problems and manage for success? To answer these questions, we must understand better our supervisees.
The Successful Clinician: Early Studies

Since the early years of the profession of speech-language pathology, there has been an assumption that clinical dynamics are a significant factor in therapeutic success. Ward and Webster (1965b) believed that “success in clinical practice is dependent not only on what the clinician does, but also on how he/she does it” (p. 103). They wondered if “the development of the humanness of our students is as basic and important as is the transmission of clinical know-how” (Ward & Webster, 1965a, p. 40), suggesting that the competent clinician has both technical skill and an appropriate relationship with others. Although Ward and Webster did not define further what they meant by clinical success or competence, many studies have focused on the narrow perspective of direct patient contact.

Several studies have considered Ward and Webster’s (1965a, b) assertion. One of the first to investigate clinical competence, Oratio (1976) attempted to find the most significant criteria for evaluating the effectiveness of therapy. Using factor analysis of 40 possible criteria and a supervisory assessment of therapeutic effectiveness, Oratio determined that 18 variables representing 2 factors were critical for good therapy: technical skills and interpersonal relationships. (Interpersonal factors included establishing rapport; demonstrating respect for the client and emotional stability; and maintaining appropriate personal appearance, attitude, and involvement in the therapeutic process.) Oratio evaluated only clinical competence in a narrow sense and did not consider clinical management or program compliance variables. Using clinical supervisors’ assessment of student therapy, Haynes and Oratio (1978) found similar results when clients were asked to judge clinical effectiveness. From a client’s perspective, the most important factors to clinical effectiveness were technical skills and the clinical demonstration of empathy and authenticity. Although these two studies did not assess student personality, they did demonstrate the importance of interpersonal relationships in the therapeutic process.

Although interpersonal skills appear to play a role in effective clinical care, the related but larger effect of clinician personality was first described by Cooper, Eggertson, and Galbraith (1972). They reported three different studies that compared student clinician personality and clinical effectiveness. In the first study, 24 undergraduate students were scored on 7-point scales relative to clinician effectiveness in therapy and administered three different personality tests: the California F Scale (Adorno, Frenkel-Brunswik, Levison, & Stanford, 1950), the Dogmatism Scale (Rokeach, 1948), and the Fundamental Interpersonal Relations Orientation–Behavior (FIRO-B) Scale (Schultz, 1958). The only statistically significant correlations were observed between the clinical ratings and the FIRO-B in terms of expressed inclusion, wanted inclusion, and expressed affection. The second study investigated the relationship between judgments of clinical effectiveness and scores on the Minnesota Multiphasic Personality Inventory (MMPI) and the FIRO-B scales. The researchers assessed 28 graduate students and observed statistically significant correlations on the FIRO-B wanted control and expressed affection scales and on the MMPI hypochondriasis scale. The third study assessed the relationship between judged clinical effectiveness and scores on the Edwards Personal Preference Schedule (Edwards, 1959) and the Inner-Outer Social Preference Scale (Kassarjian, 1962). Fifty-one graduate student clinicians served as subjects. Results found no statistically significant relationship among these personality scales and assessments of clinical skills. As a group, these three studies demonstrate that student clinicians tend to be extroverted and desirous of group identity and relationships, yet desire certain parameters of control or responsibility. Good clinicians tend to be aware of their limitations.

Shriberg et al. (1977) administered the Eysenck Personality Inventory (Educational and Industrial Testing Service, 1963), the Rotter’s Social Reaction Inventory (Rotter, 1966), and the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960) to a group of 133 undergraduate clinical students. They found that none of the personality scales were highly predictive of clinical performance. But, there were interesting trends. Clinicians who have an
internal locus of control are inclined to be better clinicians, and better clinicians tend to have a higher need for approval. Good clinicians are likely to be self-starters and care about how their behavior affects others. They found that student clinicians who have personal adjustment problems often have difficulty with clinical performance. There was no relationship between clinical ratings and scores on introversion and extroversion, but there was a strong association between a student’s interpersonal and professional-technical skills. Although interpersonal skills play an important role in the makeup of the competent clinician, Shriberg and his colleagues believed that clinical competence is not confined to a specific type of interpersonal interaction. In other words, one cannot assume that persons who are extraverted are better clinicians.

Crane and Cooper (1983) examined the relationship between personality and clinical effectiveness in a group of 130 graduate students in speech pathology at several universities. The students were given the MMPI and Oratio’s (1976) clinical effectiveness scale. When clinical skills were divided into those that were interpersonal and technical and students were grouped relative to their clinical effectiveness, the researchers observed significant differences in profiles. MMPI profiles were significantly different between dually effective (interpersonal and technical) and dually ineffective groups and between groups that were effective in one area and ineffective in the other. It is of interest that 85% of the subjects who demonstrated effective technical skills also had effective interpersonal scores. They found no single scale on the MMPI that predicted clinical effectiveness. However, group mean scores revealed that these students tended to be compliant, passive, sensitive, detail-oriented, and anxious. They also displayed tendencies toward imagination and creativity.

In an attempt to discover common personality traits shared by the profession, Flocken (1980) gave the Sixteen Personality Factor Questionnaire to 60 graduate students in communication disorders. He found no strong scores (high or low) on any of the 16 factors, suggesting that students in communication disorders demonstrate a profile similar to persons in the general population. There were mild tendencies of the students’ group profile to be reserved, intelligent, emotionally stable, assertive, imaginative, unpretentious, and experimenting (free-thinking). These personality traits were not correlated to an assessment of clinical effectiveness.

These early studies found some common descriptors among clinicians. They tended to be intelligent, emotionally stable, sensitive, and aware of their limitations. Most students were both technically and interpersonally effective clinicians. However, the sum of these early studies also found contradictory descriptors: clinicians tended to be compliant and desired an external locus of control, yet had an internal locus of control and were self-starters; they were creative and imaginative, but detail-oriented; they were extraverted, yet reserved; assertive, yet passive. These apparent contradictions present a quandary for the supervisor who is searching for a description of the typical clinician. Differing results can arise from several research variables, including studies with limited numbers of subjects, varying assessment tools with different theoretical bases, and varying academic level of subjects involved in clinical service provision.

**Jungian-Based Assessment**

Personality assessment based on Jungian theory has been popular in health-care provision and research (e.g., Davis & Banken, 2005; Hardigan & Cohen, 2003; Jamison & Dirette, 2004; Jessee, O’Neill, & Dosch, 2006; Shuck & Phillips, 1999; Winn & Grantham, 2005). Swiss psychologist Carl Jung attempted to find a few principles to explain the myriad of behaviors he observed. Jung theorized that individuals approach and solve problems differently based on their personality type. He described persons having four mental processes or psychological types (sensing, intuiting, thinking, and feeling) and two attitudes toward the world (extraverted and introverted). For a synopsis of Jungian theory and a more complete
description of the four poles, see Mills (2006), McCaulley and Martin (1995), and Keirsey (1998). The two most widely used assessments to test personality in the normal population based on Jungian theory are the Myers-Briggs Temperament Inventory (MBTI; Myers & McCaulley, 1985) and the Keirsey Temperament Sorter II (KTS-II; Keirsey, 1998). A strength of the MBTI and KTS-II is that they do not identify psychopathology but are sensitive to differences in the personality of persons in the normal population. These instruments provide similar scores and have demonstrated an acceptable degree of validity, reliability, and correlation (Carlyn, 1977; Hull, 1998; Kelly & Jugovic, 2001; Quinn, Lewis, & Fischer, 1992; Tucker & Gillespie, 1993). The theories of Myers and Keirsey are not identical: Myers focuses on how individuals think and feel and Keirsey focuses on how people behave. Thus, scores from these two popular tests may be similar but face slightly different interpretation.

The four pole Jungian system includes extraversion-introversion (E/I), sensing-intuiting (S/N), thinking-feeling (T/F), and judging-perceiving (J/P) and is used by both Myers-Briggs and Keirsey. These four poles allow for 16 different combinations of personality types. Keirsey believes that these 16 different types can be subcategorized into four basic temperaments based on how individuals communicate and how they accomplish their goals (Keirsey, 1998). Specifically, concrete individuals prefer the external world of realities and facts, whereas abstract individuals enjoy the internal world of theories and ideas. Utilitarian individuals are pragmatic, doing what it takes to accomplish the task, whereas cooperative individuals tend to act in a traditionally acceptable manner, considering group or social standards. A combination of these traits results in the temperaments:

1. Concrete and cooperative, all preferring sensing (S) and judging (J)
2. Concrete and utilitarian, all preferring sensing (S) and perceiving (P)
3. Abstract and cooperative, all preferring intuiting (N) and feeling (F)
4. Abstract and utilitarian—all preferring intuiting (N) and thinking (T)

There are no known published studies of Jungian personality and clinical effectiveness in speech-language pathology. However, the personality traits of clinicians have been assessed. The earliest known study of Jungian personality preferences in speech-language pathology was conducted by Middleton and Roberts (1981). The dominant traits found for 121 graduate students and practicing professionals were extraversion (E), intuiting (N), feeling (F), and judging (J). This study did not describe any difference between practicing clinicians and students. Similarly, McCaulley (1983) studied over 300 students and practitioners in speech-language pathology and discovered predominant preferences for NF (intuitive and feeling; abstract and cooperative), totaling 41% of the sample, and a second most predominant temperament of SJ (sensing and judging; concrete and cooperative), totaling 27% of the subjects. It is notable that both students and practicing speech-language pathologists demonstrated almost identical proportions of the same temperament (NF versus SJ). Craig and Sleight (1989) found similar results with a predominance of the NF types. Clinicians who prefer NF tend to desire meaningful relationships and work situations that are harmonious. Decisions are often made on an idealistic concern for their environment. They are often global thinkers, learning through theories, ideas, and deductive reasoning, filling in the details as they learn.

The Contemporary Clinician

The aforementioned characteristics of behavior represent students and professionals from almost a generation ago. More recently, Fraas and colleagues (2005) found the most common personality type of 84 graduate students at two universities was ESFJ (extraverted, sensing, feeling, judging; concrete and cooperative). Persons with an SJ temperament tend to be inductive thinkers who have a traditional work ethic and prefer detail, structure, routine, and experiential learning. ENFJ and ENFP were the second and third most common personality types. In a larger study of 272 graduate students at six universities, Baggs (2009) found similar results, with 62% of the students having an SJ temperament (51% of all graduate students
were either ESFJ or ISFJ) and 28% of all students were of an NF temperament. Approximately 60% of the students assessed were extraverted. The majority of students in both studies (Baggs, 2009; Fraas et al., 2005) preferred a temperament different from those of the majority of speech-language pathology students a generation ago. Although most every personality type was observed in these two studies, it is clear that the majority of graduate students demonstrated the SJ temperament.

Has the personality of the profession changed? A comparison of these two studies (Baggs, 2009; Fraas et al., 2005) with those described above demonstrates that the primary and secondary most predominant traits have changed in the past 30 years. Earlier, NF was most predominant and SJ was the second most predominant temperament. Presently, the majority of student clinicians have SJ traits, and NF is the second most common temperament. Thus, the first and second most predominant temperaments of students in speech-language pathology have reversed in the past generation. Students in other health professions have also changed. Shuck and Phillips (1999) found pharmacy students have moved from predominantly thinkers to feelers and are now predominantly SJ types. Medical students have changed from primarily perceivers to judgers (Stilwell, Wallick, Thal, & Burleson, 2000).

What is the personality of the typical contemporary clinician? Baggs (2009) found that 14 of the 16 possible Jungian personality types were represented in his population of student clinicians. There is no single personality type that describes all clinicians. However, the majority of students in speech-language pathology were found to represent ESFJ or ISFJ types.

These individuals’ preferences lie in
• Details, demonstrating good powers of observation and trusting what is tangible and practical;
• Inductive reasoning, moving from specific details to generalizations;
• Awareness of others and decision-making based on personal values;
• Task-orientation, organization, and decisiveness; and
• Tradition and group orientation, demonstrating stability and dependability.
These characteristics suggest a student or employee who is loyal and dependable but could be rather inflexible.

