Here's How to Do Therapy

Hands-On Core Skills in Speech-Language Pathology

Third Edition

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Contents

Preface

Production of this third edition of *Here's How to Do Therapy: Hands-On Core Skills in Speech-Language Pathology* continues to be a rewarding endeavor. Based on user feedback, the following changes were made to this edition.

Part I

- The information that previously composed Chapter 1 in the second edition of the text is now presented for the attention of clinical educators as an introductory chapter for using the book. This change was made so that clinical educators could have ready access to information designed for teachers in structuring classroom proceedings and activities for enhanced student learning without requiring students to engage in this information, unless desired.
- Chapter 2 was expanded to include more content on multiculturalism.
- Chapter 3 was expanded to include content on telepractice.
- Chapter 4 was expanded to include content on uses of AAC devices.

Part II

- DVD visuals were replaced with videos on a PluralPlus companion website.
- Chapter 8 was expanded to include a section on social communication for children with autism spectrum disorders (ASD).
- Chapter 9 was expanded to include information on phonological processes.
- Chapter 13 is a completely new chapter addressing adult cognitive disorders.
- Chapter 14 is a completely new chapter addressing swallowing and dysphagia.

Although maintaining the original aspects of prior editions of the text remains important, there continues to be an increased desire to expand the clinical application and teaching aspects of the third edition to enhance user outcomes. From the beginning, readers and users of prior editions of the text reported interest, delight, and benefit from the contents of *Here's How to Do Therapy: Hands-On Core Skills in Speech-Language Pathology* for both individual and small-group learning settings. Keeping in mind the positive reception of prior editions of the text, the intent of this third edition is to expand user benefits for both students and clinical supervisors by making it easier to learn and teach basic

therapeutic skills based on both the content of the text and the demonstrations offered in the web-based companion videos. To this end, this third edition of *Here's How to Do Therapy: Hands-On Core Skills in Speech-Language Pathology* is designed to accomplish the following objectives for both students and clinical supervisors: (a) increase the opportunities for learning through the expansion of examples and scenarios, and (b) enhance the training value of the text through the inclusion of graphic learning tools to help promote proficiency in students' skills through systematic guides and reminders for specific skill sets. In these two ways, this third edition of *Here's How to Do Therapy: Hands-On Core Skills in Speech-Language Pathology* is seen as an endeavor borne of decades of commitment to improving young professionals' skills across broad areas of the profession in the basics of therapeutic intervention. It is hoped that readers and users agree that this third edition of the text maintains the creative and academic aspects of the original work while also enhancing and expanding the value of the text within the clinical training arena of our profession.

Format

This text is designed to serve as a sourcebook, an easy-to read, easy-to-follow guide to enhancing foundational concepts for providing speech-language therapy services to clients of all ages, with all levels and types of speech-language disorders. This sourcebook is designed for speech-language pathology (SLP) students and professionals as a ready guide for basic, functional, practical applications of 28 underlying skills for speech-language therapy. Skills addressed in this book are cross-disciplinary in that they are basic skills fundamental for therapy across a wide spectrum of communication disorders, whether simple articulation or difficult-to-manage low-incidence disorders.

Part I of the book presents definitions, relevant concepts, and information related to the basic speech-language therapy session. When possible, figures, textboxes, or exercises are provided to emphasize the concepts being taught. Additionally, 28 specific skills associated with speech-language therapy are highlighted and discussed in Chapter 5. Readers are guided through a process for learning and demonstrating each of the 28 specific skills through use of three tools that accompany the text.

1. *Therapeutic-Specific Workshop Forms (TSW Forms)*. TSW forms are written in six sections to help guide learning for the skills presented, with each form designed to accompany one or more of the 28 different skills discussed in Chapter 5. Although 28 different therapeutic-specific skills are presented in Chapter 5, only 14 TSW forms are needed to address these 28 skills because of groupings for the skills. For example, although several TSW forms address only one therapeutic-specific skill, often two, three, and even four therapeutic-specific skills are grouped together on one TSW Form due to the nature of the skills or simply for ease in learning the skills.

2. *Video Vignettes*. Visual demonstrations of 23 of the 28 skills presented in Chapter 5 and addressed on the TSW Forms are highlighted on the PluralPlus companion website. For example, TSW forms numbers 2 to 11 have video vignette accompaniments that address a total of 23 therapeutic-specific skills visually on the companion website.
3. *One Mini Therapy Session*. A language-based telepractice mini therapy session is demonstrated in a 20-minute session on the companion website for use in learning skills presented in both Part I and Part II of the text. There is no TSW form for this mini therapy session. It is simply to be enjoyed as a culminating effort for what a telepractice therapy session might look like in real time for an adult language-based therapy session. Of course, each clinical educator and each clinician will develop his or her own style of what therapy looks like once the 28 therapeutic-specific skills are learned and implemented within the art of doing therapy.

Readers are encouraged to work through the TSW forms and, when applicable, the video vignette demonstrations of specific skills presented in Chapter 5, and are encouraged to view the mini therapy session, all as if preparing for a theatrical production (*read, learn, practice*); after all, speech-language therapy is often a matter of performance on demand, but often with an impromptu script. Viewers may replay individual segments on the companion website and work through specific segments of the TSW forms as necessary for practice and comfort in acquiring the 28 therapeutic-specific skills presented in Chapter 5 of this text. Again, the skills acquired in Chapter 5 will be applied in the therapy progression presented in Chapter 6. (See Chart 6–2 for a detailed explanation of therapy progression.)

