ABSTRACT: This article discusses academic and clinical preparation for students in the disorder area of stuttering. Suggestions for improving both academic classes and clinical practicum are provided. A detailed group supervision model for a stuttering practicum is presented. The information is intended to assist academicians as they modify curriculum and practicum to meet the forthcoming (2005) changes to the standards for the Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP). Relevant information is provided for instructors, supervisors, and students.

KEY WORDS: stuttering, fluency, treatment, education, ASHA, training

Many studies have documented the need for strong academic and clinical training in stuttering (Cooper & Cooper, 1996; Sommers & Caruso, 1995; St. Louis & Durrenberger, 1993). Recent studies have shown that speech-language pathologists (SLPs) feel that they have inadequate skills for working with people who stutter (PWS) (Kelly et al., 1997), and that less than half feel confident in their ability to establish treatment goals for their clients who stutter (Brisk, Healey, & Hux, 1997). Some researchers have argued that training in stuttering and fluency disorders may be unimportant because stuttering is a “low-incidence” disorder. But, this argument does not make sense, because nearly all SLPs, particularly those in public school settings, have at least some clients who stutter in their caseload (Molt et al., 2002). However, it might be argued that because SLPs may be less likely to receive extensive “on-the-job” experience with clients who stutter, academic and clinical training may be more important in order to allow beginning SLPs to feel comfortable and confident in their ability to help children and adults who stutter.

Many factors contribute to the problems in providing adequate academic and clinical experience with stuttering. Among these are changes in the standards for the Certificate of Clinical Competence in Speech-Language Pathology (CCC-SLP) that took place in 1993. As a result of those changes, most academic programs reduced or eliminated course work and clinical practicum in stuttering (Yaruss, 1999; Yaruss & Quesal, 2002). A second factor is the growing scope of practice in speech-language pathology, which is illustrated in the forthcoming changes to the standards for the CCC-SLP beginning in 2005 (American Speech-Language-Hearing Association [ASHA], 2002). The new standards require that students who apply for the CCC-SLP show knowledge and skills in a wide variety of areas, and these knowledge and skills outcomes must be documented by the academic programs from which they graduate. As academic programs are asked to teach more, they must determine what to teach and how to best teach it. A possible result of these new standards could be a further reduction in stuttering course work and practicum (Quesal, 2002). A third factor is the lack of available clients who stutter in many academic programs. Many universities, particularly (but not only) those in less populated areas, may be unable to find a sufficient client base to allow all students to gain face-to-face clinical experience with clients who stutter. Finally, there is the perception among many that stuttering is “too hard” to treat, or that “therapy does no good” and therefore
In this article, we will discuss ways to ensure that students are adequately trained to work with clients who stutter, in spite of the roadblocks listed above. In fact, we will argue that in some ways, the 2005 CCC-SLP standards may make it easier to implement stuttering training in the curriculum. We will present, in detail, a group supervision model for clinical practicum in stuttering. Finally, we will provide suggestions for instructors, clinical supervisors, and students to assist them in maximizing the academic and clinical experience as it relates to stuttering.

**BEST PRACTICES: SOLUTIONS FOR ROADBLOCKS**

**The 2005 CCC-SLP Standards and Classroom Preparation**

The new standards focus on knowledge and skills acquisition and outcomes-based assessment conducted regularly over students’ entire academic program. The standards emphasize that this knowledge and these skills can be acquired in a variety of experiences. This has the potential to lead us away from the old “academic” teaching versus “clinical” teaching dichotomy toward a more integrated view in which classroom learning can be more directly tied to students’ clinical preparation. This is not to say that such integration does not already occur; the new standards simply provide a different framework in which to carry out this type of activity. It appears that a purely “theory-based” class in stuttering may now be a luxury that few programs can afford. However, this is not to suggest that theory and science should be ignored or discarded. Any stuttering class should be based on students’ understanding of current theories and perspectives on stuttering. Students should be aware of the behavioral, affective, and cognitive components of stuttering and how each contributes to the disorder (Yaruss, 1998). In their classes, students should also develop an ability to evaluate existing research critically. What we know about stuttering and its treatment will continue to evolve, and our students must be equipped to continue to change as treatments change.

However, in the current academic climate, classes in stuttering should include at least some skills acquisition activities. Below are some activities that the authors (and their colleagues) have incorporated into their classes to help students develop clinical skills for working with clients who stutter:

- **“Stories of stutterers.”** Reading or hearing about the experiences of PWS can have considerable value in helping students fully understand the disorder of stuttering and to become more empathetic for their clients who stutter. This can be accomplished by having students read articles or books written by PWS, having PWS visit the class to share their stories, and having students view videotapes or listen to audio recordings of PWS talking about their experiences.
- **“Learning how to stutter.”** Part of being a good stuttering clinician involves being able to model behaviors for clients. These exercises also allow students to “put stuttering in their mouth” and to more fully understand what it is like to stutter. By learning about the different types of disfluencies and actually doing them, students become better able to identify and understand how the behaviors are produced. Students can learn, practice, and model various stuttering modification behaviors such as cancellations, pullouts, and preparatory sets. They can also learn ways to pseudostutter and can practice fluency-enhancing behaviors (e.g., prolonged speech, metronome speech, delayed auditory feedback speech, choral reading), as well as discuss the pros and cons of these various approaches to increasing fluency.
- **“Stuttering in public.”** As an extension to the “learning how to stutter” exercise, students can go into public places and use the skills discussed above (Hulit, 1989). The most obvious benefit of this experience is an increased empathy for PWS; however, there is an interesting additional result. Often, when students undertake this exercise, they find themselves postponing the assignment, looking for listeners who will be “easy” to talk with, saying things other than what they want to say, or choosing to leave situations in which they had decided they were going to stutter. These behaviors are very similar to the avoidance and postponement used by many PWS. As a result of this, students can see that some of the “bizarre” behaviors exhibited by PWS are, in fact, very normal human reactions. In addition, when students are asked to use fluency-enhancing behaviors in public, they often understand why clients who stutter do not like using them outside of the clinical setting.
- **Other “clinical” skills.** In the classroom setting, students can practice stuttering assessment, including quantifying stuttering (“counting stutters”) or administering, scoring, and interpreting attitude scales (e.g., S-24, Andrews & Cutler, 1974; CAT-R, DeNil & Bruten, 1991).
- **Skills can be acquired in other classes, and skills learned in stuttering classes can be used to treat other disorders.** The counseling skills that are helpful in working with PWS and their families may be learned in a stuttering class and applied to other clients or may be learned in a class devoted to counseling or another class in the curriculum that covers counseling. In addition, skills such as easy onsets of phonation can practice fluency-enhancing behaviors (e.g., prolonged speech, metronome speech, delayed auditory feedback speech, choral reading), as well as discuss the pros and cons of these various approaches to increasing fluency.