Even though these findings demonstrate a typical temperament for the speech-language pathology student, they do not suggest that the hiring manager or supervisor should prefer a specific temperament. Moreover, there is no known personality that describes the ideal clinician. Each type or temperament has its own strengths and limitations, allowing the clinician to make a unique contribution to the work environment. Each dichotomous type brings potentially unique and positive contributions to the workplace, and each has the potential to bring tension. For example, clinicians who are primarily judgers (J) are more likely to prefer standard protocols of care, whereas individuals who are primarily perceivers (P) are more likely to be open to new developments and perspectives. Intuitive (N) individuals are inquisitive, enjoy theory, and have a tendency to be perfectionists. They may have also a tendency toward rigidity and can miss the obvious. Persons who demonstrate intuiting types may prefer the possible world, whereas sensory (S) individuals operate in the real world. Thus, we need abstract thinkers and utilitarian individuals to dream, problem-solve, and consider the future. But, we also need concrete thinkers and cooperative individuals to help us see the workplace as it is currently. Both bring important perspectives to the workplace, and both should be respected for unique and potential contributions to the workplace.

The thoughtful supervisor may utilize the unique traits of the therapy team members to accomplish the organizational goals. Knowledge of personalities across team members may alleviate or reduce conflict among the members. One hospital in the Northeast communicates personality traits among the physicians and staff, resulting in enhanced communication among employees and reduced stress (Consulting Psychologists Press, n.d.). In higher
education, group projects are enhanced when members with complementary temperaments are included (Shen, Prior, White, & Karamanoglu, 2007).

**The Successful Clinical Environment**

Efficacious therapy is specific to patient outcomes, and successful clinicians certainly incorporate efficacious methods in therapy. But, the meaning of clinical success may depend on one’s perspective. Some individuals consider that a successful therapist meets organizational goals through means such as production quotas and reporting deadlines. Others believe that moving patients toward greater functionality and a higher functional independence measure (FIM) score defines success. Some people hope for a harmonious work environment with contented employees and limited staff turnover. It is likely that none of these individual characteristics—but, rather, a culmination of many—define clinical success. I believe that clinical success is found both in the therapy room and in the larger work environment, and this success is dependent on the cooperation of each team member. Cooperation among team members requires the understanding and utilization of each member’s temperament for the benefit of the team and organization. The manager’s responsibility is to facilitate this level of understanding and collaboration.

**A Caveat and an Admonition**

Personality inventories may be influenced by a number of internal and external variables. And, an individual’s behavior is complicated by numerous factors that cannot be explained completely by any categorical assessment system. Personality assessment reflects the mode in which the clinician operates most comfortably. Therefore, a personality type will not reflect every behavior of the clinician. These concerns require the careful use of personality assessment in higher education and the workplace. Even though persons with certain personalities are attracted to certain professions, the use of personality assessment is not recommended as a means to qualify an individual for admission to graduate school or employment. Each personality type brings unique and important perspectives to the workplace.

Most individuals have an intuitive knowledge that behavior is at least partly the result of personality. But, few managers utilize formal personality assessment to advance organizational goals. For those managers who do use personality information, an unfortunate and limiting focus of personality assessment is an attempt to predict potential difficulty with a clinician. Rather than limiting the individual, personality inventories should be used to facilitate “life-long developmental pathways that open options for fulfilling the motivations and gifts of an individual” (McCaulley & Martin, 1995, p. 232). Significant teams may be built when the strengths and weaknesses of the team members are considered. Bud Bray is quoted saying, “The most successful people are those who don’t have any illusions about who they are. They know themselves well and they can move in the direction of their best talents” (Smye, 2002, p. 170). In our search for success, we would do well to understand better ourselves and others.

**Acknowledgment**

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University

Mary Pat McCarthy, Column Editor

Student Peer Mentoring in the Clinical Training of Speech-Language Pathologists

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This phenomenological study explored the nature of clinical peer mentoring experiences from the perspectives of first-time undergraduate student clinicians, graduate student peer mentors, and their clinical instructor at one Midwestern university. Participants included five mentor–first-time (FT) clinician pairs and one clinical instructor. In-depth, semi-structured, face-to-face interviews were analyzed using Moustakas’ (1994) modified van Kaam method of analysis of phenomenological data. The findings revealed personal and reciprocal peer mentor–FT clinician relationships that impacted clinical instructor supervision. The results suggested a dichotomy between acceptance of peer mentor guidance and support and FT clinician self-confidence in clinical skills. The findings demonstrated the potential impact of relationship dynamics between peer mentor and clinical instructor on the overall clinical experience of FT clinicians. The results yielded implications for peer mentor model development.

In recent years, literature has addressed the value of mentoring in professional training and career development (Wright-Harp & Cole, 2008). A technical report on clinical supervision of speech-language pathologists (SLPs) suggested various areas of knowledge and skills that should be acquired by the SLP prior to undertaking a clinical supervision role (American Speech-Language-Hearing Association [ASHA], 2008). One such area is mentoring. Mentoring involves a relationship in which a mentor is dedicated to the professional and personal growth of 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” (ASHA, 2008, p. 4). Supervisory mentoring does not involve an evaluation of the mentee’s clinical performance. In fact, peer mentoring provides students with support, assistance, and critical feedback when working with a client without the pressure of formal evaluation (Remley, Benshoff, & Mowbray, 1987). Consequently, peer learning occurs during the mentoring experience.

Peer learning, in general, is a natural occurrence within the university environment. Lincoln and McAllister (1993) defined peer learning as knowledge obtained “through study, experience, observation or teaching of an equal” (p. 1). Peer learning can instill a sense of lifelong and cooperative learning (e.g., reduced competition among students within the learning process). Given the fact that peer learning already exists within the university setting to different degrees, and mentoring is part of the supervisory process, the study of benefits of peer mentoring within clinical training programs appears appropriate. Borders (2001) described
peer group supervision in counseling and detailed the benefits of peer feedback. A peer-mentoring model that provides advanced clinicians (mentors) a closely supervised peer mentoring experience with inexperienced clinicians (mentees) would offer the mentor valuable supervisory experience in the mentoring process (e.g., advising, tutoring, sponsoring, and instilling a professional identity in the mentee). This model would also contribute to the goal of clinical independence and enhancement of professional identity (Benshoff, 1993; Bigelow & Johnson, 2001; Lincoln & McAllister, 1993). Additionally, it could contribute to meeting the needs of first-time (FT) or beginning clinicians.

FT clinicians across a variety of disciplines come into the clinical practicum skilled in academic work but with virtually no clinical skills and, therefore, limited confidence in how to do clinic (Friedman & Kaslow, 1986; McCrea & Brasseur, 2003). For the most part, the FT clinician’s concern is performing certain skills and performing them correctly. These inexperienced clinicians exhibit a great deal of self-doubt and anxiety (Levitt, 2001). Beginning clinicians tend to feel overwhelmed by the demands of the first clinical experience (Gard & Lewis, 2008).

Carozza (2011) suggested that each clinical experience imparts distinctive features that contribute to the dynamics of that experience. Geller and Foley (2009) supported this notion and advised providing a broad, humanistic context to supervision that considers the supervisee’s internal and external behavioral and affective states, interactions, and actions. Dynamics inherent in the clinical experience and clinician–supervisor relationship may shape the FT clinician’s perception of his/her clinical success. As a result, one can assume supervisory style plays a key role in the mentoring process and relationship. The FT clinician in the field of speech-language pathology wants supervisors to use a more direct supervision style (Joshi & McAllister, 1998). A direct supervision style involves telling, directing, criticizing, offering opinion, providing suggestions, suggesting change, and evaluating (Anderson, 1988). In social work, other supervisory needs of beginning supervisees include availability, support, responsiveness to feelings, and structure within the clinical experience (Sun, 1999). In counselor education, beginning clinicians rank care, concern, and experience as important attributes of supervisors during their first practicum experience (Jordan, 2006). Wright-Harp and Cole (2008) proposed personal style compatibility between mentor and mentee as a means for student success. In summary, FT clinicians need a more directing, but supportive, clinical environment for learning to occur.

Student clinicians should be well equipped to mentor others when they reach the transitional stage or the self-supervision stage of the Anderson Continuum Model of Supervision (Anderson, 1988). During this stage, clinicians make online decisions regarding clinical skills, strategies, and intervention and benefit from independent decision-making. During self-supervision, clinicians gain confidence (Sbaschnig, 2009) and, as a result, clinical independence.

Providing the benefits of mentoring (e.g., assistance, tutoring, developing a professional identity, providing feedback) to a beginning clinician is an important component of the training process. Peer mentoring by an advanced clinician, in collaboration with a clinical supervisor, takes advantage of the peer-learning process to augment the clinical experience of the beginning clinician. Working with a mentoring peer who exhibits greater experience (i.e., knowledge regarding doing clinic) and is not involved in evaluating the student (i.e., providing a grade for the clinical experience) may allow the FT clinician to be less overwhelmed and intimidated, resulting in more focused learning. The experience provides the FT clinician with an additional source of information and guidance from a fellow student who has recently experienced being in that position. Finally, this form of triadic supervision coming out of a peer mentoring format may lead to greater clinical-skills development in both peers (Hein & Lawson, 2008) and increase the likelihood of involvement in clinical supervision after graduation.

Extant research consists predominately of supervisory process, practice, and needs. Unfortunately, there is a paucity of published data on student peer mentoring in the clinical
training of SLPs. Consequently, the purpose of this initial phenomenological study was to extract meaning from the clinical experiences of the FT clinician, peer mentor (PM), and clinical instructor (CI) at a university that exclusively grants master’s degrees. Most frequently, academic training of supervisors focuses on doctoral candidates; however, the present study targeted master’s level trainees, given the large quantity of these individuals in the profession and the likelihood that they will supervise in some capacity in the future (O’Connor, 2008).

A secondary purpose of this research was to evaluate the peer model experience and discover implications for peer mentor program development. One central research question guided this study: What is the nature of the clinical peer mentoring experience? The central research question yielded eight research sub-questions:

1. What is the nature of the PM clinician and FT clinician relationship?
2. What is the perceived impact of the peer mentor program on the overall clinical effectiveness of the FT clinician?
3. What are the perceived clinical competence needs of the FT clinician following the peer mentoring experience?
4. What are the perceived clinical competence/mentoring needs of the PM following the peer mentoring experience?
5. What is the perceived significance of the peer mentor program?
6. What is the perceived effectiveness of the peer mentor program?
7. What are the characteristics of the PM experience in the peer mentor program?
8. What are the characteristics of the FT clinician experience in the peer mentor program?

Theoretical Framework

The theoretical framework for this study included components from three theoretical models: Relational and Reflective Model (Geller & Foley, 2009), Continuum Model of Supervision (Anderson, 1988), and Phase Model (Kram, 1983). The theory of the Relational and Reflective Model used in supervision focuses on the interpersonal aspects that impact the overall supervisor/supervisee relationship. This theory purports that learning occurs through reciprocal relationships established between the supervisor and the supervisee. These relationships develop over time and impact the overall dynamics of the supervisor/supervisee experience (Geller & Foley, 2009).

Similar to the model that Geller and Foley (2009) proposed, the Anderson Continuum Model of Supervision (Anderson, 1988) outlines a developmental model of supervision that is devoid of time constraints and comprised of three distinct stages: evaluation-feedback stage, transitional stage, and self-supervision stage (McCrea & Brasseur, 2003, p. 20). This model emphasizes the supervisor-supervisee interactions that occur throughout the supervisory experience and underscores the need for the supervisor and supervisee to move along the continuum in a manner that ultimately promotes supervisee independence.

Kram (1983) suggests mutual career and psychosocial benefits for all involved in a mentor relationship (p. 613) and proposed a four-phase model of the mentor relationship. Akin to the Relational and Reflective Model and Anderson’s Continuum Model, the Phase Model describes phases the mentor relationship experiences: initiation, cultivation, separation, and redefinition (Kram, 1983). The mentor relationship progresses from the point in which the relationship shows mutual importance to the time when the relationship ends or those involved function in what Kram called a “peerlike friendship” (Kram, 1983, p. 622). A goal of this model is to explore the patterns inherent in the mentor relationship at various stages to provide focus to other existing relationships that may impact the mentor relationship (Kram, 1983, p. 623).
When applied to this study, the Relational and Reflective Model, the Continuum Model of Supervision, and the Phase Model hold the notion that mentoring is a developmental and relationship-forming experience. In sum, these theories provided the framework for the study of the essence of the clinical experience of the peer mentoring participants.