Part II of the text presents selected concepts and scripted examples of therapy sessions for seven areas of the profession:

- Language therapy for basic reception and expression; social-communication therapy for children with ASD
- Articulation and phonological therapy
- Voice therapy
- Resonance therapy
- Fluency therapy
- Adult cognitive therapy
- Swallowing and dysphagia therapy

The scripted chapters are designed to give the SLP examples of (a) how therapy proceeds from beginning to end across the three major parts of a therapy session as described in Chapter 5 of the text, and (b) what the SLP might actually say to the client to elicit the kinds of responses and results desired of the client in different types of therapy. As mentioned

earlier, one mini therapy session on the companion website adds to the viewer's understanding of information presented in Part II of the text as well. As a function of learning to work, first from a given script and then from impromptu clinician-led therapeutic interactions, students and professionals learn the fundamentals of providing appropriate intervention progressions for speech-language therapy. By learning the concepts in this book in a guided, directed pattern of speech-language therapy for different disorders, students and professionals develop a better understanding of therapeutic interactions and progressions and quickly develop their own individualized intervention styles. Students and professionals typically do not remain true to the scripts as skills and techniques are learned and perfected, but most retain the basic concepts learned through guided work in providing speech-language therapy as presented in Part II of this text.

Thank you for your continued support of the objectives of this text.

—Debra M. Dwight

To Michael Sky Dwight, my granddaughter, and the generations that will follow her.
To my parents, Jerry and Valeria Maye; my sons, Marlon and Jacob;
and the Maye men: Reginal, Julius, Samuel, and Anthony.
To all of my supporters, but especially Etta, Barbara, Glo, James, Lois,
Lydia, June, and Wynora.
To my students, who have given me more than I can ever repay.
To the memory of Renee', Chuck, and Mother Baseemah, all gone too soon.

Love you much,
Debra Kim Maye Dwight
2021

A special acknowledgment to Gloria J. McMeans, whose ideas, ideals, and motivational support contributed significantly to the outcome of this text.
Thanks, Glo—couldn't have done it without you.

INTRODUCTION

Here's How to Use This Text

For decades, clinical supervisors and instructors have found ways of teaching clinical skills that resulted in successful learning outcomes for speech-language pathology (SLP) students. Often, the tasks associated with teaching clinical skills to developing SLP students are time consuming and labor intensive. For every SLP student learning to do therapy, clinical supervisors and instructors expend hours of tedious lecturing, demonstrating, guiding, directing, observing, coaching, and evaluating to ensure SLP students acquire and appropriately implement the skills necessary to positively impact client outcomes in communication abilities. Each clinical supervisor and instructor responsible for helping SLPs learn the art of speech-language therapy has his or her own unique style for teaching and guiding students. However, several specific concepts and practices over the years have proven effective for helping ensure that developing SLP students easily learn the information presented in this text.

Teaching and Learning Pedagogy

Basic teaching ***pedagogy*** is the underlying philosophical beliefs and concepts that serve as foundations or guiding principles for the education of students. Often pedagogies are seen as simple and broad. The guiding educational principles, such as "All students can learn" and "Every child deserves a chance to learn," are broad-based pedagogies often espoused by general educators and educational leaders responsible for teaching and learning for large groups of students in typical educational settings. However, Loughran (2013) suggested that "a pedagogy of teacher education can be viewed as the theory and practice of teaching and learning about teaching" (p. 129). Loughran's work offered more focus for educational pedagogy and presented a type of pedagogical processing that served as the foundation of this text years ago when it became necessary to very quickly teach students how to do speech-language therapy; during that time, it became clear that education pedagogy was about "the teaching–learning relationship" (Loughran, 2013, p. 135). Although perhaps not a typical line of conversation for SLP professionals, the concepts of teaching and learning pedagogy are crucial to the SLP clinical supervisor and instructor,

who carry dual responsibilities of not only operating as competent clinicians, but also of serving as the points of contact for SLP students who must quickly and effectively learn both the academics of the SLP profession, as well as the clinical applications for helping others to learn (or relearn) to effectively communicate. That is an awesome responsibility, and one that is not always easily accomplished (Carter et al., 2017; Cook, Messick, Ramsay, & Tillard, 2019; Fredrickson & Moore, 2014; Makaiau & Miller, 2012).

The need to teach SLP students how to do therapy prompted questions such as, "What do SLP students need to know about how to do therapy, and how are those concepts best taught?" and, "What do clinical supervisors need to know and do to teach those concepts?" Questions of these types, and the eventual answers, led to investigations of educational pedagogy and the realization that teaching actually becomes a matter of the teaching–learning process, whereby the teacher is both teacher and learner. Oddly, the SLP student is placed in that same process of teacher–learner when he/she learns how to do therapy, with its inherent requirements of teaching, facilitating, or guiding the client toward communicative competence. The power of pedagogy in education is the focus it brings to the direction and purpose of education in the realms of planning, executing, and evaluating every teaching–learning aspect of the specific educational program for which the pedagogy applies. Adherence to such a pedagogy not only brings focus to educational practices, but also enhances clarity, and perhaps even purpose, for the day-to-day applications of specific practices within an educational setting or program.

Clinical supervisors and instructors responsible for the education of SLP students learning therapy are encouraged to explore pedagogies that undergird specific practices in teaching and learning that impact the content contained within this text. It is hoped that the content of this text is consistent with the professional beliefs and practices that clinical supervisors and instructors bring to the classroom when teaching clinical skills to SLP students. Furthermore, when possible, it is hoped that the management constructs outlined as suggestions for how to use this text might also help clinical supervisors and instructors explore underlying pedagogies related to teaching, learning, and best practices within our profession. The following pedagogical ideals undergird both the clinical teaching strategies and suggested management of the contents of this text: *cooperative learning, interactive nature of learning*, and *critical incidents in learning*. A brief overview of each of these constructs as used in this text follows.