It is important to emphasize that not all of these activities have to occur in all stuttering classes. Each instructor and each program must determine the likelihood of students acquiring the skills in other settings (e.g., on- or off-campus practicum) and determine the formula that will
ensure that each student has the necessary skills upon graduation.

Finding Clients

Before 1993, all students were required to have 25 contact hours with clients who stutter. Therefore, it is somewhat surprising that many programs now report that they cannot find any clients who stutter. There are various ways to increase the number of fluency clients in the clinic. One is to contact area schools and let them know that your services are available to augment those provided in the school. Because many children who stutter who are seen in the schools receive group therapy or sessions of short duration, the university clinic schedule may allow for more time and one-on-one treatment. In our experience, many school-based SLPs are appreciative of the additional support provided by the university clinic.

Another way to find clients is to periodically submit an informational piece to the campus and local newspapers. Better Hearing & Speech Month, National Stuttering Awareness Week, and International Stuttering Awareness Day all provide opportunities to write about stuttering and the services provided by your clinic. Paid advertisements in these newspapers are another possibility. Campus newspapers will often agree to interview you because student reporters are eager to find story ideas.

Similarly, if your university has a campus radio or television station, student reporters are often eager for stories and, if contacted, will agree to interview you and develop a story for broadcast. We will note, however, that in our experience, student reporters occasionally have problems accurately interpreting information about stuttering. Because of this, the information they present may not reflect the true nature of stuttering, so we would advise that you consult frequently with these students as they develop their stories.

University faculty members can also contact local physicians, especially pediatricians, and share information about stuttering and its treatment. In addition, physicians can be informed about the specific services offered by your clinic. This increases the likelihood of a referral.

Informational posters placed on campus can often help to bring in college-age PWS. These can be especially useful if they include language that suggests that the clinic understands stuttering (e.g., mentioning hiding stuttering, or avoiding taking classes such as public speaking). In our experience, college students are more comfortable coming to the classroom, while having considerable value, cannot replace clinical practicum. Learning to do stuttering therapy without working directly with a client has been compared to learning to ride a bicycle by watching videotapes of people riding bicycles, or practicing on exercycles (Quesal, 1999). All academic programs should strive to have an adequate number of clients who stutter to ensure that all students have an opportunity to practice the skills learned in classes (although we are aware that this ideal will not always be realized). It is important, also, to understand that in order for students to maximize their experience in clinical practice, the practicum must be structured properly and supervised effectively.

The clinical training experiences of students can also substantially impact their future perceptions of their ability to provide therapy to PWS. In fact, Dowling (2001) suggested that the clinical experience is "at the heart of preparing students to work as speech-language pathologists" (p. 151). Support for this position was also voiced by ASHA's Special Interest Division 4, Fluency and Fluency Disorders (SID-4), when they recently (2000, 2001) sponsored two leadership conferences on training issues in stuttering therapy.

Pertinent Issues Relating to Student Clinicians

We must first consider the characteristics of a good fluency clinician. Manning (2001) and others (Cooper & Cooper, 1985; Emerick, 1974; Shapiro, 1999) all believe that the clinician is central to the success of treatment. Although no exclusive list of attributes exists to define a clinician who excels at treating PWS, Manning suggested that "the best clinicians are uncommonly effective in understanding, encouraging, supporting, and guiding their clients along the sometimes long and arduous path of treatment" (p. 3).

Van Riper (1975) was one of the first to describe desirable attributes of clinicians who treat PWS. He suggested the need for characteristics such as empathy, warmth, genuineness, and charisma. Most of all, student clinicians must understand the disorder and that its treatment consists of more than focusing on the "stuttering block." As noted earlier, stuttering is multidimensional and includes attitudinal, behavioral, and cognitive features (Yaruss, 1998). Clinicians must also find working with PWS to be enjoyable and rewarding. Student clinicians who are not taking full advantage of their college experience because of a stuttering problem.

If there is a local chapter of the National Stuttering Association or other support group in your area, you can partner with this group. Support group chapters can provide clients for your clinic, but can also provide class speakers, or opportunities for students to practice skills.

If your program has a Board Recognized Fluency Specialist (BRS-FD), that should be noted in public relations efforts and materials.

Clinical Supervision

We must emphasize that knowledge and skill activities in the classroom, while having considerable value, cannot replace clinical practicum. Learning to do stuttering therapy without working directly with a client has been compared to learning to ride a bicycle by watching videotapes of people riding bicycles, or practicing on exercycles (Quesal, 1991). All academic programs should strive to have an adequate number of clients who stutter to ensure that all students have an opportunity to practice the skills learned in classes (although we are aware that this ideal will not always be realized). It is important, also, to understand that in order for students to maximize their experience in clinical practice, the practicum must be structured properly and supervised effectively.