**Method**

The researchers deemed a qualitative paradigm and phenomenological tradition the best choice for this type of study. Transcendental phenomenology was used to explore the nature of the clinical peer mentoring experience from the perspectives of the FT clinician, PM, and CI. Transcendental phenomenology was the logical choice of design for this study as it provides detailed analysis of the descriptions of lived experiences and the opportunity for extensive interviews, which supplied more depth (Patton, 2002) to discovering the clinicians’ perceptions and attitudes. Data analysis utilized Moustakas’ (1994) modified van Kaam method of analysis of phenomenological data. The researchers felt it important to focus on the specific experiences, attitudes, and perspectives of each participant. Consequently, the interviews were transcribed verbatim. Core themes extracted from the data represented participant attitudes and expectations and the benefits and challenges associated with peer mentoring and clinical supervision of mentors and mentees.

**Framework for the Peer Mentoring Experience**

The peer mentoring program consisted of a multifaceted framework. The framework included a general orientation to the program, provided a tour of the facility, outlined procedures for assessment and intervention, provided guidelines for observation, and presented orientation to the necessary documentation. The PM and CI provided a physical tour of the clinic that included not only the location but also the importance of the areas in providing clinical service. The PM also provided an orientation of the clinical practicum website found on Blackboard. The PM highlighted the content areas most relevant to providing clinical services. The PM reviewed confidentiality, infection control, and professionalism forms and topics. Additionally, the framework contained a specific paperwork review process that included guidelines and timelines for paperwork submission. Finally, the framework included timelines and provided ratios for FT clinician and PM clinical intervention with their client (i.e., the amount of time each would supply direct intervention to the client). Appendix A (see supplemental material) outlines the general framework for the peer mentoring experience. FT clinicians, PMs, and the CI received a manual that detailed their roles and responsibilities and the program process and procedures. The framework provided in Appendix A is a summary of some of the responsibilities and procedures provided in the peer mentor manual. This manual is currently being revised in response to the findings of this study.

**Participants**

Participants included five FT clinicians, five PMs, and one CI for a total of eleven participants. The FT clinicians were undergraduate students. Prior to participation in the present study, all FT clinicians obtained 25 hours of observational experience along with completion of academic coursework targeting principles of clinical management and assessment and treatment of childhood articulation, phonological, and language disorders. The PMs were graduate students who had at least four semesters of clinical practicum experience and who were enrolled in their final semester on campus. The CI held a master’s degree and ASHA certification in speech-language pathology. The CI was employed as a full-time instructor in the communication disorders department. Because of the depth of data collection, the researchers deemed the five PM–FT clinician pairs sufficient to extract the essence of the peer mentor experience. To promote consistency in supervision, the researchers used one clinical instructor for the five clinician pairs. Table 1 provides the participant profiles.
Table 1. Participant Profiles

<table>
<thead>
<tr>
<th>Peer Mentors (PMs)</th>
<th>First-Time (FT) Clinician</th>
<th>Clinical Instructor (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant 1</td>
<td>Participant 4</td>
<td>Participant 11</td>
</tr>
<tr>
<td>Participant 2</td>
<td>Participant 5</td>
<td></td>
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<td>Participant 3</td>
<td>Participant 7</td>
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<tr>
<td>Participant 6</td>
<td>Participant 8</td>
<td></td>
</tr>
<tr>
<td>Participant 10</td>
<td>Participant 9</td>
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</tr>
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</table>

Data Collection and Analysis

In-depth, semi-structured, face-to-face interviews provided the data for the study. Different interview protocols were used for FT clinicians, PMs, and the CI. Each interview took place in the university clinic and lasted 35–60 minutes in length. The interviews were completed in a quiet room to reduce distraction. The interviews were digitally recorded in Olympus DSS digital voice software, and the saved data were stored in a folder that corresponded to a number assigned to each participant. The data were transcribed using data transcription equipment. The researcher printed several copies of each transcribed interview to use for participant checks, quality control, and coding, and the transcribed interview data were color-coded. Moustakas’ (1994) modification of the van Kaam method of analysis of phenomenological data provided the means to reduce the interview data and extract themes and sub-themes.

Data collection also included use of epoche/ bracketing, researcher’s reflective journal, handwritten field notes, and participant rechecks to ensure accuracy in interpretation and relaying of participant accounts. To ensure evidence of the quality of data interpretation and analysis, the researchers used two methods of coding. The Microsoft Word processing program and the NVivo 8 coding program provided coding, categorization, theme extraction, and labeling. Triangulation of data; participant checks; rich, thick description of analyzed data; and peer debriefing, using a second examiner to code the data using the NVIVO program, provided additional quality checks. Critical comparisons of the printed and audio-recorded data provided a final layer to certify trustworthiness of research.

Results and Interpretation

Data from the 17–23 interview questions generated description of the overall peer mentoring experience. Participant responses to the structured interview questions yielded 14 composite codes and themes in relationship to the research sub-questions. The following themes emerged and reflected the clinical experiences of the FT clinicians, PM, and CI:

1. Relationships Established
2. Shared Experiences
3. Joint Learning Opportunity
4. Lack of Supervisory Guidelines
5. Schedule Conflicts
6. Positive Experience
7. Ill-Defined CI Expectations
8. Externships Hindered Mentors
9. Initial Ill-Defined Mentor/Mentee Roles and Responsibilities
10. Collaborative Experience
11. Mentor Support and Guidance
12. Mentor Satisfaction With Performance
13. Difficult CI/Mentor Interaction
14. Mentee Learn by Doing

Table 2 provides a description of the 14 composite themes and their relationship to the research sub-questions.

Table 2. Composite Codes and Themes in Relationship to Research Sub-questions

<table>
<thead>
<tr>
<th>Code</th>
<th>Theme</th>
<th>Research Sub-questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Relationships Established</td>
<td>1, 2, 5, 7</td>
</tr>
<tr>
<td>2</td>
<td>Shared Experiences</td>
<td>1, 2, 7</td>
</tr>
<tr>
<td>3</td>
<td>Joint Learning Opportunity</td>
<td>1, 2, 5, 7</td>
</tr>
<tr>
<td>4</td>
<td>Lack of Supervisory Guidelines</td>
<td>2, 6</td>
</tr>
<tr>
<td>5</td>
<td>Schedule Conflicts</td>
<td>2, 6, 7</td>
</tr>
<tr>
<td>6</td>
<td>Positive Experience</td>
<td>1, 2, 6, 7</td>
</tr>
<tr>
<td>7</td>
<td>Ill-Defined CI Expectations</td>
<td>4, 7</td>
</tr>
<tr>
<td>8</td>
<td>Externships Hindered Mentors</td>
<td>4, 6, 7</td>
</tr>
<tr>
<td>9</td>
<td>Initial Ill-Defined Mentor/Mentee Roles and Responsibilities</td>
<td>1, 2, 6</td>
</tr>
<tr>
<td>10</td>
<td>Collaborative Experience</td>
<td>1, 2, 5, 6, 7</td>
</tr>
<tr>
<td>11</td>
<td>Mentor Support and Guidance</td>
<td>1, 2, 3, 6, 7</td>
</tr>
<tr>
<td>12</td>
<td>Mentor Satisfaction With Performance</td>
<td>4, 6, 7</td>
</tr>
<tr>
<td>13</td>
<td>Difficult CI/Mentor Interaction</td>
<td>2, 4, 7</td>
</tr>
<tr>
<td>14</td>
<td>Mentee Learn by Doing</td>
<td>2, 3</td>
</tr>
</tbody>
</table>

Of the 14 composite themes that emerged from the peer mentoring experience, the most salient were Positive Experience, Relationships Established, Collaborative Experience, Mentor Support and Guidance, and Ill-Defined CI Expectations. Although compelling alone, these themes jointly described the essence of the peer mentoring experience for the FT clinician and PM. Moreover, these 5 themes clearly paralleled other themes—Joint Learning Opportunity, Lack of Supervisory Guidelines, and Initial Ill-Defined Mentor/Mentee Roles and Responsibilities—and communicated the substance of the experience.

Positive Experience

Overall, similarities existed in FT clinician and PM perceptions of the peer mentoring experience. Both groups described the experience as positive and beneficial, yet not without difficulties. Participant 3, a PM, stated, “I think it’s a great opportunity for having the mentors and mentees work together.” Participant 2, also a PM, concurred, stating, “So, the overall experience, it was beneficial. I felt it was a great learning opportunity.” From the perspective of the FT clinician, the experience proved positive and beneficial, because it provided guidance and support. Participant 5 demonstrated this in her comment, “It was a positive experience. I think because you kind of get thrown into clinic and don’t know what we’re doing. And so, it was nice to have someone be there that had the experience that could guide you.” Participant 8 indicated a positive and beneficial experience. One FT clinician, however, reported an initial lack of enthusiasm for the process. She stated,
I don’t know. I wasn’t very enthused I guess about being placed with a mentor. But as time went on, I was like, “ok.” I can see how it has helped me out. So, I mean, overall it was good. I guess.

Likewise, PM participants demonstrated less than enthusiastic attitudes because of the concurrent nature of their externship (clinical practicum outside of the university clinic in schools or other offsite placements) with the peer mentoring. Participant 2 stated,

I am very organized and very particular and, you know, with getting my school work done, and that is my priority. But being in my externship, it was difficult because I am only here two days a week to fully provide her with the amount of time that I wish I could have, especially since I also work on campus as a graduate assistant. You know, those days that I am here, if I am not in class or clinic, I mean, that’s you know for work. . . . So, I mean it worked out, by, by you know, we had a lot of great times and stuff, but I really do think that I would have felt better as a mentor if I would have been able to been here, you know, maybe all five days or at least not in my externship where I am off campus in the school for two days. That made it a little more challenging.

Similarly, Participant 3 said,

I also feel it was a little confusion, and stressful for the mentor having a mentee being that we were in our externship and so we are only on campus two days a week. So, at the beginning, I felt that I was kind of cheating my mentee.

Although participants proclaimed the peer mentor experience as positive, some indicated hurdles that needed surmounting to enable them to fully benefit from the experience. Inasmuch as the CI described an overall positive experience, she also defined the experience as one filled with obstacles. She expressed,

Being a clinical supervisor for the peer mentoring program is like walking through a cave that is dark with maybe some spider webs and things in your face that as you continue to walk and explore, you see a light and you know that, that there’s something good coming if you can get to it. . . . And then, you know, little obstacles like rocks that we don’t want to trip over, and we’re trying to go around this and that. So as the instructor, kinda my goal was to get through it all without being taken down by an obstacle. And that we did. We made it around all the obstacles, and I think that in the end everybody came out with a positive experience.

Participant 7 and Participant 9 conveyed that scheduling times to meet and not knowing their expectations were obstacles to overcome. Participate 9 stated, “I was not sure at first, you know, what to expect, like what kind of role I was supposed to have in the whole thing.” Participate 7 said, “I wish they would fill out some kinda like a scheduling thing beforehand before they pair us with our mentor and match our schedules . . . it was just hard cause we couldn’t be in the clinic together when it was open.”

Despite the difficulties encountered, the participants perceived the overall peer mentoring experience as positive and beneficial.

Relationships Established

One can surmise that as a result of the positive experience, the FT clinician and PM established personal and working relationships. For the most part, the participants indicated that relationships had been forged between them. In fact, some participants stated the experience produced lasting friendships. Participant 4, a FT clinician, stated,

At first it was kind of awkward trying to figure out how to work together, but once we got the hang of it, I consider her a good friend and would have no problems going to her in the future if I had any questions.

Similarly, Participant 7, also a FT clinician, stated, “We have become really close and really good friends. And I’m gonna miss that.” When asked to describe her relationship with the FT clinician, Participant 6 stated, “It was very good. We got along really good. And like I said
before, I could see how if you didn’t get along with someone, that could be more difficult, but we got along really well.” Participant 1 declared, “I would say it was a really good working relationship and a friendship by the end.” Each of the FT clinicians and PMs reported mutual cooperation and good working relationships with their partner.

Supervisory style may have contributed to the building of positive relationships. The supervisory style that the mentor employed proved successful for the pair. FT clinician Participant 7 reported, “. . . we didn’t think we were all going to get the same opportunities. But after we worked everything out, to figure out like who was gonna do what, it ended up being better than I thought it was gonna be in the beginning.” Participant 3 encouraged her FT clinician to ask questions and demonstrated an easily accessible mentoring style. She stated,

I told her from the very beginning that I was a very honest and open person, and if she had any questions that she wanted to ask, or if she needed any advice on anything, she was more than welcome to come talk with me. We did talk. We had set aside an hour after each therapy session where we would work on paperwork or we would answer questions that she had, or I would give my comments to her that we had.