Cooperative Learning

Johnson and Johnson (1989, 1999) defined ***cooperative learning*** as the instructional use of small groups so that students work together to maximize their own and each other's learning. Cooper (1994) similarly defined cooperative learning as a structured, systematic instructional strategy that incorporates small groups of students who work together under the direction their instructor to produce a common product. Although made popular in educational literature by Johnson and Johnson (1989), the concept of cooperative group learning was promoted in the SLP literature by Perry (1990) and Mowrer (1994). Perry (1990) reported exciting results when students were placed in cooperative learning groups.

Perry noted that "goals were achieved quicker, new friendships developed, and responsibility, rather than competition, became the norm" (p. 120). Mowrer (1994) noted that "cooperative learning activities encourage students to take responsibility for their own education because they are empowered to share in the planning and execution of educational activities that encourage learning through total involvement with their instructor and peers" (p. 82). Even though these researchers (Perry, 1990; Mowrer, 1994) make powerful appeals for the SLP profession to consider the use of cooperative learning in both clinical education and in daily services to students enrolled in speech therapy in schools, the concept of cooperative learning in speech-language intervention was introduced to the communication disorders profession as early as 1951 by SLP writers, researchers, and clinicians Ollie Backus and Jane Beasley. Backus and Beasley (1951) wrote:

> . . . as we have experimented with clinical practice, our theories about speech therapy have grown progressively broader in scope, more detailed in structure; such modifications in theory have resulted in certain marked differences in clinical practice.
>
> Such differences may be summarized as follows for purposes of this text:
>
> 1. Group instruction should form the core of learning.
> 2. Group membership should be nonsegregated in respect to kinds of speech symptoms.
> 3. The teaching situation should be structured to provide a corrective "emotional" experience.
> 4. The teaching experience should be structured in terms of those interpersonal relationships which involve conversational speech. (p. 5)

For purposes of this text, Backus and Beasley's (1951) underlying theoretical assumption related to group instruction in speech therapy learning equates to the tenets of cooperative learning as presented by Johnson and Johnson (1989, 1999), Terry (1990), and Mowrer (1994). Clinical supervisors and instructors are, therefore, encouraged to consider cooperative learning when teaching therapy skills to larger groups of student learners. Two concepts serve as foundations for cooperative learning as applied to teaching the 28 therapeutic-specific skills of speech-language therapy presented in Chapters 5 and 6 of this text: *cooperative groups* and *heterogeneity within groups*.

1. *Cooperative Groups*. The clinical supervisor or instructor is encouraged to develop cooperative working or learning groups for all teaching, demonstrating, and guiding tasks associated with teaching SLP students to do therapy. To the degree possible, students are assigned to *working groups*, a cooperative learning arrangement, whereby students study and learn therapeutic skills in small groups consisting of the same group members throughout the learning process. For example, students are assigned, or voluntarily form, *groups of four* early in the process of learning speech-language therapy skills; students remain in the same group for the duration of the learning process. Practice time for the groups is given in class and guided by the clinical supervisor or instructor, but other practice times outside of class are also required and expected. All group members are expected to participate in practice sessions both during and outside of class times.

2. *Heterogeneity Within Groups*. For purposes of teaching therapy within the confines of this text, group membership should be heterogeneous for type of speech problems represented within the make-up of the cooperative groups as suggested by Backus and Beasley (1951). Heterogeneous groups more accurately emulate a typical interactive learning setting in that typical societal settings for communication and speech-language learning are rarely homogeneous. For example, it is unlikely that everyone present in a social setting will have difficulty pronouncing the /s/ phoneme, or that a group of children converging for social interactions will all have difficulty with the /r/ sound. More commonly, groups of communicators are likely to be composed of speakers with typically developing speech-language skills as well as a few speakers who may have speech-language disorders of varying types. Of the few speakers with identified speech-language disorders, it is highly unlikely that everyone with a speech-language disorder will have the same speech-language disorder.

Based on prevalence indicators reported by the American Speech-Language-Hearing Association (ASHA) (n.d.), articulation and language disorders represent the largest categories of speech-language disorders for children during the developmental years. Within any given age range or typical classroom, it is likely that children within those age ranges and within those classrooms will present with articulation and language disorders consisting of varying characteristics of the disorders rather than consisting of homogeneous characteristics. Although a practicing professional SLP certainly has a choice of homogeneous or heterogeneous grouping for intervention, for purposes of teaching therapy based on this text, heterogeneous grouping is preferred. In this way, when clients serve as models, the likelihood of one client actually having skills strong enough to model for another is higher. In contrast, if all clients within the group present with the same sound or concept disorder, there is little opportunity for any client to serve as a peer model, thereby lessening the interactive learning parameters of group therapy.