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must develop confidence in their skills and possess the commitment to engage in continuing education once they leave the university. Of course, this list of desirable qualities for a clinician is extensive, and the university cannot be responsible for developing all of these characteristics. Obviously, many of these attributes are related to an individual’s personality; fortunately, the majority of students attracted by the desire to help people will possess at least the fundamental qualities required, although perhaps these qualities will not be fully developed. As supervisors, we can facilitate the development of these desired traits in nearly all students.

Pertinent Issues Relating to Supervisors

Supervisors must be knowledgeable, skilled clinicians in treating stuttering. It is necessary that they possess the interest and creativity necessary to work successfully with this complex disorder. Ideally, supervisors should have their own minimum caseload of PWS as a means to maintain clinical skills. Although not a mandate, supervisors would also benefit by joining ASHA’s SID-4 and eventually becoming a BRS-FD in the treatment of fluency disorders.

Research has documented that student clinicians experience significant anxieties as they engage in clinical work, and that these feelings interfere with the acquisition of skills (Gazda, 1974; Lovell & Wiles, 1983). Supervisors can reduce these anxieties by implementing the concepts of “permission,” “protection,” and “potency” (Steiner, 1975). Permission is approval given by the supervisor to the student that allows them to engage in new, sometimes risky clinical behaviors. Protection is the safety net the supervisor provides to the student as he or she actually attempts the new behaviors. Potency is the strength and understanding that supervisors must, at times, demonstrate when students fail in their attempt to apply a new clinical skill successfully. Supervisors must be ready and able to provide explanation, support, and redirection to help the student maintain focus and a sense of success. Further description of how these concepts can be used to enhance student learning will be discussed later in this article.

Consistency of Supervisor

Clients who stutter may be enrolled in therapy for lengthy periods of time in comparison with clients with other speech or language disorders. Unless a personality conflict develops, it is imperative that these clients maintain the same supervisor (case manager). As we are all aware, stuttering therapy has a number of complex challenges as the client progresses. Consistency in supervision ensures that relevant issues in progress or relapse are noted and that new student clinicians fully comprehend the client’s past history and current status.

Modeling and Team Therapy

There are minimal differences in teaching procedures used with student clinicians and clients. One of the more successful procedures used with both groups is modeling or guided practice (Gregory, 2003). Supervisors are indeed the experts and can more easily and efficiently teach new behaviors by first demonstrating what those behaviors are. However, to accomplish this effectively, the supervisor must become an integral member of the therapy team. This concept is rejected in some training programs for various reasons. One of these is that students learn best by taking full responsibility for their clients. We do not support this belief. Clients who stutter enroll in university programs for many reasons, such as reduced costs and location, but for many, the university clinic is attractive because they believe that it will provide the most up-to-date, efficient, and successful stuttering therapy procedures. The majority of clients understand that their primary contact may be with students in training but, ultimately, they depend on the knowledge and skill of the supervising case manager. This paradigm is perfect for a team approach to supervision. Clients should initially meet with both supervisor and student clinician and be presented with the concept of a working team. Student clinicians should be introduced and treated by supervisors as competent skilled clinicians, with the acknowledgment that the supervisor, with extensive expertise, may at times possess important insights in the therapy process. This may necessitate that supervisors enter the therapy room to demonstrate a technique or facilitate discussions regarding a particular client’s attitude or feeling. Using this model, supervisors have tremendous opportunities to use spontaneous teaching strategies, capitalizing on the “teachable moment.” Of course, caution should be exercised in the frequency and style of the supervisor’s presence in the therapy room. Too many “visits,” or an interaction style that challenges or degrades the student clinician’s abilities, will significantly disrupt the team therapy concept and jeopardize the student’s ability to develop trust and rapport with the client. However, when the roles of client, student clinician, and supervisor are well defined and understood by all parties, and when the supervisor intervenes in a way that encourages learning by both the client and the student clinician, the chance of negative reactions to the supervisor’s participation in therapy is greatly reduced.

Supervisor Observation Schedule

As we have noted, stuttering therapy is complex, and many students feel ill prepared and uncomfortable working with PWS. Student clinicians benefit from frequent supervisory feedback. It is true that many university clinics are understaffed, and that supervisors are inundated with observation demands. However, ASHA’s minimum supervision standard of 25% (ASHA, 2000, 2002) is unrealistic in our view. There is frequently a need for immediate changes during stuttering therapy, and new information must often be imparted to student clinicians. For maximum client and clinician success, the supervisor must be present to recognize the need for change and initiate the appropriate feedback. Although there is no research to determine the best amount of supervisory observation, we recommend that supervisors observe at least 20 min of every other session.
as a minimum. It is more productive for the supervisor to observe at least half of every session, especially early in the semester. Ideally, of course, the supervisor should observe most of every session, but this is often impractical, if not impossible. The formula for the amount of supervision should, and will, of course, vary according to the complexity of the client and the skills of the student clinician.

A FORMAL MODEL FOR SUPERVISION

No discussion of best practices for training students to work with PWS can ignore supervisory models, especially the supervisor–clinician conference component. A review of the supervision literature suggests that a beneficial supervisory process is a complex, dynamic, ongoing interaction between supervisors and student clinicians that will enable both parties to strengthen clinical behavior and promote professional growth (Anderson, 1988). Anderson (1988), Geoffrey (1973), and Schubert and Aitchison (1975) indicated that this supervisory process is composed of a variety of parts, including preparation, observation, and analysis, that are integrated during the conference component, which appears to be the most common avenue for providing feedback and determining future therapy procedures. Additionally, one-to-one supervision (student–supervisor) is the most traditional and frequent method of conferencing, but supervisors have been motivated to use group or team conferencing because of the large number of students they must supervise (Anderson, 1988).

