THE TRAINING OF CLINICAL PERSONNEL: II
A CONCEPT OF CLINICAL PREPARATION

by

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This is the second of two articles dealing with what the writers consider to be issues in the preparation of clinical personnel for speech pathology and audiology. The first article (1965) dealt with issues in conceptualizing about students and about the meanings to them of their academic and clinical preparation. Here we discuss the idea that the content of professional preparation can provide opportunities for the clinical student to further explore, understand, and modify his own behavior.

In the early development of the profession of speech pathology and audiology, it was appropriate that the content of professional preparation for clinicians be centered chiefly on the behavior of persons with speech and hearing disorders. However, it is recognized with increasing clarity that this content must focus also on the behavior of the clinician. This behavior must be dealt with in its qualitative as well as its quantitative aspects.

Evidence of a recognition of the importance of qualitative aspects of clinician's behavior comes from many sources; some of the sources also postulate certain desirable behaviors for clinical personnel. Travis (1963) advises the clinician to ". . . be supersensitive to the speech of our patients, to listen with more than our ears." Van Riper (1964) warns that ". . . unless the therapist conceives of his patient as a dynamic system in a field of force, unless he can perceive that system, he will remain little more than one more random influence in a threatening world." English and Lillywhite (1963) instruct the speech pathologist or audiologist to use his "clinical sense" in evaluating his diagnostic or therapeutic data; further, in discussing clinical reporting, they say ". . . we may use certain projective terms which will serve to indicate to 'self' and to 'others' that we are conscious of our own feelings or projections."

Employers recognize the importance of qualitative aspects of clinicians' behavior; they almost invariably request information relating to an applicant's ability not only with respect to his technical skill, but also with respect to his ability to enter into satisfactory relationships with clients, parents, and staff associates.

Further evidence of the need to include the behavior of the clinician in the content of professional preparation comes from supervisors of clinical practice in both speech pathology and audiology. Day after day, supervisors confront the fact that success in clinical practice is dependent not only on what the clinician does, but also on how he does it. For example, supervisors encounter one student able to administer a valid audiological evaluation to a four-year-old child and another unable to do so, although both have an excellent knowledge of testing procedures with children. They see a child restless and inattentive with one student clinician, but alert and interested with another, although both clinicans use the same techniques. They know student clinicians who enjoy working with children, but who are terrified of work with adults. They see clinicians who can work well with adult clients, but not with teachers or parents. They find students who have been effective in on-campus clinical situations having great difficulty in clinical practice in off-campus settings, for example, public schools, hospitals, or rehabilitation centers. They see many students who are unable to set and maintain effective limits on clients' behavior.

One can enumerate the kinds of behavior a clinician should have and attempt to screen out at the outset those persons who have not developed the acceptable behaviors; but this does not solve the problem creatively. Further, this approach is not consistent with clinical assumptions; the clinical profession is committed to the belief that it is possible for human beings to change in positive directions. Therefore, those who hold clinical assumptions must reject the "some have it, some don't" attitude regarding these critical aspects of clinicians' behavior; it must be acknowledged that probably not all excellent clinicians are "born that way." Instead, it seems to the writers that it must be assumed that these desirable behaviors are potentially present in each student in his own unique way. It is the extent to which the student can realize his potential, within time limits imposed by educational institutions, which makes a critical difference in his excellence in clinical activity.

Those who teach and supervise clinical students must assume responsibility for providing means whereby these persons can realize their potential as clinical personnel in effective and satisfying ways. Thus, it

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seems that teachers and clinical supervisors must clarify their thinking about which attitudes and behaviors are desirable in clinicians. Further, they must clarify their ideas about ways in which students can develop these attitudes and behaviors during the course of their clinical preparation.

The writers present some beginnings made in formulating a concept of clinicial preparation which emphasizes clinicians' behavior. Included is a discussion of: (1) clinical practice, (2) barriers to effective clinical practice, and (3) basic areas of study.

CLINICAL PRACTICE

Since clinical practice takes place within a human relationship, the development of the ability to enter into mutually satisfactory relationships with other human beings is conceived as the larger whole of the clinical training process.