Interactive Nature of Learning

A second pedagogical concept that undergirds the basic tenets for the structure of this text is the ***interactive nature of learning***, wherein learning occurs through the give and take transfer of information from one person to another (Lawrence & Butler, 2010). Several researchers studied the interactive nature of the learner in areas of initial and generalized language learning (Nelson, 2011; Paul, 2011). Nelson (2011) found that students acquiring a second language learned various aspects of the target language through conversations rather than through solely writing for expressions of the concepts. Use of conversational or social exchanges in therapy is fundamental for providing a setting for clients to acquire communication interaction through social interaction activities such as typical conversational exchanges. The features of language that lend themselves to interactive learning included semantics, phonology, morphology, syntax, and pragmatics of language (content, form, and use) as presented by Bloom and Lahey (1978). The

exchange noted to best promote learning of these language concepts involved one partner serving as listener while the other partner served as speaker, and vice versa. Typical daily conversational interactions serve as examples of social interaction activities and support Backus and Beasley's (1951) concept of providing therapy within interpersonal relationships, which involves conversational speech. Fox-Turnbull (2010) also discussed the positive role of conversation in a student's learning. Therefore, except for drill-based work sometimes desired to correct phoneme productions, the stimulus for basic language interactions is the sentence, or some portion thereof. The sentence stimulus is used in an attempt to both model and elicit basic conversational structures during therapy to the best degree possible. For purposes of teaching the basics of therapy, this text is founded on the concept of the interactive nature of learning, based on conversations whereby one member serves as group leader to facilitate teaching of skills (the student "SLP"), while other group members simultaneously serve as learners who also facilitate teaching of skills by serving as listeners, models, and evaluators (student "clients"), with each role carrying its respective responsibilities.

Interactive Roles and Responsibilities of Group Members

It is appropriate, here, to highlight information regarding beginning students' perceptions of classes that served as an important part of their education. Furr and Carroll (2003) found that,

> For students just beginning to learn to be counselors, the importance of the skill-based introductory counseling class is a dominant force in their education. Although the students' primary focus was on the development of basic counseling skills, students in this study repeatedly mentioned the importance of the experience of being both the counselor and the client in terms of dealing with the dynamics of the [therapeutic] relationship. Instructors . . . need to be alert to helping students process these interactions in addition to focusing on skill attainment. (p. 487)

For more than 20 years, the conceptualization and constructs whereby beginning SLP students have been introduced to and taught how to do speech-language therapy have been based on the elements of *cooperative learning* (Backus & Beasley, 1951; Johnson & Johnson, 1989, 1999), whereby students take responsibility for not only their own learning, but also for the learning of peers within the group. An effective way to achieve this shared responsibility for learning is found in the research on the *interactive* or *dynamic* nature of the therapeutic process presented by Furr and Carroll (2003).

To achieve the interactive aspects of group learning, groups of four members within each cooperative group are established, with each of the four members performing specific roles and responsibilities within the teaching and learning process. For example, at any given point, one group member serves as the "SLP," while the remaining three group members serve as "clients." As the SLP facilitates learning through direct intervention with one selected client (the "target client"), each of the other two clients are engaged in learning by serving in alternating positions as (a) peer models and (b) peer evaluators

for the target client. For example, when the student SLP is working with the target client, both remaining clients also are engaged in therapy by serving as peer models (with the SLP's lead) for target sounds or concepts being worked on by the target client. Then, as the target client produces the target structure, both remaining clients now serve as peer evaluators (with the SLP's lead) for the target client's productions. Note, however, that engagement of remaining clients as either peer models or peer evaluators is at the SLP's discretion. When the SLP completes the target client's responses and corrective work, engaging the remaining clients as peer models or evaluators, at discretion, the SLP then goes to the next target client within the group. The former target client now becomes a peer model and peer evaluator for the current target client. In this manner, the SLP works with all clients as the target client for direct intervention, and also works with all clients indirectly as each client, in turn, becomes a peer model and/or peer evaluator.

Group members, including the student SLP, rotate roles throughout the teaching–learning process so that at any given time, one group member serves as the student SLP while the other three group members serve as the clients within the group. Once the student SLP has practiced the assigned process or skill, roles within the group are changed and another member of the group becomes the student SLP; the original student SLP now serves as a client member of the group. The roles and responsibilities of group members constantly rotate and are detailed as follows:

- Student SLPs lead, guide, teach, demonstrate, model, elicit, coach, evaluate, and reward.
- Student clients respond, model, and evaluate.

The group member serving as student SLP is responsible for leading the group through the processes of therapy by guiding the group systematically through the *introduction, body*, and *closing* of the therapy session. In this way, the student SLP serves as facilitator of group learning for the concepts targeted in therapy. Student SLPs lead the session and guide client behavior by teaching, demonstrating, modeling, eliciting, coaching, evaluating, and rewarding client efforts. Student-facilitated skills were addressed by Savion (2009) and reported to be important elements in the teaching–learning process.

Each group member serving as a client is responsible for his or her own learning of the skills targeted for the session. However, the interactive nature of cooperative learning suggests that each client is also responsible for engaged and interactive learning in ways that support the learning of other clients in the group as well (Johnson & Johnson, 1999; Kent, 2006; Savion, 2009). Johnson and Johnson (1999) found that students learning newly introduced concepts often retained presented information better when sharing learned concepts with a peer. This peer sharing is accomplished in therapy when the target client is directed to tell or show another client a production of the target skills. For example, when the target client correctly produces the /k/ phoneme, the SLP might instruct the target client to "Show Max your /k/" or "Make the /k/ for Maggie." In general education, a number of facilitative and educational presentation formats, such as think-pair-share, a popular interactive or facilitative technique, and case-based teaching (basic

teaching pedagogy) incorporate the concept of peer-shared learning (Dennett & Azar, 2011; Kantar, 2013; Savion, 2009; Schommer, 1990, 1993; Williams, 2011).