Examination of the one-to-one conferencing model of supervision has demonstrated a variety of flaws or problems. Monopolization by supervisors of speaking time has been an area of concern. Hatten (1966) found that supervisors talked significantly more than student clinicians, and the most frequent topic in conferences was therapy techniques. Culatta and Seltzer (1976) demonstrated that the students’ role in conferences was to provide raw data while the supervisors suggested therapy strategies. Roberts and Smith (1982) found that supervisors assumed the more initiatory and prescribing roles while clinicians demonstrated a more reflexive role. Finally, a study by Shapiro (1985) found that conferences most often were used to discuss client rather than clinician behavior.

A review of the group supervision literature suggests that it has been beset by many of the same problems mentioned above (Anderson, 1988). Also, many times, group supervision has been done by default, initiated according to the time needs of the supervisor (Munson, 1983). A group conference presents both advantages and disadvantages with respect to the traditional one-to-one conference. Kadushin (1976) and Hart (1982) noted that students benefited from group meetings because of their exposure to a wider variety of clients and the emotional support provided by peer interaction. Disadvantages were that students might get limited individual attention, some students could be uncomfortable in the group setting, and students may not be compatible with each other.

For years, the authors had engaged in one-to-one supervisor–clinician weekly conferences. The meetings generally involved the clinician first providing data regarding past therapy sessions, followed by supervisor feedback and guidance provided for the clinician to plan future therapy. We found this to be a somewhat unsatisfactory supervision model, especially when there were a number of students working with different clients who stutter in a particular semester. Besides being labor intensive and time consuming, we were continually repeating similar information to all of the clinicians. Those students were also limited to learning stuttering therapy based only on their single client. Our observations suggested that most clinicians experienced similar therapy problems, and each student appeared to believe that he or she was the only one having that particular problem. Also, unless we did a great deal of demonstration therapy, the clinicians had little opportunity to view other clinical skills—both positive and negative. Additionally, because clinicians met only individually with us, the opportunities to develop professional “group presentation” skills were limited.

Our search for a better supervisory model suggested that Murphy and Watson’s BIGS: Blended Individual–Group Supervision (2002), which combined group and one-on-one conferencing, was a viable, dynamic approach. This model primarily uses group supervision with an occasional individual supervisor–clinician meeting. In our experience, we found a somewhat modified approach, which alternates weekly between individual and group supervision conferencing, to better fit the needs of our student clinicians. The following describes this conferencing approach for supervising students who are learning to work with PWS. It is important to note that what follows is presented as an ideal. In many academic programs, it may not be possible to use all of the components. In spite of that, many of the components can be used to improve supervision and students’ learning experiences and skill acquisition.

Introduction

Dowling (2001) reported that the style of supervision should vary according to student skill levels, interpersonal styles, and the complexity of the client’s disorder. As supervisors, we must recognize the differences among our student clinicians and modify our behavior accordingly. Anderson’s (1988) continuum model of supervision provides us with a framework for varying supervision as needed. Anderson described three stages in supervision: evaluation/feedback, transition, and self-supervision. In the beginning stage of evaluation/feedback, a direct supervisory style is required with maximum guidance to the student clinician. As skills increase, the clinician moves to the transition stage, characterized by collaboration, where the supervisor and student jointly plan, observe, and problem-solve the clinical issues. The last stage is self-supervision, where the supervisor acts as a consultant to the student. Our model reflects this supervisory continuum.

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Supervisory Goals

Although the model alternates weekly between group supervision and the traditional one-on-one supervisor–clinician conference, the primary training happens during the group meeting. The goals and procedures of group supervision meetings will be discussed first.

- Group supervision not only allows students to learn from their own client, but also provides for more secondhand, vicarious learning from other clinicians’ experiences. These would include:
  - exposure to a larger number of clients
  - greater variety of presenting problems
  - clients at different stages of therapy
  - male versus female clients and the issues involved
  - adult versus child clients and family issues
  - motivated, invested clients versus resistant clients
  - clients with different primary management strategies

- The group setting allows clinicians to observe fellow students’ strong clinical skills and “achievements,” as well as others’ difficulties and mistakes. These experiences encourage students to take information gained through discussion and relate it to their own experience, incorporating strong, effective skills and avoiding “typical” errors others may have shared. There is also an acquired knowledge that other peer group members experience similar problems. This has a tendency to reduce the students’ feelings of anxiety and self-defeating doubts regarding their abilities.

- Group work provides the opportunity to develop both individual and group problem-solving skills. As described later, clinicians are asked to first independently attempt to solve a problem, and this is followed by a group problem-solving experience. This not only helps to develop the student’s identity as a “professional,” able to work through a problem and come to a solution, but also encourages the development of strong cooperative working behavior that is so necessary for future employment in a variety of clinical settings.

- Problem-solving with others allows students to have “firsthand experience” in the difficulty of self-disclosure. Experiencing this increases their ability to empathize with stuttering clients’ struggles with self-disclosure issues. As will be discussed later, it is important that the supervisor provide all group members with a sense of emotional security while engaging in these activities.

- The conferencing model structures the clinician into preplanning what problem(s) will be addressed during the group meeting. It helps the students to consider not only client issues, but also what they as student clinicians need. This planning stage is a critical part of the supervisory process (Anderson, 1988; Cogan, 1973). It also lays the groundwork for students’ future work as professionals. Supervisors and colleagues in professional settings will not be receptive to helping someone solve a problem if the problem is presented with poorly formulated questions and concerns.