Participant 10 encouraged her FT clinician to ask questions as well. She reported, “I told her to ask about anything she had questions for . . . there’s no such thing as a dumb question.” She also explained, “I didn’t want her to feel like she had two supervisors. I wanted her to feel comfortable with me.” Participant 1 provided specific feedback and praise to her FT clinician and avoided negative feedback. She stated,

So lots of times to let her know, I’d be like, “Oh, that was really great session. I liked how you did this.”  Afterward, I would say, “Hey for next time we might want to try, you know x, y, and z for this activity,” or usually, I mean I would try to provide the specific praise that I was getting, you know, from the supervisor’s standpoint. You know, she reinforced an activity or was using language models that I felt were really appropriate, or I tried to be as specific as possible about, I think definitely, she did a great job. I really didn’t have anything to say like, “You messed up this. Do this this way.”

The CI’s supervisory style seemed to have an impact on the peer mentor pairs and the intervention provided. The CI reported,

Part of my supervision style is that I really go in the room a lot. You know, I try to take advantage of, as much as I can, of teaching opportunities as they’re happening. So, that’s a good thing, and then in other ways its reflected on my feedback form cause, sometimes I spend time actually giving them that feedback verbally and in the moment, and then I have to go back in and kind of write a little bit about it, so it takes a little extra time. So my feedback varies from being face-to-face feedback with the client sitting there and me demonstrating something with them, or actually coming in saying, “So how is this working? How can we change it?”

When asked how she perceived the PM’s and the FT clinician’s response to her going into the therapy room, she responded,

The first-time clinicians love that. And I think the mentors, who I’ve never had before, are a little bit startled that I come in the room, but as the semester went on, they became used to it, and they actually expressed that they appreciated that. And that they often don’t have supervisors that will do that. So that’s why I think they were a little bit put-off at the beginning that I come in, because their perception is if someone comes in the room, that means you’re doing something negative . . . .

Seemingly, the PM’s supervisory style contributed to the overall working relationship and inspired a bond between the peer mentoring pair. At the same time, the CI’s supervisory style impacted the relationship between the CI and the peer mentor pairs. Subsequently, participant collaboration contributed to developing positive peer relationships and impacted the overall peer mentoring experience.
Collaborative Experience

Generally, the participants reported collaboration throughout their experience. To a great extent, the CI compelled the participants to collaborate in the management and intervention of their clients. The CI reported some of the FT clinicians preferred independence in intervention. She remarked,

Most of the concerns came from the first-time clinicians. You know, they said, “Oh yeah, it’s great that I felt supported, and yeah it was less stressful,” but on the other hand some of them really said, “I would’ve loved to have the client on my own and just do what I want to do.”

Participant 8 supported the CI’s interpretation of independence in intervention and stated,

I want to figure things out for myself and I think, I mean it probably did help me out more than if I didn’t have one. But, especially in the beginning, I was like, I really wish I would have been able to figure all of this stuff out for myself rather than having someone just sit there and tell me the end and stuff like that.

Additionally, Participant 7 suggested the FT clinicians desired independence. She remarked, “And so at first I think we were all kinda mad that we had to do this, cause we wanted to do this, we wanted to do this on our own.” Similarly, Participant 5 remarked, “I didn’t get the trial and error that other clinicians do when they’re by themselves, because if she saw something she didn’t like, she would correct it right away.” Despite the desire for independence in intervention, four of the five FT clinicians reported collaborating with their PM. Participant 9 explained,

Like I said, we did most of the planning and everything together and so if she would come up with an idea and it didn’t seem right to me, I would just tell her, “Oh I don’t know if that will work because . . . ” Or, if I would come up with something and she’s like, “Well, I don’t know if that would work, because we didn’t have time for that.” So, we kind of just worked on it together.

Participant 5 conveyed a dislike for all of the necessary deadlines, but stated, “But I mean, I understand their purpose, because we had to collaborate and work together.” She also commented,

I would just talk to her about stuff I felt like, my peer mentor. I felt comfortable with her that I could bring up ideas and stuff. We had a meeting time after therapy each day. We would work on our paperwork or talk about things we wanted to try because that’s how I provided feedback to her.

Participant 4, who did not specifically report collaboration, reported that while she expected assistance from the PM, she did not expect joint intervention with the PM. She stated,

I didn’t think that they would be the mentors [emphasis added]. I thought they would be more like the clinical instructors, kind of just watching from the glass. . . . I mean helping but letting the mentee do everything, just kind of being there if we got into trouble. Like, if we had questions. I didn’t think we would be doing therapy together.

The common challenge of providing effective intervention to clients instigated joint collaboration between the peer mentoring pairs and the CI. Participant 1 reported collaborating with her FT clinician and reported that she wanted the same type experience in the future. She stated,

I did like the collaborative part of it. And because I always kind of thought that maybe, you know, when I got out into a setting, I would want to be in a cooperative setting where I could ask somebody something.

Participant 10 remarked,

My mentee and I, we worked jointly as a team. We worked together. We had to figure out what we needed to do with the client, and we had to work 50/50, so that meant we
need to put our heads together and figure out what in the heck we had, we needed to do, because then we had to please the supervisor. We really had to please everyone, the client too. It put me under pressure to know what to do so I could teach the mentee. So, it was good when we figured things out together. I mean the mentee had good ideas too.

The CI collaborated with the peer mentor pairs both jointly and individually. However, she perceived a degree of resentment and feelings of superiority from the PMs. She stated,

We had face-to-face meetings. A lot of e-mail communication, I felt like the mentors often would send the mentee to talk to me instead of them doing it themselves. And I'm not quite sure why. I don't know if that's because of the negativity that we had from the beginning, or because they weren't on campus sometimes and so they would send the mentee in, or they just didn’t, again, I think they felt some feelings of superiority so I think they had difficulty wanting to come talk to me about some issues. So they would send the mentee.

In describing the method for providing feedback and evaluation, which was part of the collaborative process, the CI explained,

We, we met typically two or three times a week, before or after their sessions, with any questions and concerns they had. At the beginning, we occasionally scheduled an additional time to go over issues or concerns, and then we had mid-case conferences individually . . . and then their final case conferences individually.

The findings clearly indicated that the participants perceived the collaborative nature of the experience and acknowledged their role in the process. Inasmuch as collaboration existed throughout the peer mentor experience, that collaboration occurred in tandem with forged relationships, unambiguous supervisory styles, and mentor support and guidance.

Mentor Support and Guidance

Every FT clinician indicated they received mentor support and guidance. Moreover, the FT clinicians expressed gratitude for the support provided. Participant 5 stated, “It was nice to have somebody to rely on . . . ” Similarly, Participant 7 indicated, “I learned a lot from her, and it was nice to have somebody to talk to. And once we figured out more about like how we worked together, it was nice having people to bounce ideas off.” When asked what she perceived as the best part of the program, Participant 4 stated, “Having someone I could bounce ideas off of. And then, if I get stuck she would be there to help.” She further expressed how overwhelming the experience was and indicated that having the PM was a benefit. She said,

It’s kind of overwhelming, like being completely overwhelmed with paperwork and everything. Just having her there just saying, “Just take it one day at a time. It’s going to be ok. We’re going to get through this.”

The CI encouraged mentor support and guidance and indicated mentor support and guidance as fundamental to their role as PMs. When asked what advice she gave the PMs to help them mentor, she stated,

I think we had a lot of discussion, you know, about their role and responsibilities first off. And, you know, they were the mentors, were encouraged to follow the policy and procedures outlined on Blackboard and in my syllabus. . . . I would think that’s the most outstanding part of the whole situation, was the way they started out the semester with the mentees as far as all of the Blackboard stuff, and the policies and procedures, and the paperwork, and where do you go to find this, and where do you go to get materials, and this is where we find the oral motor stuff and that was to me the most mentoring, the most effective mentoring. And I don’t know that I really prepared them for that other than saying that’s what you need to do for them, that’s your role [emphasis added]. Your role is not to teach them how to do therapy; your role is to guide them through the process.
Although the PMs reported that they provided support and guidance to their FT clinicians, some also saw this part of the peer mentoring experience as the most challenging in their role as PM. Participant 1 indicated,

I think it was just questioning whether I was telling her the right thing to do. And it did challenge me. It did challenge me to say, “Ok. Well, am I telling her the right process? Am I telling her the right thing to look for? Am I showing her the right way to do something?” I don’t know. It was just challenging, just challenging for me to think a little bit more about stuff and how to explain it to somebody else.

Similarly, Participant 6 perceived mentor guidance as challenging. She voiced,

I guess making for sure that she had all the information she needed and things like that. That I kind of feel like I want everything to be perfect . . . I guess one thing that can’t really address is your ability to work with a client. That was her first time ever having a client . . . so I think that that’s not something I could teach her . . .

Mentor support and guidance proved foundational to defining PM role and responsibilities. For the FT clinician, these aspects were central to the learning process.

Ill-Defined CI Expectations

Clearly defined CI expectations for the FT clinician–PM pairs also proved substantive to the peer mentoring process. Participants did not agree that CI expectations were clearly defined. In fact, three out of five PMs perceived that the CI did not provide them with clearly defined CI expectations. Participant 10 remarked, “It would have helped had I known what was expected of me from the beginning. I really didn’t, did not always know.” Likewise, Participant 3 noted,

I do feel at times, at the beginning of the semester, we hadn’t gotten, when we started, we hadn’t gotten the breakdown of the role and idea for the mentor and the mentee, which when we got that, it moved along a lot more smoothly. . . . For me just in the beginning it was kind of a mad dash and kind of crazy going through everything because we hadn’t yet got from ____ the guidelines and expectations.

Participant 1 stated,

I know it was a learning experience. I just felt like for the first, you know, couple MT plans that would be fine, but I felt like we just did it ad nauseam. I guess would be the word. Like, did a lot of stuff just more than necessary. . . . Just doing a lot of stuff more than I thought was necessary. Like repeating activities that I feel like, you know after one or two times, she’d probably get down . . . I wished I would have had the supervisor that I had previously to beginning this experience because it was difficult for me to tell my mentee what to do when I didn’t know the supervisor’s way of doing things . . . I felt like I was redoing all, a lot of stuff with me and with my mentee and us doing things together just because I didn’t know about supervisor’s method of paperwork.

PM beliefs that CI expectations were ill-defined markedly impacted the CI–PM relationships. When asked to describe her relationship with the CI, Participant 1 remarked, “Honestly, it was kind of tumultuous at first. Just because, again, it was frustrating because I didn’t know what she expected of me.” Participant 10 explained, “Because I didn’t have any expectations from her at first, it caused problems, because I didn’t know what I was expected to do. It caused problems that maybe we wouldn’t of had.” Similarly, Participant 3 remarked, “I think at times maybe our personalities were either similar, or too similar, to where certain things we would butt heads on.” Although Participant 2 did not specifically state ill-defined CI expectations, she did acknowledge tension with the CI. She commented,

I mean not knowing a lot about the mentee/mentor program, then when I knew I was doing it, that added, that kind of, you know, that new level of anxiety, and then finding out that that was my supervisor. That added more tension to the tension I already had.
But it was, we were able to open up the lines of communication and sometimes you learn a lot more from that than you think. It worked out fine though.

Contrary to the perceptions of some of the PMs, FT clinician Participant 7 reported that PM and FT clinician roles and responsibilities were clearly defined. She remarked, “I felt the program was pretty thorough in explaining what each of us had to do in each of our roles. And, we knew, you know, what our responsibilities were.” Participant 7 also reported a positive relationship with the CI in her statement, “She’s really positive and uplifting, and she always like tells me I’m doing a really good job, and that she’s proud of me.” Similarly, Participant 8 perceived the CI as positive and helpful. She stated,

She was great and she would give us ideas on how to do therapy. She would come in while we were doing therapy and say, “Maybe you should try this. This might get more responses out of her.” And she’s very, when it came time to turn in things, and she had a set date, but if you came to her early and said, “I’m not going to be able to get it in on time,” she was like, “That’s ok,” and she was always there when I needed her to talk to. And she was, she would answer my questions right then, or get back to me quickly.

Participant 8 also referred to printed material that outlined the PM roles and responsibilities. She remarked,

But once we had that sheet of what we were both supposed to do, it made more sense, and I was expecting her to just, you know, tell me what to do, and then I would be doing everything from point A to the end of the semester.