When peer-shared learning is applied to the interactive nature of learning in speech-language therapy, the roles of the client members of the group are twofold, as mentioned earlier: (a) target clients serve as learners or responders and (b) remaining clients serve as peer models and peer evaluators. Client learners (i.e., target clients) respond to the student SLP as instructed, led, directed, or guided, based on identified needs for the client learner. However, at the same time, remaining clients also work along with the SLP to serve as peer models for other members in the group, based on the student SLP's lead. The same remaining clients also serve as evaluators of peer productions within the session, based on the student SLP's lead. Roles are rotated in this way until all group members have practiced his or her designated target skill(s) and have experienced the dynamics of the therapeutic relationship by serving as both a peer model and a peer evaluator—all within the contexts of basic conversations established by the SLP. In this way, the student SLP and all group members are constantly engaged in the teaching–learning processes of therapy to fulfill Johnson and Johnson's (1989) definition of cooperative learning: the instructional use of small groups so that students work together to maximize their own and each other's learning. More importantly, cooperative groups of four provide the experience of being both the SLP and the client within the therapeutic relationship as suggested by Furr and Carroll (2003).

Again, clinical supervisors and instructors are encouraged to establish cooperative learning groups early in the teaching–learning process when teaching large groups of students how to do therapy. Small groups are established as cooperative learning groups (Johnson & Johnson, 1999), with all learning based on interactions between and among group members who each serve different functions at given times within the learning process (Furr & Carroll, 2003) as discussed earlier in the chapter. Figure Intro–1 shows a rudimentary graphic of the interactive nature of the therapeutic process with roles and responsibilities of group members. Figure Intro–1 only depicts one instance of remaining clients as peer models and evaluators; however, there are typically at least two clients serving in the "remaining" peer model and evaluator roles at any given time. In fact, there could conceivably be up to three, or even four, clients serving in the remaining peer model and evaluator roles at a given time for therapy groups of four or five students, respectively.

■ **Textbox Intro–1.** Reminder to Form Cooperative Learning Groups for the Teaching–Learning Process

> Clinical supervisors and instructors are encouraged to establish cooperative learning groups early in the teaching–learning process when teaching large groups of students how to do therapy. Small groups are established as cooperative learning groups, with all learning based on interactions between and among group members who each serve different functions at given times within the learning process.

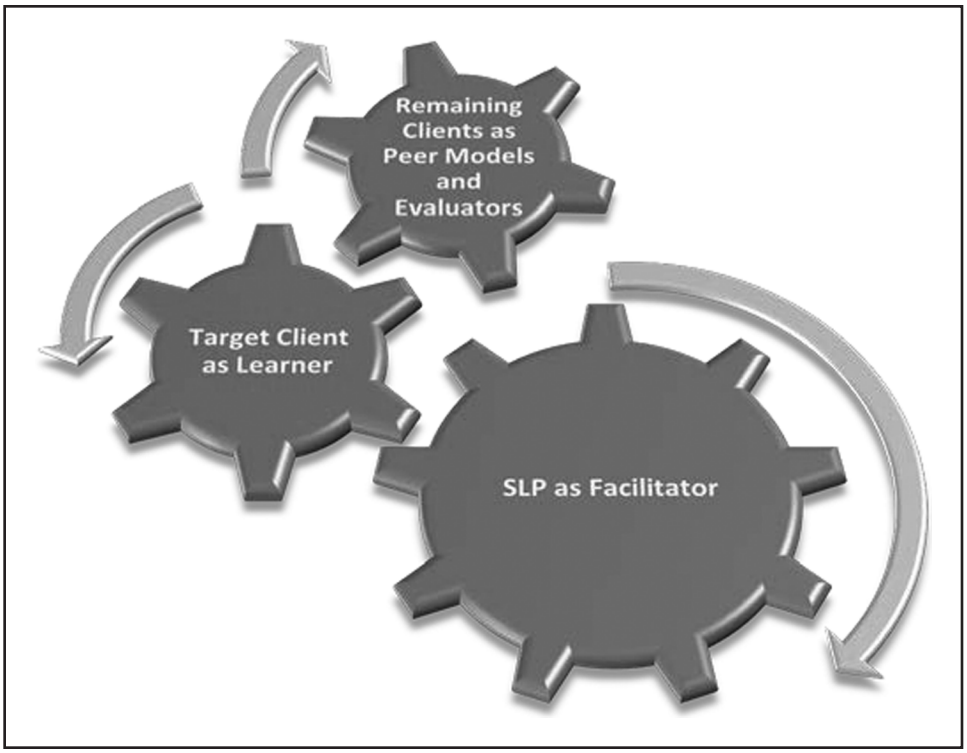

Figure Intro–1. Interactive nature of the therapeutic process.

Critical Incidents in Learning

The third, and final, pedagogical concept that undergirds the basic tenets for the structure of therapy presented in this text is the concept of *critical incidents in learning*. Furr and Carroll (2003) described ***critical incidents*** as positive or negative experiences recognized by students as significant because of the influence on the student's development in learning how to do therapy. These researchers believed that for counseling majors, in processes with multiple parts and learning that takes place over longer periods of time, there are critical incident activities along the way that significantly influence the learner's development of skills related to counseling. Similarly, close observations of developing SLP students suggested that these students also encountered experiences and activities that served as critical incident activities in the processes of learning to do basic speech-language therapy. Meyer and Land (2005) and Wilcox and Leger (2013) referred to these significant experiences in learning as "threshold" experiences in that these experiences serve to help define a student's "characteristic ways of thinking and practicing in a discipline" (Wilcox & Leger, 2013, p. 2). In the search to determine the experiences and activities that might qualify as threshold, or critical incident experiences for speech-language pathology students learning to do therapy, 18 different learning-focused activities were identified in the processes of teaching students how to do basic speech-language therapy. Although it was not clear exactly which experiences or activities served as critical incident experiences, it was clear that, while engaged in the process

designed to teach the basics of therapy, something significant happened in students' learning experiences that facilitated learning to do therapy. It is important for clinical supervisors and instructors to be aware of the 18 different learning-focused activities that were found to be present in the progression of teaching basic speech-language therapy skills. These 18 different learning-focused activities are presented in Figure Intro–2 under three major focused activity clusters.