- Finally, this supervision model reduces supervisory time investment without decreasing the quality of supervision provided to students.

Pre-Group Meeting Procedures

Students are typically assigned fluency clients only after completing the department’s stuttering disorders course work (although in some cases, they may be working with a client and taking an advanced stuttering class concurrently). During the first week of the semester, students are required to review their clients’ files and make an individual appointment to present a case file summary to their supervisor for the purpose of discussing therapy procedures, degree of progress, interfering client/family factors, the need for possible additional diagnostic assessment, and so on. The supervisor and graduate student engage in a discussion of the client and mutually prepare possible lesson plans for the first few sessions. This meeting may or may not be more supervisor directed, depending on the degree of information regarding the client that is available to the student clinician. The supervisor also briefly introduces the student to the nature of the semester’s group conferencing model, and emphasizes that the student should be able to have the majority of his or her questions or concerns solved during the group meeting. However, if this does not occur, the supervisor will always be available for an individual meeting. This “requested” meeting is not the individual conference that is held on alternative weeks (when the group does not meet), but is an additional “emergency” conference. Although it is possible that the supervisor may request this individual conference, it is emphasized that it is the student’s responsibility to recognize his or her needs and limitations and ask for the “emergency” meeting, and that there are no penalties for scheduling this meeting.

Also before the first working group conference, the supervisor may hold a small number (2–6 hr) of “teaching clinics,” where information regarding stuttering therapy is presented and students are encouraged to practice modeling pseudostuttering and the various speech-motor fluency-enhancing/stuttering modification techniques. If incorporated, these meetings can be individualized to each program and are based on teaching information and skills that the students have not acquired from their stuttering course work.

Two Stages to Help Students

Adjust to the Group Supervision Model

There are two stages to prepare students to begin group supervision.

- Introduction to the rationale for group supervision and preparation for the second stage, the group supervision orientation. As previously noted, the students have been provided with some information about the group process during the initial individual case management meeting with the supervisor. A worksheet (Appendix
A) is provided for the students to analyze their communication styles.

- The **group supervision orientation** is a group meeting that includes “ice breakers,” exploring communication styles and their effect on personal and professional relationships, setting personal communication goals, trust building, and an introduction to personal self-disclosure. Guidelines for how the group will function are also provided.

These two steps precede the first group problem-solving meeting where students first present their problems/concerns and receive feedback from other group members. This meeting is generally led by the supervisor. In subsequent meetings, the role of group leader is alternated among the group members.

**Preparation for the Group Supervision Orientation Meeting**

All group meetings are usually scheduled for 2 hr, and experience has shown that six to eight student clinicians are ideal to provide for a viable group. Before the meeting, students complete a worksheet (Appendix A) containing questions pertaining to their interaction styles. The worksheet is designed to help students analyze and understand their communication style and appreciate that most people’s styles were learned from their families. Information is provided, both on the worksheet and later verbally, by the supervisor, that interpersonal communication styles not only affect each person’s participation in the group meeting, but also their interactions with clients and clients’ families. The worksheet asks clinicians to examine how their family conflicts were handled, how negative and positive feedback was provided, and how family members reacted to such messages. Other questions have the clinicians consider the impact of their family’s style on their present-day communication skills. They are asked to describe their current communication style, interpret how it might affect relationships with others, and consider what might be the easiest and most difficult parts of group interaction for them.

Students are told that this worksheet will not be read by anyone and they can decide what information they choose to self-disclose. However, another worksheet (Appendix B) requires students to list a specific communication pattern that they wish to increase or decrease while participating in the group. This worksheet will be given to the supervisor, and the chosen pattern will be monitored by the student and supervisor and discussed during the student’s individual midterm and final conference.

The key to experiencing a successful group supervision orientation is, in part, dependent on the supervisors’ facilitating skills. Supervisors at this stage should never be judgmental about students’ past or current communication styles. Supervisors may provide permission and protection by self-disclosing for the group some of their family’s communication styles. Explaining mistakes you have made communicating with other students or professionals may also encourage students to share. Supervisors may ask probing questions or may help students clarify what they are saying. The goal is to help students understand that everyone has different styles, and even if you have learned a style that may not be facilitating for group work or therapy, that style can be altered, at least temporarily, to better achieve a goal. Additionally, by helping students to share, clinician anxiety may be reduced and rapport and trust among and between student clinicians and the supervisor will begin to develop.

**The Fundamentals of the Problem-Solving Group Supervision Meeting**

The development of this particular group supervision format had its origins in Dowling’s teaching clinic (1979), a specifically structured peer-group form of supervision. Although it contains some structure of the original format, the current group supervision model is less directive and may allow for more flexibility.

In our group supervision meeting, students are required to preplan questions and concerns and to determine what type of feedback they desire from the other group members. Group meetings begin at a designated time, and members are expected to arrive on time unless they have previously notified the supervisor and other members that they will be late or absent. The supervisor initially takes the role of group leader, but the position is rotated during the semester, thereby allowing each member to experience the role. The group leader initiates the meeting by requesting that each participant verbally describe his or her questions or concerns in a very brief statement. These short descriptions are transcribed by the group leader, who later asks each participant to expand upon their concerns when it is their turn to take the role of “working clinician.”

Each clinician is also asked to determine the length of “working time” he or she will require to self problem-solve and receive input from the group. Although this may be difficult for clinicians to determine initially, experience has shown that clinicians quickly become facile with the task. Clinicians may also request time from other students or give up part or all of their time. Relinquishing time happens frequently as the semester progresses and students find that their peers are posing and problem solving questions similar to their own.