The CI confirmed the initial lack of ill-defined roles and responsibilities. She indicated that she eventually provided the participants with printed documents that outlined their roles and responsibilities. In spite of this, the CI felt the participants probably did not read them. She explained,

Well, we had our first-time staffing and we discussed how it would look and how, again, there weren’t well-defined roles and responsibilities yet, at that point. But, I just gave them an overview of what a goal was. And then, as we got more, we got the documents that actually had the roles and responsibilities. I shared that with them. Honestly, I’m not quite sure if they read them, but they were given, and we discussed, and I went over the main points. But, I don’t know if the roles and responsibilities, I think that the little chart we gave them with columns might be a little cumbersome. I mean, I think it’s, maybe too wordy. I don’t know if they read them. That’s what I’m saying. Yeah. Perhaps if we made them, you know, still had all the good info in there but made them easier to read, or like a checklist. Or, I don’t know, a tree. Yeah, maybe.

The CI perceived that the dynamics inherent in the PM–FT clinician pair dictated the roles and responsibilities of the groups. She stated,

And you know, what I would like to say, I don’t know if this plays into it, but because of the dynamics of each mentor pair and their client’s needs, it was difficult to follow, even though the roles and responsibilities that we had them set out, we had to make changes, depending on the needs of the clinicians and their schedules, kinda, you know, this one pair, sure they were able to do it to the letter of the way it said, and this other pair, well, you know, this aspect is just not gonna work. So I had to say, “That’s fine. You know, we’ll do it this way then for you guys.” And so, that was a little difficult too for me to remember which mentor group was doing things a certain way.

By and large, the participants acknowledged that CI expectations were ill-defined. The reasons for this, from the standpoint of the CI, were twofold: (a) cumbersome documents designed to outline the roles and responsibilities and (b) inherent dynamics within the PM–FT clinician pairs.

The core themes extracted from the data lend meaning to the peer mentor experience. The findings illuminated the essence of the peer mentor experience. Despite the ill-defined roles
and responsibilities, the experience, as a whole, yielded opportunities for learning. In sum, the data showed the PMs and the FT clinicians perceived the experience as a joint learning opportunity. The core theme of Joint Learning Experience surfaced as important to all of the participants.

**Interpretation of the Findings**

Following are the interpretations of the findings in relationship to the research sub-questions. Interpretation of the peer mentor experience was best achieved through the nexus provided via the research sub-questions. The composite theme codes further informed interpretation of the experience. The findings revealed a multifaceted experience for each of the triads. The FT clinicians vacillated between feelings of dependence and independence. The PMs exhibited self-confidence, self-satisfaction, and, at times, arrogance. The CI acknowledged the need to specifically outline the roles and responsibilities of all involved in the program and for explicit supervisor guidance. Answers to the research sub-questions provided interpretation of the nature of experience. Table 4 provides interpretation of the findings in relationship to the research sub-questions.
Table 4. Interpretation of Findings in Relationship to the Research Sub-Questions

<table>
<thead>
<tr>
<th>Research Sub-questions</th>
<th>Interpretation</th>
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<tbody>
<tr>
<td>1. What is the nature of the PM clinician and FT clinician relationship?</td>
<td>A positive, shared experience characterized by newly formed friendships, team building, and collaboration.</td>
</tr>
<tr>
<td>2. What is the perceived impact of the peer mentor program on the overall clinical effectiveness of the FT clinician?</td>
<td>Provided a safety net for the FT clinician. Created in the FT clinician a dichotomy in confidence in their clinical skills.</td>
</tr>
<tr>
<td>3. What are the perceived clinical competence needs of the FT clinician following the peer mentoring experience?</td>
<td>Greater independence sooner in the mentor-mentee experience.</td>
</tr>
<tr>
<td>4. What are the perceived clinical competence/mentoring needs of the PM following the peer mentoring experience?</td>
<td>Clearly defined CI expectations. Clearly defined roles/responsibilities. Schedule free of off-campus responsibilities. A more positive relationship with the CI.</td>
</tr>
<tr>
<td>5. What is the perceived significance of the peer mentor program?</td>
<td>A positive, shared learning process, which established clinical teams that benefitted all who participated. A collaborative opportunity for guiding and supporting clinical skills development.</td>
</tr>
<tr>
<td>6. What is the perceived effectiveness of the peer mentor program?</td>
<td>Overall, an effective program that provided the FT clinician opportunity to learn documentation, assessment, and treatment in a non-threatening manner. A supervisory component that provided guidelines and outlined the responsibilities and expectations of the CI would have added to the CI’s overall perceived effectiveness of the program.</td>
</tr>
<tr>
<td>7. What are the characteristics of the PM experience in the peer mentor program?</td>
<td>Mentors displayed confidence, self-satisfaction, and perceived themselves as providing positive guidance and support to the FT clinician. Mentors voiced uncertainty about their roles and responsibilities with the FT clinicians and toward the CI, which ultimately impacted the relationship with the CI.</td>
</tr>
<tr>
<td>8. What are the characteristics of the FT clinician experience in the peer mentor program?</td>
<td>Grateful for the support and guidance. Enjoyed the experience. Overwhelmed by the paperwork. FT clinicians demonstrated dependence but desired independence in intervention. FT clinicians voiced trepidation at independence in clinical practicum the subsequent semester.</td>
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</table>

The findings supported the reciprocal and personal nature of the mentoring experience and confirmed the role of relationships in the overall supervisor/supervisee experience. Additionally, the findings confirmed the need to move along a supervisory continuum that ultimately results in FT clinician independence and self-confidence in clinical skills. The peer mentor-mentee relationship grew from teacher-student to friend. The findings indicated a mentoring experience progression from challenging and tumultuous to positive and
collaborative. In sum, the peer mentor experience provided a learning experience for all involved and generated implications for peer model development.

**Future Implications for Peer Mentor Model Development**

This study served as a foundation for developing a model for student peer mentoring in the clinical training of SLPs. The triads provided opportunity to evaluate peer mentoring from multiple viewpoints. Each contributor to the encounter provided data that inspired closer evaluation and instigation of outcomes favorable to the peer mentor process. The results of this study yielded the following recommendations for peer mentor model development:

- Establish clearly defined roles and responsibilities for the PM.
- Ensure PMs and FT clinicians understand their roles and responsibilities.
- Establish a continuum of clinical responsibilities that advances the FT clinician to a level of independence in the process as soon as possible.
- Establish clearly defined CI supervisory guidelines.
- Coordinate peer mentor–mentee schedules to ensure maximum availability for assessment and intervention planning and follow-up feedback.
- Consider the relationship dynamics between CI and PM.

Future questions to guide peer mentoring model development might include:

1. How, if at all, does CI supervisory style impact FT clinicians’ response to their PM?
2. What are the perspectives on the benefits, if any, of the peer mentor program of past FT clinicians who participated in the program?
3. How, if at all, does participation in the peer mentoring program impact the clinical fellow in his/her role as the FT working professional?

**Conclusion**

This study was designed to determine the essence of the peer mentoring experience from the perspectives of the clinicians in their first clinical experience and from the perspectives of the peer mentors assigned to guide them through the process. The study also sought to determine the perspective of the experience from the lens of the clinical instructor assigned to the novice clinician and to determine the substance of the relationship between the peer mentor, first-time clinician, and clinical instructor. The findings furnished insight into the elements inherent in this joint learning episode.

The peer mentor experience provided a positive, shared experience characterized by newly formed friendships, team-building, and collaboration. The mentor–mentee relationship is personal and reciprocal. The experience is a shared learning process. The dynamics of the PM–FT clinician pair impacted both the CI’s supervision and the bond that the PM–FT clinician pair shared. Central to the success of the program and central to positive relations between the participants were clearly defined roles and responsibilities. Many of the participants perceived that the roles and responsibilities were not clearly defined. As a consequence, the ill-defined expectations, roles, and responsibilities negatively impacted the relationship between the CI and PM and affected PM instruction to the FT clinician. The CI perceived the mentor role as guidance rather than as teaching the FT clinician how to provide therapy. Although the FT clinicians perceived PM guidance and support as positive, they questioned their abilities to perform independently in the subsequent semester.

Despite the limitations, the experience yielded collaborative clinical teams and provided learning occasions that benefitted all involved. Likewise, the experience provided opportunities to develop leadership skills for career development and professional growth. This peer mentor program has implications for future learning and research from the standpoint of continued
program development and generalizability to communication disorders doctoral-level study and clinical fellowship year mentorship and within other fields of study.

References


Building clinical training teams in the Spanish-bilingual preschool classroom is one way to prepare student clinicians for the diverse populations that future speech-language pathologists can expect to serve. Team-building supports the training needs of bilingual student clinicians, while also exposing monolingual student clinicians to bilingual children and colleagues.

Providing clinical training in bilingual settings is complex, because clinical students vary considerably in their bilingual backgrounds. Typically, only a small number of students might have equivalent fluency in both languages. The majority of bilingual students will have a range of fluencies, having acquired their second languages through a variety of means, such as home exposure to a second language without formal knowledge of grammar or learning a second language in an academic setting (Bedore, Méndez Pérez, & White, 2008).

Although the American Speech-Language-Hearing Association (ASHA) standards for bilingual clinicians require native or near-native fluency in both languages, ASHA takes the position that lesser degrees of fluency in the second language can be utilized effectively in clinical settings (ASHA, 2004). Our profession cannot afford to overlook these potential second-language resources residing in our future clinicians. This is particularly true during clinical training, because at this point in their professional development, student clinicians have unique opportunities to learn how to utilize both their first- and second-language knowledge effectively. Most speech-language pathologists can expect to work with bilingual clients. Clearly, it is essential that every student clinician receive the clinical training that supports his or her current and future degree of bilingualism.

A bilingual training experience developed within the program in communicative disorders at San Francisco State University embraces this perspective by providing clinical training in a way that utilizes all degrees of bilingualism possessed by the group of participating students. In order to provide varying levels of bilingual support while also building on existing bilingual skills, a team-training model has been developed. Utilizing clinical training teams as a component of clinical training provides opportunities for greater collaboration and independence (Sbaschnig, 2009). The present model incorporates three dimensions in building teams: degree of bilingualism, level of clinical training and experience, and utilization of the preschool classroom arena.
The Mission Head Start Clinic

The Mission Head Start Clinic, located in the predominantly Latino Mission District of San Francisco, CA, is a training clinic placed within two adjoining Spanish-bilingual preschool classrooms. Children are served within the classrooms, as well as in a small room off one of the classrooms that is available for one-on-one and small group interventions. Typically, four graduate students are trained within this setting, two per classroom. In addition, two undergraduate clinical data assistants participate, with one assigned to each classroom.

A relatively small number of students who participated in the Mission Head Start Clinic in the past 3 years had equal fluency in both languages (9 out of 35 graduate and undergraduate students), compared to those who did not. Furthermore, many of the fully bilingual students were undergraduate students who participated as clinical data assistants (7 out of 11 total undergraduate students). The graduate students (totaling 24 out of 35) typically had more academic information, clinical training, and experience that they could offer in return for bilingual support (see Table 1). The undergraduate and graduate students each possessed something useful to the other, which was ideal for team building and collaboration.

Table 1: Three Years of Students in Mission Head Start Spanish-Bilingual Training Clinic

<table>
<thead>
<tr>
<th></th>
<th>Graduate Students</th>
<th>Undergraduate Students</th>
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<tbody>
<tr>
<td>Native/near-native fluency</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>in both Spanish and English</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monolingual in</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>English/non-fluent Spanish</td>
<td></td>
<td></td>
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<tr>
<td>skills</td>
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Building Teams: Degree of Bilingualism and Clinical Training

Two dimensions that emerged as being important for developing effective bilingual teams within the preschool classroom arena were (a) the degree of bilingualism each student had acquired and (b) the degree of academic experience and clinical training each student had received.

In order to build training teams across the dimensions of bilingualism and clinical knowledge, each semester began with a group discussion of the bilingual and training backgrounds of each of the students. Once the language skills and training backgrounds were known by the group, the teams were developed first according to language knowledge. Students who did not speak Spanish well often required a boost of confidence by knowing that they would have bilingual support in their clinical work. Therefore, the strongest bilingual speakers were often initially paired with those knowing less Spanish. The teams were then enhanced and balanced by adding additional team members as available, based on what clinical skills these additional team members brought to the equation. Undergraduate clinic aides, particularly those who were fluent in both Spanish and English, oftentimes worked across the two teams and within both classrooms.