Although there is overlap in occurrences of the 18 different learning-focused activities associated with learning basic speech-language therapy as presented in Figure Intro–2, the majority of the 18 identified learning-focused activities are shown as separate elements of either (a) the clinical supervisor- or instructor-focused activity cluster, (b) the textbook- or companion website-focused activity cluster, or (c) the interactive learning group-focused activity cluster. It is important for clinical supervisors and instructors to grasp these three separate focal points (i.e., supervisor-based, textbook/companion website-based, or interactive group-based) for presenting and managing the aspects of teaching the 28 identified therapeutic-specific skills of therapy presented in this text (Chapters 5 and 6). It is within the context of one or more of the 18 learning-focused activities shown in Figure Intro–2 that student SLPs actually learn to do the 28 therapeutic-specific skills of basic speech-language therapy. These 28 therapeutic-specific skills are referenced later in this chapter, but for the moment, the concept of using the 18 different learning-focused activities (see Figure Intro–2) to teach the 28 therapeutic-specific skills is captured in Table Intro–1 (matrix of focal points [supervisors, textbook, and interactive groups] and activities in which therapeutic-specific skills may be addressed).

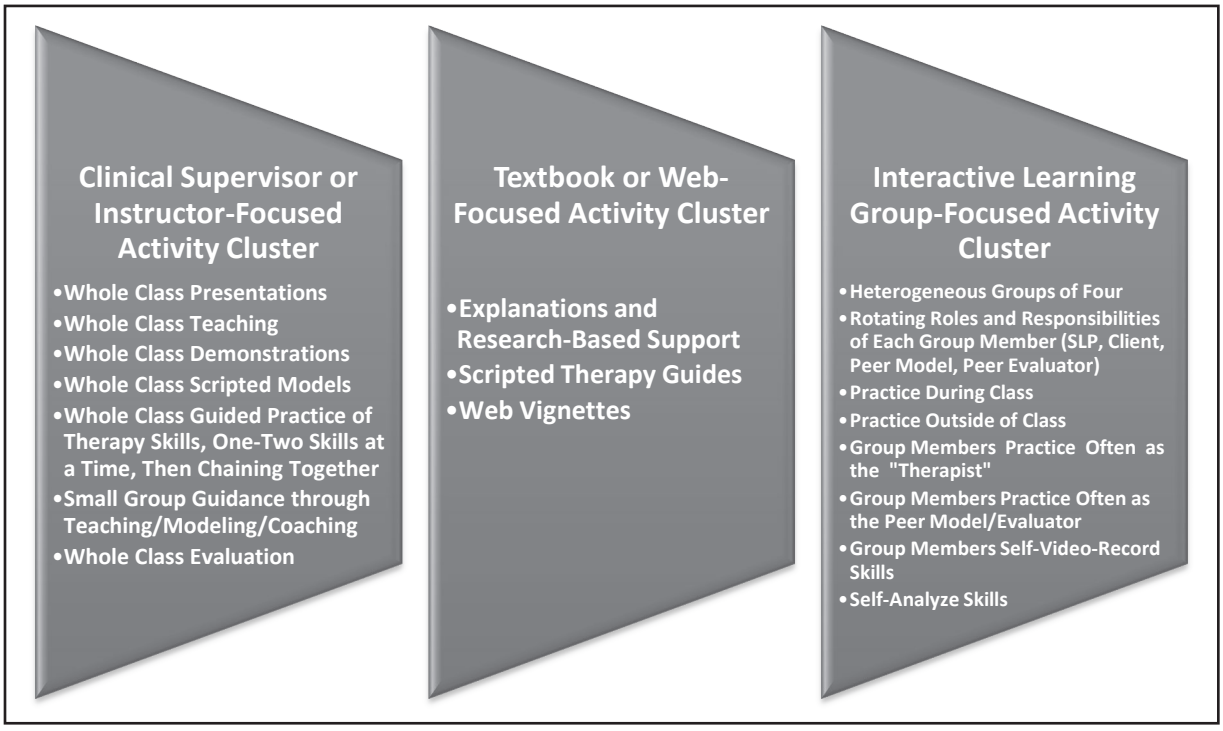

Figure Intro–2. Focused activity clusters for critical incidents learning.

Table Intro–1. Matrix of Focal Points (Supervisors, Textbook, and Interactive Groups) and Activities in Which Therapeutic-Specific Skills May Be Addressed.