To track time limits requested by clinicians, a timekeeper role is assigned, which rotates to a different member each week. The timekeeper’s task is to notify the “working clinician” when 5 min of allotted time remains and also when the time period is completed. Again, at the end of a specific time period, the “working clinician” may negotiate more time from other group members. Experiencing the role of timekeeper and requesting additional time helps develop assertive behavior.

Student clinicians’ questions or concerns should primarily come from self-analysis of their past therapy session, but topics, questions, or requests to show clips of videotapes may also come from the supervisor.

After the “working clinician” has described the problem, he or she is asked by the group leader to share ideas, possible solutions, or other therapy procedures under
consideration to deal with the problem. The “clinician” may also be asked to describe what the possible outcome of any of the potential solutions might be. Once the “clinician” has completed describing possible solutions, the remaining group members are asked to provide feedback and to problem-solve the issue(s) presented. If the “clinician” is satisfied with the results of problem solving, the next group member assumes the role of “working clinician” and the process is repeated. If the “working clinician” is not satisfied, he or she can request more time or ask for an individual supervisor meeting. It should be noted that it is the ultimate responsibility of the supervisor to make sure the client is not harmed in therapy. The supervisor, therefore, has to judge the validity of any therapeutic strategy suggested by the group.

Two other issues are worth discussing here. First, no matter whom the group leader is during a particular meeting, the supervisor must make it absolutely clear that if a clinician has not been able to develop viable goals or strategies for his or her next session, he or she must take the responsibility to see the supervisor on an individual basis before his or her next therapy session. These extra one-on-one clinician–supervisor meetings are generally short, and during them, questions are resolved, immediate therapy strategies are determined, and both the clinician and supervisor leave the session satisfied. Second, it is neither helpful, nor good for the development of self or peer analysis and clinician–supervisor rapport building, for the supervisor to demand that clinicians attempt to solve problems when they do not have the basic background information available to them. An example would be asking the students to “figure out” how to teach a “pullout” if they have not been exposed to the concept of stuttering modification and the psychological and motor mechanics necessary to use the technique. This activity usually wastes precious time. Instead, the supervisor is better off temporarily taking the role of “information giver” and spending a portion of the conference engaging in teaching procedures. Care must be taken, however, that this role is not assumed too often because it then becomes more difficult for students to engage in a collaborative working relationship.

Another situation that demands a balance between supervisors being directive and allowing clinicians to take the lead is when the students are not presenting pertinent problems, either about their own or their clients’ behavior. Supervisors may respond to this by asking questions or providing strategies in their role as a group member. If an immediate solution is not required, the supervisor might also send the student a written note, asking him or her to consider these pertinent problems. If all else fails, the supervisor can request an “emergency” conference to discuss the therapy issue and address the student’s reluctance to participate in the group.

Other learning experiences occurring in group supervision may include role-playing and viewing/analyzing clinicians’ videotapes in terms of both clinician and client behavior. Guests such as researchers, psychologists, social workers, and early intervention specialists may also be invited to visit the group to help invigorate the problem-solving process.

The Individual Supervisor–Clinician Meeting

As noted, this supervisory model for conferencing alternates each week between an individual and a group meeting. This is the primary distinction between Murphy and Watson’s (2002) Bigs model and this format. Even though students could request individual meetings in the BIGS model, a regularly scheduled period where the supervisor meets privately with each student is necessary. These sessions can be used to discuss client management issues, but they are generally used to help students problem-solve issues solely related to their performance and to discuss issues that would not benefit fellow student clinicians. Examples include meetings to discuss what information should be included in a specific client’s report, and mid-term and final conferences, where the student’s strengths and weaknesses are examined and grades are given. For many students, as the semester progresses, the need for individual conferences diminishes, and individual meetings may be temporarily stopped for several weeks at a time.

To complete the semester on a note of enthusiasm and camaraderie, a closing ceremony may be prepared. The supervisor can read a humorous prepared text, congratulating students on their accomplishments. Certificates can then be presented as each student is asked to come forward to accept the award while the graduation music of Pomp and Circumstance is played.

Feedback and Grading

Throughout the semester, both individually and in group sessions, the clinicians are asked if they are receiving the supervision and information they need in order to feel comfortable in therapy and to treat their clients effectively. If students feel that their needs are not being met, they are encouraged to define what they want and how the supervisor may aid in that acquisition.

The supervisor and student formally meet individually at the midterm and final grading/feedback periods. The students are first asked to analyze their performance based on a set of clinical competencies that all students in the master’s program are given at the beginning of each semester. Students are also asked to consider the status of the communication goal they chose to work toward and to evaluate their performance in the group supervision meetings. Performance criteria may include the importance and relevance of their questions, how they accept feedback from the supervisor and peers, and their ability to help other group members problem-solve.

Following the student’s self-evaluation, the supervisor presents his or her observations/data on the clinician’s performance. If differences occur between the clinician’s comments and those of the supervisor, every attempt is made by the supervisor to come to a consensus in a supportive, nonthreatening manner. At both the midterm and the final evaluation, the student is asked to formulate, with the supervisor’s help, personal and client-oriented goals to be worked on during the second part of the semester or with future clients.
No doubt, the clinician-supervisor evaluation process just described can be threatening, especially if the supervisor is inexperienced or inconsiderate of students’ needs and attitudes. There is, however, in the group supervision model, an additional aspect to clinician self and supervisor evaluation. There are two anonymous methods for students to evaluate themselves and their supervisor.