Because the strongest bilingual speakers were often the undergraduate students, they took on considerable responsibilities as team members. They participated in planning and collaboration, observed graduate students closely, received feedback, and often served as translators or interpreters. As such, this training model provided support for these students who continued their clinical training at the master’s level, where bilingual students are typically underrepresented. Conversely, graduate student clinicians had an opportunity to work purposefully with an undergraduate student who served as a bilingual clinic aide, thereby
acquiring skills in working with clinic aides that they would likely need in their future professional settings.

In some cases, a graduate student did not have adequate knowledge of Spanish but wished to acquire the skills offered by the clinical experience. The monolingual graduate student was paired with an undergraduate student who was fully bilingual. Through this collaboration, the undergraduate student typically collected data and translated. The graduate student generally was in charge of all planning, plan execution, data interpretation, and paperwork requirements.

**Considerations of Bilingualism in Child Clients**

Child clients were usually assigned to graduate students, who had primary responsibility for them. When children preferred English or did not speak Spanish, they were likely to be assigned to student clinicians who were less proficient in Spanish. Student clinicians with less bilingual proficiency needed to collaborate with more proficient bilingual student clinicians to promote rich, supportive peer interactions in the classroom for both their clients. During therapeutic interactions, student clinicians with less bilingual proficiency were often more focused on the non-linguistic environment and, thus, potentially offered enhanced non-linguistic support and feedback, whereas those with greater bilingual proficiency acquired more linguistic information from clinical interactions to share with their collaborators. Regular case conferencing as a team ensured that each team member appreciated and shared the insights and skills of the others.

In cases in which the child clients were monolingual Spanish speakers, child clients were paired with graduate students who had strong Spanish language skills. These fluent or near-fluent student clinicians focused on the acquisition of a strong foundation of Spanish language clinical basics. In addition, because virtually all the Mission Head Start children whose primary language was Spanish had varying amounts of exposure to English, bilingual student clinicians in particular had the benefit of observing and analyzing the implications of bilingualism on culture, language acquisition, and clinical practice.

**Building Teams in the Preschool Classroom Arena**

An additional team-building factor stemmed from the classroom context. The classroom context presents unique and valuable opportunities for clinical training (Epstein, 2009). At Mission Head Start, the training clinic is situated within two Spanish-bilingual preschool classrooms, each consisting of 17 children and 3 teachers. The classrooms share a large space that is divided by a partial wall. Because each classroom had different teachers and different constellations of children, each developed a unique culture and a unique set of needs to be served. Student clinician teams needed to co-plan both clinical goals and activities to take place within their assigned classrooms. These plans and activities needed to incorporate classroom culture, child needs, language proficiency, and graduate skill level in order to be successful in the classroom arena.

For example, many of the preschool children did not willingly engage in one-on-one activities within the classroom context. It then became incumbent upon the student clinicians to plan engaging activities that allowed for activation of clinical objectives, generally within ongoing classroom activities, through interaction with classroom peers. Graduate students assigned to a particular classroom worked jointly with undergraduate data assistants, who were often responsible for specific tasks such as data collection or modeling targeted behaviors.

Delivering therapy within the classroom arena presented unique challenges. The Mission Head Start philosophy rests on supporting children to develop their own play agendas (following the Creative Curriculum for Preschool [Dodge, Colker, & Heroman, 2002]). Student clinicians hoping to work one-on-one with children in the classroom according to tightly
designed lesson plans soon found that they needed to shift both their planning and their way of thinking about therapy. Therapy in the Mission Head Start classroom meant following the child’s agenda and including peers in activities whenever they decided to join in. Student clinicians needed to continually be conscious of the clinical goals and objectives for their clients in order to seize and meld emerging activities to therapeutic outcomes. That team planning and information sharing are essential to this approach to therapy may seem counterintuitive because of the seeming spontaneity of the therapeutic interactions. However, student teams were required to operate and communicate like well-oiled machines to be effective in the classroom arena.

For example, if a child client chose to play in the pretend kitchen area, the student clinician needed to be prepared to work on the child’s objectives within that setting. The student clinician was required to be ready to take the child’s verbalizations and utilize them in a way that was functional, authentic, and therapeutic. Whether the therapeutic objective for the child was identifying the number of syllables within words, including particular vocabulary in utterances, or imitating the /s/ sound, the student clinician needed to be prepared with data sheets, elicitation and modeling procedures, and instructions for a data assistant, if required. All these clinical tools needed to be adapted to the child’s chosen setting.

In addition to serving children within individual classrooms, students were also required to coordinate activities and goals across the two classrooms when possible. One important goal of the training clinic is to provide preliteracy experiences and support for kindergarten readiness. Student clinicians from each classroom had to co-plan and organize a prekindergarten group that included children from both classrooms. This planning added complexity to team building, because it required a trans-classroom team component. As with the other team functions, organization and communication were essential, with close attention paid to who knew Spanish well, as well as clear definitions of the roles each team member played to benefit the children optimally.

The prekindergarten group also focused student clinicians on what communicative demands lay ahead for individual children as they left the preschool classroom arena and entered kindergarten. This perspective lends appropriate urgency to and focus on the need for preliteracy skills and feelings of competence on the part of entering kindergarteners and helps student clinicians to hold these goals uppermost in their minds as they work with the children as preschoolers.

**Two Clinical Examples**

In order to demonstrate how bilingual teams functioned in specific circumstances, I present and describe two clinical examples. The first example is how a bilingual team organized to serve A, age 4, who had selective mutism. A’s first language was not Spanish, but another language spoken by A’s family (specific biographical information has been changed here to preserve confidentiality). The family’s second language was English, spoken by the child’s older sister in elementary school and by both parents. After several months in the preschool classroom, during which time the child was exposed to Spanish and some English, the teachers noted that A did not verbalize or vocalize in the classroom with the teachers, student clinicians, or peers. However, A was observed to talk animatedly with her mother in her family’s first language during both drop-off and pick-up times. In addition, A’s pragmatics skills were strong, and she was an effective nonverbal communicator. She participated in all classroom activities fully and had strong peer connections, even though they were nonverbal connections.

A non-fluent Spanish-speaking graduate student was assigned to work with A. The graduate student was teamed up with two other graduate students in the classroom who spoke Spanish fluently and who were serving Spanish-speaking children in the classroom. The graduate students planned and organized their activities together so as to encourage pairings
of the other target children with A within a variety of contexts and activities. These pairings encouraged peer interactions and generalization of target behaviors (such as vocal play) to more settings and partners. The team also co-planned data collection to share observation and data collection among the team members. The non-fluent Spanish speaking clinician had the benefit of exposure to Spanish through collaboration with her fellow students, which provided her and the client increased access to peer interactions. Fellow students gained an awareness of how to support a non-Spanish speaking colleague to access the ambient language of the classroom, while also appreciating the wealth of her knowledge and observations.

In a second example, two girls both aged 4 years, B and C, who were monolingual Spanish speakers in the same classroom. Both presented with unintelligible speech and poor pragmatic skills. The girls spent classroom time circulating aimlessly through the classroom without engaging in toys, peers, or activities. To serve the girls, one fully bilingual graduate student clinician was paired with a graduate student whose Spanish language skills were less strong. The clinical team developed a therapy plan that incorporated one-on-one therapy, two-on-two therapy (the two clinicians and the two target children), and group therapy through opening activities to other children in the classroom.

Each graduate student clinician shared knowledge, academic expertise, and experience when planning the one-on-one therapy. This planning also provided for the establishment of targets that were further supported and facilitated in the two-on-two therapy activities. Group therapy was provided in the classroom arena, which allowed for spontaneous practice of targeted peer-directed skills when the two children were approached by other preschoolers in their class. These interactions were facilitated by the clinician whose Spanish was strongest, while clinical data was gathered by the clinician whose Spanish was less strong. Through their collaboration, each clinician offered and learned skills to the benefit of the children and their own clinical training.

**Conclusion**

Clinical training must meet the needs of future bilingual clinicians and bilingual children alike by building upon and supporting all bilingual abilities. Working in student teams provides an ideal context for this essential training. A careful consideration of the dimensions to be incorporated into team planning by the clinical instructor can lead to fuller development of bilingual clinical skills in all team members, thereby enhancing preparation and utilization of the language skills that each clinical trainee may possess.

**References**


Multicultural Issues
Corey Herd, Column Editor

Supervision and Multicultural Issues: Supervisors and Supervisees

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Nova Southeastern University
Ft. Lauderdale, FL

Multicultural influences may impact the supervisor and supervisee relationship within the fields of speech-language pathology and audiology. This article summarizes the themes that have emerged in the literature on multicultural issues in supervision, including cultural competence, mixed-race and same-race supervisory relationships, and social power.

For decades, individuals from across the globe have migrated to the United States with hopes of freedom and the opportunity to achieve their dreams. Many of these individuals have maintained their language and culture as they attempt to assimilate into a predominantly English-speaking society. As a result, racial and cultural variations are commonly found in many U.S. social environments, including the workplace. Historically, the U.S. workplace has faced interracial challenges. For example, racial and cultural variations may impact the supervisor and supervisee relationship. This can occur in any field, including within the fields of speech-language pathology and audiology. Therefore, the impact that racial and cultural similarities and/or differences have on the supervision process is a topic that needs to be explored. A number of themes have been uncovered in the research on multicultural issues in supervision, including cultural competence, mixed-race and same-race supervisory relationships, and social power.

Cultural Competence

The process of supervision is deliberated in many fields, including psychology, education, counseling, and speech-language pathology. The American Speech-Language-Hearing Association (ASHA) recognizes the impact cultural and linguistic differences can have within the supervision process of speech-language pathology (ASHA, 1998a, 1998b, 2004, 2005, 2011a, 2011b, 2011c). ASHA states that supervisors and students should be culturally competent as they relate to each other and to clients from diverse cultural backgrounds (ASHA, 2005). Schroeder, Andrews, and Hindes (2009) defined supervisor multicultural competence as “the ability of supervisors to work with clients or trainees from other cultures and races” (p. 297). According to Schroeder et al., supervisees are more at ease engaging in dialogue about cultural differences when supervisors are culturally competent. In order for supervision to be effective, supervisors must be willing to engage in dialogue about issues related to cultural differences (Estrada, Frame, & Williams, 2004; Gatmon et al., 2001; Newman, 2001; Yabusaki (2010).
Gardner (2002) examined the positive effects that supervisors’ cultural competence had on supervisees. Based on the results of Gardner’s study, culturally competent supervisors had open discussions regarding differences that exist in cultures and the effect that racial differences have on the relationship between supervisors and supervisees. In addition, culturally competent supervisors did not hold stereotypical views of minorities; rather, they used cultural informants to develop an understanding of minority cultures. Furthermore, supervisees perceived supervisors as being culturally competent based on the types of feedback that was given. In contrast, when supervisors lacked cultural competence, conflicting views about patients’ assessments and intervention procedures were evident.

Supervisors capable of engaging in dialogue related to cultural and racial differences promote an increase in the supervisee’s confidence and contribute to positive changes in clients (Tummala-Narra, 2004). Open dialogue allows the supervisee an opportunity to develop skills to address and understand cultural differences with supervisors and clients. Furthermore, supervisees may increase their willingness to discuss issues related to race with clients and invite clients to open discussions on cultural and linguistic differences. In a study involving 289 trainees in the field of psychology, Gatmon et al. (2001) examined the effect that conversations on cultural differences, in relation to “race/ethnic, gender, and sexual orientation” (p. 103), had on communication between supervisors and supervisees. The authors found that there were few discussions initiated by supervisors related to cultural differences. In situations where frequent dialogues did occur, supervisees were more content and had a better working relationship with the supervisors.

Burkard et al. (2006) investigated the effects that supervisors’ reactions or insensitivity to topics related to cultural differences had on 13 minority and 13 White supervisees. The participants described situations in which supervisors of different races reacted either appropriately or negatively to topics related to culture. The researchers found that when supervisors engaged positively in exchanges regarding cultural matters, there were clear benefits to supervisees and patients, and the experience enhanced the relationship with the supervisors. Conversely, supervisors who disregarded or overlooked cultural concerns brought up by the supervisees may have compromised patient care as alliances were damaged and discontentment occurred. In this study, the minority supervisees reported more intense negative experiences than the White supervisees when cultural situations were brought to the White supervisors’ attention. Similar deficits in cultural competence were noted in Hird, Tao, and Gloria’s (2006) study that examined multicultural competence of 442 supervisor–supervisee dyads of similar and different race combinations. The authors found that White supervisors reported lower levels of cultural competence than minority supervisors. In addition, minority supervisors spent more time than their White counterparts conversing about cultural topics with supervisees of all races. Though supervisees may have negative experiences in same-race supervision relationships, minority supervisees experience more conflicts when they are supervised by someone of another race (Jernigan, Green, Helms, Perez-Gualdron, & Henze, 2010). Although one might assume that minority supervisees may have more positive experiences with minority supervisors, a number of research studies have found mixed results in the experiences of supervisees who had mixed-race or same-race supervisors.