Diagnosis and Therapy

The particular characteristics of diagnosis and therapy are viewed as parts within this framework of human interaction. Thus, diagnostic and therapeutic procedures are viewed as interactive processes between clinician and client. The effectiveness of these procedures depends, first, on the clinician's ability to create and maintain a relationship which is mutually satisfying. Second, effectiveness of procedures depends on the clinician's ability to apply knowledge of the nature and treatment of speech and hearing disorders.

Experience of those engaged in professional clinical practice supports such a concept. Time and again, clinicians report that where they have been unable to effect a mutually satisfying relationship with a client, little has been accomplished; however, where they were able to effect such a relationship, diagnosis or therapy tended to be successful, even though they used the same methods.

Experience of supervisors of clinical practice also supports such a concept. They deal over and over again with intelligent students whose difficulties in human encounters prevent their success in a variety of ways, some of which will be discussed in greater detail below.

Supervision

Clinical supervision is conceived as an interactive process between student and supervisor in which both are working together to find the most productive ways of effecting the diagnostic or therapeutic relationship. This concept implies also that student and supervisor are working together to find factors which are operating to prevent more effective and satisfying clinical practice. The behavior of the supervisor, then, must reflect rational authority (Fromm, 1947) based on current clinical interest, a great deal of clinical experience, and a willingness to examine his own attitudes and relationships. The behavior of the supervisor must also reflect attitudes of respect for the student.

BARRIERS TO EFFECTIVE CLINICAL PRACTICE

In the writers' experience students show a recurring pattern of problems in interpersonal relationships; these problems operate as barriers to their effective clinical practice. Discussions with students verify that such difficulties account for many of the negative meanings particular clinical training situations have for them.

The following examples illustrate some of the interpersonal problems encountered in students. These examples also indicate some of the applications of this concept of clinical preparation in which development of the ability to enter into satisfying human relationships is of primary importance.

Many students find that their fears of not being liked by a client prevent their setting of rational limits that are needed to provide them and their clients freedom. As this barrier becomes conscious, and the conflict reconciled, they often find they can maintain an atmosphere of order, which often results in their being better liked.

Problems in authority relationships may be the chief factors which interfere with students' ability to work with parents or with other adults, including the clinical supervisor. Problems student clinicians have with authority relationships are exemplified by the difficulty many have with accepting the supervisor's rational authority. As these problems become conscious and are dealt with courageously, and as students in training have continuing encounters with rational authority, they are often able to effect new and more satisfying relationships with authority figures.

Other students report that attempts both to conform to and compete with others have for so long blocked them from doing and being what they have known they could do and be, that they are no longer sure what they would do if they could choose. Often, indeed, these persons show great lack of creativity in their application of clinical procedures. The supervisor can help the student become more conscious of those things he can create as himself, without competition with others. It follows that if the supervisor is to live out his willingness to let the student create as himself, the supervisor must then give him opportunities to experiment with his own creations without comparing them to others'. Here the writers are not implying that each person should be free to do just as he likes; we are in agreement with May's (1953) statements that each individual must courageously move from conformity to living out his own creative abilities as a person who is concerned with the welfare of other persons.

Many students report great difficulty with accepting responsibility, both for their behavior and for their learning. They continue to exhibit patterns of dependency in their relationships. The supervisor can reinforce these patterns, or he can encourage more independent behavior. He cannot make the student behave more independently, however, by insisting that he be more independent. The supervisor can help to struc-

ture situations which call for more independent functioning by the student, and can support his feelings of satisfaction with his acceptable performance in these situations.

Again, it is emphasized that these examples are representative of a broad range of student difficulties with human relationships; they are not limited to "difficult students." These behaviors are potential barriers to effective clinical functioning. They must be understood by the student and dealt with not only rationally but also emotionally.

BASIC AREAS OF STUDY

If those engaged in preparing clinicians are to implement a concept of training which places primary importance on development of the ability to enter into satisfactory human relationships, professional preparation must provide the student with tools for understanding and changing his own behavior. Finally, it must provide situations in which students may experiment with new behavior.

Thus, the clinical student's study of *himself*, that is, of his own attitudes, emotions, behaviors, must be an integral part of his program of professional preparation. The writers consider continuing self knowledge as basic to the meaningful utilization of such other aspects of professional preparation as knowledge of principles of human behavior, of normal processes of speech and hearing, and of the clinical content of speech pathology and audiology, that is, the nature of speech and hearing disorders and of principles and methods by which they are treated. The student's continued self-study is also considered crucial to his repeated successful experience in the variety of supervised clinical practice situations provided for him.