Focal Points	18 Focused Activities	28 Therapeutic-Specific Skills																											
		Motivation	Expectations	Enthusiasm	Animation	Volume	Seating	Proximity	Touch	Preparation	Pacing	Fluency	Alerting	Cueing	Modeling	Prompting	Modalities	Demonstrate	Questions	Wait Time	Shaping	Verbal Praise	Tokens	Reinforcers	Feedback	Data Collect	Probing	Behavior	Troubleshoot
Supervisors	Presentation	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Teaching	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Demonstration	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Scripted Models			•	•	•						•	•	•	•	•			•	•	•	•			•		•		
	Guided Practice											•	•	•	•	•	•			•	•	•			•	•	•		
	Small Groups	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Evaluations	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Text	Supports	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Scripted Guides			•	•					•	•	•			•	•		•	•			•			•				
	Web Vignettes		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•	•	•	•	•			
Interactive Groups	Groups of Four	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Roles in Group	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	In-Class Practice	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Outside Practice	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Focus as Therapist	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Peer Tutor														•							•			•				
	Video Record	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
	Self-Analyze	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

For each of the 28 therapeutic-specific skills that needs to be taught (e.g., *animation, enthusiasm, volume, proximity*), student learning appears to be greater if that skill is aligned properly and taught or presented within the confines of one or more of the above learning-focused activity clusters (i.e., supervisor-based, textbook/companion website-based, or interactive group-based), then refined in an additional learning-focused activity cluster, and finally, specifically mastered in yet another learning-focused activity cluster, as applicable. For example, the therapeutic-specific skill for *proximity* in therapy is often first introduced to students through use of the clinical supervisor- or instructor-focused activity cluster whereby the clinical supervisor or instructor *presents*, or *teaches*, the concept of proximity in a lecture to the entire class (i.e., whole-class presentation), followed by having the entire class physically stand or rearrange seats to *demonstrate* appropriate proximity for the therapeutic setting (i.e., whole-class demonstration). This type of whole-class presentation or teaching, then, demonstrating, is first introduced as a clinical supervisor- or instructor-focused activity. However, to continue student learning in the area of proximity, the clinical supervisor or instructor either directs students to the textbook/companion website segment on proximity, or directs students to practice proximity within interactive learning group-focused activities. Regardless of choices for sequencing in this learning experience example, the clinical supervisor or instructor uses as many learning opportunities as possible to support student learning, and does so with full awareness that, most often, the student SLP's learning of targeted skills takes place in a variety of settings arranged for the student within and across (a) clinical supervisor- or instructor-focused activities, (b) textbook- or companion website-focused activities, or (c) interactive learning group-focused activities. It is believed that one or more of the 18 learning-focused activities will serve as critical incident activities for student SLPs as they work to develop the 28 therapeutic-specific skills across the three different focus activity clusters (i.e., supervisors or instructors, textbook/companion website, or interactive learning groups).

Critical Incidents in Learning to Do Speech-Language Therapy

It is not always possible to pinpoint the exact moment, nor the exact experience in learning to do therapy that can be identified as the "critical incident," the significant experience that influences an individual student's development in learning to do therapy as noted by Furr and Carroll (2003). However, during observations of student learning in the development of skills for speech-language therapy, student learning is evident. Additionally, student learning is significant and, more often than not, is accurate—or at the very least—is adequate for the initial development of skills in basic speech-language therapy.

In an attempt to localize or pinpoint those activities that students rated as critical incident activities for learning to do therapy as suggested by Furr and Carroll (2003), 60 students were given an informal survey and asked to rank each of the 18 learning-focused activities that appear in the three focused activity clusters listed in Figure Intro–2 according to perceived value of the activity in helping the student learn to do therapy.

Additionally, each student was asked to rank order the top three activities according to perceptions of whether the selected activity was (a) the most valuable, (b) the second most valuable, and (c) the third most valuable in learning to do therapy. Surprisingly, students indicated 15 of the 18 learning-focused activities as critical incident experiences. However, three experiences were rated as extremely valuable by student respondents. Fifty-six of the 60 surveys (93% return rate) were returned as usable for analysis. Results indicated twofold findings:

- Students rated the following activities as *valuable*, with combined results for *valuable* and *extremely valuable* also given for consideration for the power of activities in learning to do therapy:
  - *Small-group teaching, guiding, coaching, or modeling by the instructor during classroom time*: 90% of students rated this activity as extremely valuable, with the percentage increasing to 98% for the combined valuable and extremely valuable ratings.
  - *Instructor's classroom demonstrations of therapy*: 85% of students rated this activity as extremely valuable, with the percentage increasing to 100% for the combined valuable and extremely valuable ratings.
  - *Verbal/scripted model by the instructor of what the therapist should say for the introduction, body, and closing of a therapy session*: 86% of students rated this activity as extremely valuable, with the percentage increasing to 100% for the combined valuable and extremely valuable ratings.
- Students ranked the following three learning-focused activities, in order given, as the activities that qualified as the *top three* critical incident experiences in learning to do speech-language therapy:
  - *Instructor's classroom demonstrations of therapy*
  - *Small-group teaching, guiding, coaching, or modeling by the instructor during classroom time*
  - *Verbal/scripted model by the instructor of what the therapist should say for the introduction, body, and closing of a therapy session*

Although not generalizable to a typical population of student SLPs due to the small sample size and informal nature of the survey, clinical supervisors and instructors are, nonetheless, encouraged to note the activities designated as either (a) clinical supervisor- or instructor-focused activities, (b) textbook- or companion website-focused activities, or (c) interactive learning group-focused activities, and are encouraged to arrange classroom learning experiences in ways that provide students with opportunities to engage in each of the 18 focused activities presented in Figure Intro–2. Much of the remainder of this chapter will focus on presentation of information designed to help clinical supervisors or instructors, and SLP students, benefit from engagement in these 18 learning-focused activities.