Mixed-Race Supervision Dyads

According to ASHA (n.d.), of the 128,949 speech-language pathologist (SLP) members and affiliates in 2010, only 6,127 identified themselves as belonging to a race other than White. Given this data, it is clear that most non-White/non-Hispanic SLPs will be supervised by a White clinician. According to the literature, this may result in either a positive or negative experience for the clinician.

Duan and Roehlke (2001) examined the implications of mixed-race supervision of 60 psychology trainees in the process of completing a doctoral degree. Overall, the results of the
survey indicated that supervisors and supervisees were content with the supervisory relationship. Supervisees reported that supervisors could be trusted and relied on when in need and that supervisors appeared to have a positive regard for the supervisees. At the same time, supervisees reported fewer attempts by the supervisors to discuss topics related to differences in culture than what the supervisors reported. In addition, supervisees did not sense that supervisors had the same level of positive regard for them as the supervisors reported. Furthermore, supervisors felt that supervisees were less willing to divulge information about themselves than the supervisees expressed. Although some individuals reported negative aspects of the supervisory relationship, participants in this study were primarily positive in their responses regarding their mixed-race supervision experiences.

Unfortunately, not all mixed-race supervisory relationships produce positive results. Hernández, Taylor, and McDowell (2009) investigated the cross-cultural events that occurred during the training of 10 minority supervisors. Unlike Duan and Roehlke’s (2001) study, the participants did not feel that supervisors recognized or saw the importance of working through cultural differences. In addition, participants reported that racist remarks were directed at supervisees, supervisors favored same-race supervisees, and they were “blinded to diversity issues” (Hernández et al., 2009, p. 94). Supervisors also took advantage of their power by pairing supervisees with supervisors of the same ethnic background and avoiding discussions related to cultural differences.

Several studies also suggest that an individual’s prior and present encounters can create “cultural mistrust” (Phelps, Taylor, & Phyllis, 2001, p. 214), which may impact future relationships with individuals of different races. With this scenario in mind, mixed-race supervision situations may be vulnerable to conflicts and miscommunications. Nilsson and Duan (2007) reported conflicts in the supervisor/supervisee relationship with 69 doctoral students and interns representing six minority groups and their White supervisors. The results of the study revealed that strife in the relationship with supervisors and supervisees and confusion about job responsibilities occurred when supervisees believed that the supervisors were biased toward them. This uncertainty also impacted the supervisees’ “beliefs in their abilities to effectively counsel” (Nilsson & Duan, 2007, p. 220). The authors stressed that supervisors need to consider the history of racism that supervisees have been exposed to and how this history might impact the supervisory relationship.

**Same-Race Supervisory Dyads**

Although race is an important factor in a supervisory relationship, some individuals believe that a supervisors’ cultural competence is a more significant factor than race itself (Hernández et al., 2009). Studies have indicated both positive and negative outcomes can occur when minority supervisors and supervisees are engaged in a supervisory relationship. Goode-Cross (2011) conducted a study that explored the supervisory relationship between 12 African American doctoral psychotherapists and their African American supervisees. The study stated that most supervisors developed a closer bond with their African American supervisees than with other minority or White trainees, and some of these bonds led to lifelong friendships. In addition, the supervisors engaged in frequent dialogues about race with their supervisees, guided them in working with African American clients, and felt obligated to help them succeed. Additionally, personal accounts of supervisors and supervisees demonstrated that same-race supervisory dyads can support the growth and development of both parties involved in the process (Millán, 2010; Reynaga-Abiko, 2010).

Unfortunately, not all same-race supervisory dyads produce the positive results found in these studies. In contrast to Goode-Cross’s (2010) study, Jernigan et al. (2010) stated that the experiences of counseling psychology supervisees in same-race supervisory dyads were not always positive. The authors reported that supervisees more often initiated dialogues about race than minority supervisors. In addition, some supervisees did not always receive positive
responses from supervisors when they broached the topic of race; these negative or neutral responses created feelings of inadequacy, loneliness, and helplessness. In some cases, supervisees were discouraged from incorporating concepts related to ethnicity into their clinical work, and supervisors did not provide the appropriate support to help supervisees navigate the racial climate of the work setting. In situations where supervisors showed interest and guided supervisees to discuss cultural issues, supervisees felt empowered and inspired to explore the issues in greater depth.

Hird et al. (2006) examined the experiences of 442 predoctoral psychology supervisees and supervisors. When the supervisory dyads were racially or ethnically different, the White supervisors had more dialogues related to “language, race, and racial identity issues” (p. 114) with minority supervisees as opposed to same racial or ethnic supervisees. In contrast, minority supervisors engaged in more dialogues that focused on racial or ethnic issues with minority supervisees than White supervisors did with supervisees from their same cultural background. Based on the findings within this review, it is evident that supervisors of all races need to take the lead in discussing topics related to differences in culture with supervisees.

**Social Power**

Given the power that comes with the supervisory role and historical events that have impacted racial/ethnic minorities in the United States, supervisors need to be mindful of the influence they can have in various supervisory dyads. Rahim (1989) defined power as “the ability of one party to change or control the behavior, attitudes, opinions, objectives, needs, and values of another party” (p. 545). Supervisors hold a significant amount of power that can have either a positive or negative effect on supervisees. As discussed earlier in Nilsson and Duan’s (2007) study, a supervisee’s perception of the supervisor’s level of prejudice can impact the supervisee’s performance and level of communication within the dyad. These negative beliefs can contribute to confusion about job responsibilities, performance appraisal, and management of multiple functions (Nilsson & Duan, 2007). Duan and Roehlke (2001) also highlighted the “power differential” that exists between supervisors and supervisees and the need to take into account the manner in which beliefs and attitudes are used to address concepts related to culture (p. 132). Hernández et al.’s (2009) study described how supervisors abused their power over racial/ethnic minority supervisees when they “made racists comments, showed preference to supervisees of their own ethnic class . . . or matched supervisors and supervisees based on their ethnicity” (p. 94). Minority marriage and family therapy supervisees in McDowell’s (2004) study felt that supervisors were less interested and responsive to them. In addition, a White supervisee described how supervisors appeared to respect the White supervisees’ opinions more than the minorities’ opinions (McDowell, 2004). Abuse of supervisory power was also noted in Verdinelli and Biever’s (2009) study in which monolingual, English-speaking supervisors placed additional responsibilities on Spanish-speaking supervisees, including tasks involving interpreting, translating documents, performing bilingual evaluations, and conducting training workshops on issues related to multiculturalism. It is clear that behaviors of this nature do not contribute to a sense of trust or a working alliance within a supervisory relationship.

Murphy and Wright (2005) investigated the level of perception of power within supervisors by 11 White supervisees involved in a marriage and family training program. Unlike the supervisees in Hernández et al.’s (2009) and Verdinelli and Biever’s (2009) study, the authors found that supervisees had a positive view of power and that they generally accepted the supervisors’ use of power in the relationship. Only a few cases of inappropriate use of power were reported, including supervisors who addressed their desires over the supervisees and those who breached the supervisees’ privacy. In addition, supervisees exercised their power by talking to other trainees about their supervisors and concealing relevant facts from supervisors. In other studies, minority supervisees who faced culturally incompetent supervisees exercised their power by exhibiting passive stances, withholding
information from supervisors, withdrawing, or becoming combative (Burkard et al., 2006; McDowell, 2004).

**Summary of Themes**

Although there are areas in the literature in which mixed perspectives have been presented regarding multicultural issues in supervision, several common themes have become clear. The most consistent theme is that supervisors should be culturally competent. Another theme that has been pervasive throughout this review is the importance of supervisors taking the lead to discuss issues related to race and culture. The studies discussed in this review all indicate that open dialogues about topics related to cultural differences create stronger bonds within the supervisory relationship, improve the supervisees’ confidence levels, and produce positive results in patients (Burkard et al., 2006; Gatmon et al., 2001; Tummala-Narra, 2004). The literature also focused on the supervisor’s power and influence, as well as the use and abuse of power by supervisees, within the supervisory dyad (Duan & Roehlke, 2001; Hernández et al., 2009; Murphy & Wright, 2005).

Finally, the relationship between supervisors and supervisees of the same and mixed races has been addressed. Mixed results were noted when supervisors and supervisees shared the same race as well as when they did not. Ultimately, it appears that the most important variables to consider within a successful supervisory relationship is the supervisor’s cultural competence (Hernández et al., 2009) and willingness to support and allow the supervisee to explore cultural and racial topics as needed (Burkard et al., 2006; Gatmon et al., 2001).

**Application**

When working with supervisees of similar or different backgrounds, it is vital to acknowledge that cultural differences and past experiences will have an impact on supervision. Supervisors need to continuously examine themselves to determine if they are culturally competent when working with supervisees and clients whose backgrounds are different from theirs. Even supervisors from racial/ethnic minority backgrounds need to come to terms with their own prejudices (Murphy-Shigematsu, 2010). Although these biases may manifest in subtle non-verbal ways, they may have damaging effects on the relationship between supervisees and supervisors. In situations in which supervisors are not familiar with the norms of a culture, a culturally competent supervisor would utilize the expertise of supervisees and clients from diverse cultural groups, as noted in Gardner’s (2002) study. Furthermore, SLPs who take on a clinical supervisor role need to take advantage of opportunities to educate themselves so that they are competent when working with different racial and ethnic groups. As presented in the literature, it is vital for supervisors to initiate dialogues on topics related to race and ethnicity (Burkard et al., 2006; Gatmon et al., 2001; Newman, 2001; Tummala-Nara, 2004; Yabusaki, 2010). It is equally important for supervisors to respond appropriately when supervisees bring up issues related to race (Burkard et al., 2006).

In both personal and professional relationships, situations exist in which past experiences can have an impact on the way individuals relate to each other (Geller & Folley, 2009, p. 28). Supervisors need to take into account historical events that have shaped society’s view of racial/ethnic minorities and the supervisees’ past experiences that may influence their judgment of their supervisors (Nilsson & Duan, 2007). In addition, supervisors should consider the power that accompanies supervision and how that power can be used both by supervisors and supervisees. In conclusion, both supervisors and supervisees play important roles in directing the tide of the supervisory relationship; however, supervisors need to take the lead in creating an atmosphere through which trust is developed, open dialogues can occur on issues related to cultural topics, and power is not abused.
References


At some point in time, all leaders face the issue of having to initiate a conversation considered to be “difficult.” This article discusses what makes conversations difficult and addresses the benefits of resolving issues that are related to difficult conversations. I discuss evidence-based approaches and tools for facilitating difficult conversations and use examples related to speech and hearing to illustrate the approaches and tools.

As a department chair, clinic director, faculty member, or clinical preceptor, it is inevitable that at some point in time, a conversation perceived as “difficult” will arise. Whether this conversation occurs with an individual or group, it is likely to be challenging due to the emotions and perspectives of the individuals involved. Despite the fact that these conversations occur in relation to one’s job responsibilities, these conversations are not easy, because they are often emotionally charged for individuals who “react rather than respond” in the conversations (Kelly, 2011). Based on a frequent desire to maintain the status quo, avoiding difficult conversations may seem a better choice in the short term. However, avoiding difficult conversations may have significant negative consequences over time, including undermining organizational goals, negatively impacting patient/client care, and reducing work satisfaction (Kelly, 2001). The purpose of this article is to provide tools that help to facilitate “difficult conversations” in order to improve personal and organizational outcomes.

One might postulate that those involved in fields related to communication, such as the speech and hearing sciences, would be better at communicating in difficult situations based on studying the underlying science of communication. The joke that people who work in departments of communication disorders “specialize in disordered communication” aside, the types of conversations in question are perceived as difficult regardless of training, education, or experience. Additionally, the nature of the helping profession often presents an added burden in these types of communications because confronting an issue may result in conflict. Individuals in helping professions often view their role as to “therapy-ize” the situation in order to help resolve the issue quickly. When faced with a difficult conversation, the desire may be for the source of conflict to magically disappear. However, the reality is that the issue does not disappear and may consume individual and organizational resources. Time and energy spent on an issue without resolution can be counterproductive. For instance, individuals may express frustration to colleagues, friends, and family members, which may not relieve the situation and cause the source of conflict to grow.