The clinical student's study of human behavior must cut deeper than mere coursework in psychology. The clinician's education must provide him not only with an academic knowledge but also with an operational familiarity with basic principles of human behavior. This means that these principles must be applied to the student's study of himself. As the student applies the principles of human behavior to himself he also can apply them meaningfully to others, including those with disordered speech and hearing, and those whom he encounters in his clinical practice situations. Knowledge of the principles governing human behavior and application of these to oneself does not replace knowledge of the more traditional content of speech pathology and audiology; rather, this is conceived of as a basic context in which to build knowledge of content.

The group climate in classes and clinical practice settings must be one which will promote the student's courage to seek knowledge about himself and courage to accept what he finds. Teachers and supervisors bear responsibility for promoting such a climate; many have written about the role of teachers in this endeavor, for example, Rogers (1950), Jersild (1957), Peck and Prescott (1947).

Courses can be designed specifically for the purpose of exploring principles of human behavior and attempting to apply these principles to oneself. The writers have taught graduate and undergraduate courses geared to these purposes. In such courses, students are asked to observe and describe their own behavior; they are required to keep journal records of this investigation. Such projects are undertaken to help provide students with tools for self-study. As these tools prove helpful, they can be utilized throughout the entire educational program.

Issues in human behavior also arise in courses such as those dealing with speech and hearing disorders. For example, students may come to recognize conditions within themselves which limit their ability to acquire or to demonstrate knowledge in these courses. If given the opportunity to do so, they may talk about and better understand their blocks to studying, their blocking on examinations, and their resistance to learning specific material. Awareness of forces which are operative as barriers can help them to deal consciously with these forces, and, often, to change their behavior.

Thus, it is thought that the student's ability to apply knowledge of speech and hearing disorders and diagnostic and therapeutic procedures can be facilitated by his continued study of himself. If self understanding helps students to apply knowledge and techniques, it seems a particularly important facet of clinical preparation, since the gap between a fine academic knowledge and a fine clinician in practice is a common problem. The writers' experience is that many students find great meaning in the study of themselves as they continue with it; they see it as deepening with understanding not only of their professional courses but also of other subject matter areas, such as, history, philosophy, etc.

The statement has been made in many areas of endeavor that a technique is no better than the human being using it. This statement seems equally applicable to our clinical profession. Our purpose is not to enter arguments about the "best" clinical theories or techniques; important theories and techniques abound in our field. And it is our experience that argument fails before a clinician who is able to release a warm, mature personality into the human relationships known as clinical practice. Our concern is with the human beings who implement the theories and use the techniques. Success and satisfaction in professional endeavor are obviously not dependent just upon theories or techniques, but upon the meanings of the professional endeavor to the clinician.

There are still many unanswered questions regarding the implementation of the concept of professional preparation of clinical personnel presented here. Certainly not all students who complete training programs so conceived accomplish the purposes discussed above. Nevertheless, experience in such programs has been convincing of the validity of this concept. A sufficient number of successful students and successful practicing clinicians report greater meaning to their academic

and clinical work and greater depth to their satisfactions to suggest continued experimentation with this idea.

The writers suggest that in this maturing profession, further research is crucial if we are to attempt to delineate productive and desirable behaviors for clinicians. Further, research is necessary to suggest additional means of providing for the development of these behaviors in clinicians as part of their educative process.

SUMMARY

As clinical practice in speech pathology and audiology continues to mature, the content of education of clinical personnel must focus not only on the behavior of persons with speech and hearing disorders, but also on the behavior of clinicians. If it is desirable for clinicians to develop certain behaviors, they need tools for attempting to develop these behaviors during the course of their professional preparation.

A concept of clinical training is discussed in which the development of the clinical student's ability to enter into satisfactory human relationships is regarded as the larger whole of the process of professional preparation. The specific human relationships called diagnosis and therapy in speech pathology and audiology, and the abilities to apply diagnostic and therapeutic techniques are conceived as parts of this whole. Implementation of this concept and implications for the training program and for research are discussed.

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