The first is common to most university programs. The clinicians are asked to fill out a bubble sheet form ranking supervisory performance on a scale. A section for written comments is also provided. To ensure anonymity, the comments are transcribed by the department’s secretaries. The transcribed written comments and rankings are then given to the supervisor. Given the nature of these ranking scales, the feedback provided may have limited value to the supervisor. To obtain more detailed information from the students regarding their perceptions of skill acquisition, perspectives on group supervision, and other topics, several anonymous evaluation forms were developed (Appendix C). (Other forms can be developed based on the structure and needs of individual academic programs.) Preliminary data suggest that a majority of graduate students enjoy the group conferencing, especially if it is combined with the opportunity to have traditional individual sessions with the supervisor. Supervisory observation and clinicians’ self-evaluation also support that group conferencing facilitates learning, trust building, and self-disclosure skills.

Problems With the Group Supervision Model

The primary problem in using the group supervision model, of course, is that it requires a reasonably large cohort of students doing stuttering therapy at the same time. Many academic programs do not have this luxury, and therefore the model presented here, as we mentioned, is an ideal. Most of the ideas can be implemented with smaller groups, and many of the ideas may also be implemented by a supervisor working with a single student. Even in the ideal, a noncommunicative student, or one who never effectively uses the group problem-solving methodology, will likely not benefit from this model. Significantly weak clinicians can also be embarrassed by having their performance and poor skills on display for peers. Also, there is the occasional student who may be quite proficient in therapy, but seldom raises issues to the group, instead choosing to always request individual clinician-supervisor meetings. This latter type of student can be gently confronted by the supervisor, who can explain the nature of group supervision and why the clinician is not performing as expected. Supervisors should always first explore with all types of students their reasons for nonparticipation and facilitate, with students’ input, how any changes may be made in their behavior.

Selection of a group meeting time can be one of the most frustrating issues. Supervisors and graduate students are heavily scheduled. To find an appropriate time, early morning or evening periods must often be used. These extreme times can find clinicians and supervisors less alert, with reduced energy and motivation for group participation.

The group supervisory conferencing process can be stimulating, allowing us to invest more energy into our work with clinicians. Supervisory time, even with the addition of a one-on-one clinician meeting on alternative weeks, can be reduced by a minimum of 50%.

SOME FINAL THOUGHTS ABOUT SUPERVISION

For Instructors

Theory and science are important and must be part of a good class in stuttering. However, changes in our profession require that classes go beyond theory and provide students with opportunities to apply their knowledge. We should look at this as a positive thing. We are asking our students to demonstrate what they have learned in our classes, and to show how they will use that knowledge. If we teach well, we and our students should be pleased with the outcome of this type of approach to teaching and learning.

For Supervisors

We have described a model for helping students acquire a foundation for developing the necessary skills required to work with PWS. You, the supervisor, are the most important facilitator in this model. Supervisors have extraordinary responsibilities. Teacher, mentor, active listener, and taskmaster are all part of the job. Our model, too, places high demands on the supervisor. We, from experience, know all too well the many burdens the supervisor faces. Supervision of multiple disorders, large numbers of students, and time demands of other department assignments comprise only a portion of the job. But remember that our model is not rigid. It is a working plan, and although much detail has been provided, the primary purpose is to highlight pertinent training issues. How these issues are addressed can be as varied as your imagination allows.

Although specializing in the treatment of stuttering is beneficial, it is not a requirement. To be successful, supervisors do need to love working with PWS. To do a job well, one needs passion, and supervision of stuttering therapy is no different. As discussed earlier, knowledge and skills are also necessary. But do not allow feelings of uncertainty regarding clinical skills or research knowledge stop you. You can acquire this knowledge if the desire is present. The annual ASHA convention; many state conventions; workshops by the Stuttering Foundation of America, National Stuttering Association, and ASHA’s SID-4; and selected readings all offer excellent opportunities for you to become a proficient supervisor in stuttering therapy.

For Students

You should not be afraid of stuttering or PWS. Many people may argue that we do not know much about stuttering; it is a difficult disorder to treat; we cannot help PWS; or (heaven forbid) it is not reimbursable, and
therefore is not worth our time. Those attitudes have no place in our profession. As a student, you should try to learn as much about stuttering as you do about other disorders that are part of the SLP’s scope of practice. You should seek out opportunities to work with clients who stutter. What you are likely to find is that you can help children and adults who stutter, and you can make a difference in their lives. Like anything else, you will find that with practice and experience, you will become quite good at what you do. If you avoid learning about stuttering or choose to learn only what is presented in your class, or if you choose to avoid working with clients who stutter, you will likely find yourself among those who report that they are uncomfortable working with PWS. You have a choice—we hope you will decide wisely.

REFERENCES


Murphy, W., & Watson, J. (2002). Enhancing stuttering clinical teaching through blended individual–group supervision. Perspectives on Fluency and Fluency Disorders, 12(3), 18–24.


APPENDIX A. INTERACTIONAL STYLES

As adults, we often continue to use the same interaction or communication styles that we learned to use in our family of origin. Thinking about the way our families communicated can increase awareness of why we interact with others as we do.

Many graduate clinicians find that their interpersonal communication styles affect their participation in group supervision and their interactions with clients and clients’ families. In an attempt to identify how your personal style might affect your experience, please answer the following:

1. How did your family of origin communicate with each other? Please consider the following:
   a. Conflictual situations – How were conflicts negotiated?
   b. How was negative feedback given to each other?
   c. How did/do you react when given negative feedback?
   d. How did/do you react when given positive feedback?
   e. How easy/difficult is it for you to share feedback (both positive and negative) with others?
   f. Fun or happy times – Did you share good experiences?