The reasons a conversation may be considered difficult are as varied as the conversations. One factor is a perception of an imbalance of power, where one party is perceived as having the ability to make a unilateral decision. Another factor may be the history in which patterns of communication have been established. For instance, the communicators
may anticipate the individual positions of “the opposing side.” In some cases, the difficult conversation is shrouded in a philosophical divide. Most often, difficult conversations are thought to have a high-stake result or outcome. Examples of difficult conversations that may happen in departments of speech and hearing science include informing a well-qualified student that he or she has not been accepted into a graduate program, evaluating the teaching abilities of a faculty member who is struggling to connect with students, or deciding to expand the employee base to include speech-language pathology assistants in the delivery of clinical services. Although no one relishes participating in any of these conversations, the work environment will be presented with similar issues. Embarking on a difficult conversation can resolve issues that prohibit a person, relationship, or department from moving forward. Resolving issues can help people be more productive in their jobs or, in the case of graduate students, help with clinical placements. Additionally, as leaders and mentors, it is imperative to model conflict resolution and negotiation skills for colleagues, employees, and students. Many of the difficult conversations have a legal or ethical overtone that must be addressed professionally. Perhaps most significantly, engaging in difficult conversations and resolving issues contributes to saving of time, money, and stress.

**Helpful Tools**

Just as there is a science that underlies our professions, there is a science that underlies leadership. Leadership encompasses areas such as conflict resolution, mediation, negotiation, and consensus-building. The processes presented can assist in initiating and resolving difficult conversations. Additionally, these strategies can provide coaching that effectively directs energy at resolving problems. Approaches to addressing difficult conversations are described in *Difficult Conversations: How To Discuss What Really Matters* (Stone, Patton, & Heen, 2010) and *Switch: How To Change Things When Change Is Hard* (Heath & Heath, 2010). Information presented here incorporates ideas from both of these sources. The reader is directed to these books to learn more about the framework for having difficult conversations outlined in this article. Both books propose an evidence-based approach to conflict resolution and negotiation.

Heath and Heath (2010) propose a “happiness hypothesis,” which suggests that the best platform for change is when emotion and rational thought are in balance. Difficult conversations are often fraught with emotion, which often supersedes rational thought. The ideas presented are not designed to be a panacea but to expand the leadership toolbox when addressing difficult issues.

In addressing difficult conversations, the dilemma always begins at the same place: to avoid or confront. Maintaining the status quo may be perceived as the path of least resistance. However, maintaining the status quo by avoiding a dilemma does not allow for an opportunity to improve the situation. Avoidance may lead to intense feelings and may result in negative long-term consequences for the relationship or organization. Conversely, if confrontation is the choice, the concern is that the person given the information may choose to reject it and the relationship may be damaged (Stone, Patton, & Heen, 2010).

In providing information to others, there is a belief that tact and diplomacy may make the situation easier. This belief is challenged if one considers the following example: A graduate student is struggling to apply classroom concepts to clinical practice. Additionally, the graduate student has difficulty consistently demonstrating professional behavior (e.g., does not dress appropriately for clinic, arrives late, etc.). The student has several conferences with his/her clinical supervisor, yet appears to not understand the gravity of the situation, because the behavior continues. An experienced clinical supervisor may provide feedback in a tactful and diplomatic manner, focusing on the student’s behavior and making suggestions for remediation. Despite the presentation style and experience of the supervisor, this is likely to be a difficult conversation for both parties. Stone, Patton, and Heen (2010) suggest that delivering
this type of information is “like throwing a hand grenade” (p. 31). No matter how tactful and
diplomatic the “grenade” (i.e., the message to be presented), it still has the potential to do
damage. Regardless of the tact or diplomacy, the delivery of difficult news—such as terminating
an employee, dismissing a graduate student from a program of study, or discontinuing a
popular clinical program—is never easy.

**Common Structures: The Three Types**

Stone, Patton, and Heen (2010) suggest that all difficult conversations have a common
structure. In addition, the gap between what is spoken and what is unspoken in the
conversation is part of what makes the conversation difficult. The framework described by
Stone, Patton, and Heen (2010) suggests that difficult conversations actually fall into one of
three types of conversation: *what happened* conversations, *feelings* conversations, and *identify*
conversations.

In *what happened* conversations, classified as the most difficult, participants disagree
about what happened or what should happen. In this type of conversation, the focus is often a
debate of facts, as in who said what or who did what. It has often been said that every
discussion has multiple perspectives and truths, and the *what happened* conversation is a
prime example of this. This type of discussion is challenging because each person's perspective
is considered reality. Three assumptions are involved in this conversation: the truth is the
truth, the intention of truth can be assigned, and the focus of the conversation is to assign
blame. As noted, each individual has a personal view of the truth. Intentions cannot be
assigned, and, when attempted, it is generally assumed to be a bad intention.

The intent of others cannot be known without asking, which is a good place to start in a
difficult communication. For example, in the supervisor/student scenario, it is possible that
the supervisor attributes the student's intention to being lazy or unmotivated. However, when
asked, the student has an extenuating personal situation that is impacting clinical
performance. Knowing this information does not negate the situation but provides a roadmap
for addressing issues based on accurate and honest information. Similarly, looking for a
scapegoat to blame in the conversation results in disagreement, denial, and little opportunity
to learn. A more effective approach in the difficult conversation is to jointly address and learn
the cause of issues and work on plans to correct them.

The *feelings* conversation is generally part of every difficult conversation because this
type of conversation is usually emotionally charged. The conversation is made difficult as the
feelings may be unrelated to the facts of the situation and/or to rational thought. However, the
feelings must be addressed in order to resolve issues. As noted by Stone, Patton, and Heen
(2010), the questions that arise from the feelings conversation are related to the validity and
appropriateness of the feelings expressed and the perspective of how the other person's feelings
are addressed. There is a mistaken belief that if the facts are presented in a rational manner,
feelings will be avoided. Emotions are not a by-product of the discussion, but rather an integral
part of the conversation.

The third conversation, *identity*, is a conversation of introspection. Those involved in the
conversation will ask themselves the question, “What does this situation mean to me?” Issues
of competence, self-image, and self-esteem are germane in the discussion. Consider the clinical
supervisor discussing professional performance with the student from earlier in this article.
Despite the fact that the supervisor focuses on the student's clinical behaviors, the difficulty in
the conversation for the student may be related to questioning if he or she is a “good person.”
Conversely, the conversation with the supervisor may be dismissed if the student concludes
that he or she is a “good person” and that the supervisor is just picking on him or her.
The Harvard Negotiation Project

Stone, Patton, and Heen (2010) frame resolving difficult conversations using the learning conversation, a tool that has been developed based on years of research through the Harvard Negotiation Project. According to this research, the initial stance of most participants in a difficult conversation is that of delivering a message that allows the person to persuade, get their way, and win. This sets up a conflict that is counterproductive. The learning conversation is an evidence-based technique that can be used to facilitate a difficult conversation.

The learning conversation starts with the desire to understand what has happened from the other person’s point of view. This invites the other party into the conversation with the desire to understand the situation rather than to assign blame. The learning conversation provides the opportunity to explore each perspective, which requires moving from certainty to curiosity (Stone, Patton, & Heen, 2010). A learning conversation requires an “and” stance, accepting that there can be multiple viewpoints that are true. This allows the strength of one viewpoint to be expressed without minimizing the value of another. The result of this type of learning conversation is an understanding of the issues and development of effective ways to manage the problem.

Learning conversations acknowledge that when things go wrong, there is plenty of blame to go around. This approach supports the fact that all parties usually contribute in some way to the issue. An example of this may be related to a misunderstanding in the 4th year placement for an AuD student. Although the student expectations or clinical performance may be the target of the blame, further analysis of the situation would suggest that the expectations of the preceptor and/or the university may not have been clear. The multiple sources of responsibilities can be incorporated through joint contribution. Once the specter of blame is removed, people are more forthcoming and problem-solving is enhanced. Feelings are acknowledged as part of this process. However, instead of an emotional rant, the learning conversation focuses on a clear expression of emotions as part of resolving issues. Learning conversations also acknowledge that difficult conversations can threaten the identity of the participants. This is particularly true when the balance of power is a mismatch, such as in the case of a student/preceptor. In the learning conversation, three truths are used to empower participants: mistakes will be made, intentions are complex, and each participant has contributed to the problem (Stone, Patton, & Heen, 2010).

The learning conversation provides a strong framework for initiating difficult conversations. It incorporates three purposes in directing the difficult conversation: (a) to learn the story of the participants, (b) to express views and feelings, and (c) to create a partnership for problem-solving. If data are missing in this process, an opportunity to collect additional data is provided. For example, in the supervisor/student scenario, a video-recording of a clinical behavior could help to provide a new perspective to both parties and add to the learning conversation.

It is the responsibility of the leader—whether the department chair, clinical supervisor, faculty member, or president of a professional organization—to create a culture that supports the difficult conversation. These conversations enhance personal growth, relationships, and organizations. Creating that culture requires accepting several principles. The first is that those involved in the conversation should understand that expressing feelings is acceptable, but that they must follow the ground rule that emotions should be expressed without being sensitive. If change is to happen, participants in the conversation must believe that the leader will seek to understand the situation without assigning blame.

Joint decision-making is a cornerstone in the success of the difficult conversation. However, it is recognized that exceptions of a circumstance where a unilateral decision must be made, such as terminating an employee, can occur. However, in this circumstance, it is assumed that a number of opportunities to participate in joint decision-making occurred prior
to termination. Creating a culture that supports the difficult conversation requires an investment of time; these types of conversations cannot happen in the moment, and the parties involved must have the opportunity to discuss and resolve issues raised.

A challenge of leadership is negotiation and consensus-building to reach mutual goals. This requires a strong foundation of communication and willingness to confront issues as they arise. Having the strength to approach rather than avoid difficult topics, using the strategies such as those presented in this article, can help to provide opportunities for professional growth and positive change within the organization.

References


Appendix A: General Framework of the Mentoring Program

- The clinical instructor completed orientation in which both the mentor and mentee were present. Verbal and written descriptions were provided that indicated the roles of the mentor and mentee during the 15-week semester.

- The mentor provided guidance and support for the mentee’s first clinical experience. The mentor provided a tour of the clinic, emphasizing important features as they related to clinical service delivery; reviewed all procedures and paperwork needed to initiate therapy; and answered any questions. The clinical instructor fielded questions outside the knowledge-base of the mentor, within and outside supervisory meetings.

- The mentor and mentee collaborated on assessment and treatment planning. The mentee was responsible for all paperwork (e.g., assessment plan, session goals, SOAP notes, and summary report) associated with therapy sessions. The paperwork would first be reviewed by the mentor. The mentor provided written and verbal feedback. The mentee made the suggested changes and submitted the paperwork to the clinical instructor for final changes and approval.

- The mentor and mentee were both active in the assessment and treatment process during face-to-face interaction with the client. For instance, as one administered a formal test, the other member of the mentor-mentee pair documented test performance on each item. The clinical instructor guided the roles played within a given therapy session.

- The mentor provided more instruction to the client at the beginning of the semester, while the mentee played a supportive role (e.g., charting performance on a formal/informal assessment instructing, keeping data on correct/incorrect responses for a treatment goal). This gradually changed over the semester to the point that by the end of the semester the mentee performed the majority of the instruction and the mentor played a supportive role.

- Supervisory meetings were attended by both the mentor and the mentee. The frequency of occurrence of supervisory meetings was made based on the discretion of the clinical instructor. The clinical instructor designed the organizational framework of the meetings. The meetings reflected the needs of the client, mentor, and mentee. In general, the meetings focused on discussing the direction of therapy sessions based on client performance, assigning duties for the mentor and mentee for the following sessions, and providing feedback on the performance of the mentor and mentee. The clinical instructor attempted to equally engage both individuals.

- The clinical instructor observed a portion of each session and provided written and verbal feedback regarding the session based on a standard clinic feedback form.

- Typically, before and after sessions, the mentor and mentee discussed aspects of assessment and treatment surrounding the client’s behavior and the procedures and performance of the mentor and/or mentee. The mentor attempted to answer the mentee’s questions and referred the mentee to the clinical instructor when appropriate.