2. What level of communication would you say your family experienced? Did you share everything or very little?
   a. On a scale of 1 to 10, how much would you say you shared on an emotional level?
      
      |     | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
      |-----|---|---|---|---|---|---|---|---|---|----|
      |very little| | | | | | | | | | very much |
   
   b. On a scale of 1 to 10, how much would you say you shared on an informational level?
      
      |     | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
      |-----|---|---|---|---|---|---|---|---|---|----|
      |very little| | | | | | | | | | very much |

3. What impact would you say these early patterns have had on your present-day communications?

4. What are the most difficult parts of group interactions for you?

continued on next page
Power in Interpersonal Communication

5. In order to increase your awareness of the way power messages are sent nonverbally, identify and describe the following. How did you feel in each of these relationships?

(a) a relationship in which you see yourself as operating on a level of equality with the other person:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

(b) another relationship in which the other person is dependent on you: ________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

(c) still another relationship in which you are dependent on the other person: ___________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

6. How do you perceive the distribution of power in the supervisory process?

7. How comfortable is this distribution to you?

8. How do you perceive the distribution of power between you and your client and/or client’s family?

9. How comfortable does this distribution of power seem to you?

Communication Styles

1. What have others told you about your communication style? How do others perceive you?
   (a) Negative aspects: _________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

(b) Positive aspects: _________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

2. What do you consider to be the most salient aspects of your communication style:
   (a) Negative aspects: _________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

(b) Positive aspects: _________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

3. When you have had communication difficulties in the past, what would you say have been some of the primary problems? _______________________________________________
___________________________________________________________________________
___________________________________________________________________________
4. Please check any of the following that you think describes your interaction style:

_____ a. I withdraw and remain quiet.
_____ b. I tend to talk too much, often dominating the conversation.
_____ c. I am quick to anger.
_____ d. I rarely become angry or emotional when communicating.
_____ e. I am an emotional communicator. In other words, I let people know my feelings.
_____ f. I am a better listener than I am a talker.
_____ g. I am a better talker than I am a listener.
_____ h. I like to make decisions.
_____ i. I would rather others make decisions for me.
_____ j. I am a better follower than I am a leader.
_____ k. I am a better leader than I am a follower.
_____ l. I find it difficult to stand up for my rights.
_____ m. I find it easy to stand up for my rights.
_____ n. I sometimes resort to aggressive communication in an effort to stand up for my rights.
_____ o. I am very direct in my communications with others.
_____ p. I tend to “beat around the bush,” rather than coming out and directly speaking my mind.

Special thanks to Suzanne Bufano, who created much of this worksheet while completing her PhD in the Department of Psychology, Purdue University.

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**APPENDIX B. PERSONAL SEMESTER GOALS**

Take a few minutes to think about interaction objectives or goals that you would like to work on this semester in group supervision. Write down one or two of these goals. What specific steps could you take to meet these goals? Although you may share these goals with the group if you choose, you will not be asked to do so.

Communication pattern I wish to work on: ______________________________________________________
___________________________________________________________________________________________

Specific goal: ______________________________________________________________________________
___________________________________________________________________________________________

Specific steps to achieve goal: _________________________________________________________________
___________________________________________________________________________________________

How will I measure success?: _________________________________________________________________
___________________________________________________________________________________________

Example:

*Communication pattern I wish to work on:*
“I do not share enough in group situations.”

*Specific goal:*
“I want to contribute more in group supervision.”

*Specific steps to achieve goal:*
“I will try to contribute more of my thoughts and ideas during supervision meetings.”

*How will I measure success:*
“I will consider myself successful if I share at least two unsolicited thoughts or ideas during each supervision meeting.”
APPENDIX C. GROUP SUPERVISION FEEDBACK AND RATING SCALES

Here is a list of questions for you to consider. We will be discussing each of these during our final group meeting. Later, please write out your impressions and ratings as completely as possible and return them to the report secretary. Your responses will be anonymously transcribed and given to me. Your feedback will help shape my future group supervision practices.

1. What was the most beneficial part of supervision?
   - Was there one particular activity that was especially helpful?
   - Was there one particular topic that was especially important?

2. What do you wish we had done in supervision that we did not do?

3. What did we do in supervision that you wish we had not done?

4. Think about various personal characteristics of your client.
   - Which characteristics made it particularly easy for you to work with him/her?
   - Which characteristics made it particularly difficult for you to work with him/her?

5. Did you experience progress in learning how to cope with these difficult characteristics?

6. Did any of the characteristics of your client remind you of parts of your own personality? If so, please explain.

7. Did you prefer the group supervision meetings you experienced this semester or would you have wanted only individual clinician–supervisor meetings?

8. Did you have enough individual meetings with me this semester?

Self Rating
As a clinician working with people who stutter, please give yourself three rankings on the continuum for each of the following items. The rankings are to reflect (1) your skills at the beginning of the semester, (2) your performance now, and (3) where you would like to be. In some instances, certain issues will not apply to you.

1. Skill in teaching speech/motor techniques.
   Low ——————————————— High

   Low ——————————————— High

   Low ——————————————— High

4. Skill in providing information to parents
   Low ——————————————— High

5. Skill in facilitating parents’ participation in therapy
   Low ——————————————— High
As a member of the supervisory group, please rank yourself on the low/high continuum.

1. Your comfort in sharing your achievements with the group.
   Low ............................... High
   Frequency with which you do share your achievements.
   Low ............................... High

2. Your comfort in sharing disappointments with the group.
   Low ............................... High
   Frequency with which you do share your disappointments.
   Low ............................... High

3. Your comfort in contributing ideas to your colleagues regarding their clients.
   Low ............................... High
   Frequency with which you do contribute ideas.
   Low ............................... High

   Low ............................... High
   Frequency with which you engage in critical self-analysis.
   Low ............................... High