Based on years of clinical teaching experience in working with students using all three types of focused activities (clinical supervisor or instructor, textbook/companion website,

or interactive learning group), it is believed that, although difficult to pinpoint or project for any given student, the combined experiences of these 18 learning-focused activities help each successful student achieve the critical incidents needed for maximal learning. Let's briefly overview the tenets of each activity in which the student learner will engage to relate the 18 focused activities to the 28 therapeutic-specific skills needed to learn how to do speech-language therapy, as shown in Table Intro–1.

Overview of Focused Activities

Focused activities refer to clusters of activities that are centered around three different focal points that serve as foundations for the tasks that students will be learning. For purposes of this text, the three different focal points that anchor the student's learning tasks are (a) the clinical supervisor or instructor, (b) the textbook/companion website videos, and (c) the interactive learning groups composed of the student learners themselves. (See Figure Intro–2.) Each focused activity cluster features tasks important to learning to do therapy. Note that some activities occur in more than one focused cluster; this is by design, based on the nature of what—and how—the student is being asked to learn. There are some tasks that simply must be addressed from several perspectives to support best learning. Following is a brief overview of the three focused activity clusters with accompanying details of the type of activities contained within each cluster.

Clinical Supervisor- or Instructor-Focused Activity Cluster

Although not necessarily an exhaustive list, for purposes of this discussion, the clinical supervisor- or instructor-focused activity cluster is composed of seven different activities that clinical supervisors or instructors provide for student SLPs learning to do therapy. These seven activities are shown in the clinical supervisor- or instructor-focused activity cluster in Figure Intro–2 and consist of the following tasks conducted by clinical supervisors or instructors as basic activities designed to help the student SLP learn how to do therapy: (a) *whole-class presentations*; (b) *whole-class teaching*; (c) *whole-class demonstrations*; (d) *whole-class scripted models*; (e) *whole-class guided practice of therapy skills, one to two skills at a time, then chaining together*; (f) *small-group guided practice through teaching/modeling/coaching*; and (g) *whole-class evaluation*. Explanations and possible implementation suggestions for each of these seven activities may prove helpful to clinical supervisors and instructors.

Whole-Class Presentations

Whole-class presentations are defined as more formal lectures or presentations that clinical supervisors or instructors engage in when introducing a new skill or concept. The term

presentation, for practical purposes, may be sometimes used synonymously with the word *teaching*; however, for purposes of this discussion, presentation as a concept is suggested as being separate from teaching as a concept based on the formality associated with presentations. Typically, presentations are formal orations characterized by sequenced information designed to introduce, explain, or help the listener conceptualize information within a lecture or speech-type format. There is often very little intent for audience interaction with the speaker during a presentation. For example, a presentation on the concept of *therapeutic proximity* might call for prepared information related to the various elements of personal, communicative, and public spaces. A formal presentation on this topic that includes handouts or other media supports for the presenter is appropriate. Often whole-class presentations equate to an overview of general concepts to be learned in more detail following the presentation.

Suggested Uses of Whole-Class Presentations: Clinical supervisors or instructors may choose to use presentations in lecture formats to introduce new therapy concepts and skills in an overview, or to move quickly from point to point in presenting work that has several sequential parts.

Whole-Class Teaching

Whole-class teaching is much less formal than a presentation. In whole-class teaching, the clinical supervisor or instructor's objective is to ensure students begin learning the information presented in overview or presentation format. Teaching takes place in several stages with there being any number of teaching methodologies available to clinical supervisors or instructors. For example, when teaching, a lesson might be divided as follows:

1. *Introduction, attention, or motivation*, whereby the intent is to pique the learner's interest in the lesson and help the learner focus on the selected topic. Goals and objectives of the lesson, interesting background, relevant concepts and questions, interesting uses of materials (even costumes) that help the learner focus on the topic are appropriate for this teaching phase.
2. *Direct teaching* includes uses of lectures, definitions, salient points, demonstrations, media presentations, models, and so forth to help the learner conceptualize the foundations of the topic and connect the content to other areas of knowledge.
3. *Guided practice* may occur in two forms: (a) *whole-class guided practice* is recommended when a concept is being presented for the first time. The clinical supervisor or instructor literally guides the entire class through practice of the concept or technique, step by step, so that everyone in the class participates as responders in unison for the first few times of practice, based on modeling/imitation, scripts, and so forth, and (b) *small-group guided practice*, wherein, following apparent increased comfort with the new concept or skill as a whole-class event, the class is divided into the interactive or collaborative work

groups. During small-group guided practice, the clinical supervisor or instructor goes from group to group, listening, guiding, and providing feedback to the groups as needed.

4. *Independent practice* is encouraged *only after the clinical supervisor or instructor determines that the group members are practicing correctly enough to be allowed to practice outside of the watchful eye of the supervisor or instructor*. This is important in that, as we will see later, if groups are allowed to practice independently *but incorrectly*, it becomes more difficult to achieve the desired outcomes in learning.

There are, of course, numerous other approaches to teaching and learning (Brackenbury, 2012; Çakmak, 2008; Selahattin & I˙lknur, 2010; Tetsuo, 2011; Vajoczki, Savage, Martin, Borin, & Kustra, 2011; Wright, 2011), and each clinical supervisor or instructor may already have a preferred method or approach to teaching that may easily be continued under the structure of whole-class teaching. For purposes of this discussion, whole-class teaching is described as any activity designed to engage the entire class and help students move to progressively higher levels of awareness, understanding, and skill building for a targeted subject or skill. In this sense, explanations, graphic representations, explorations, conversations, facilitation techniques, corrective feedback, and so forth might all qualify as teaching. The point here is not to lock in a clinical supervisor or instructor into a set of behaviors called "teaching," but rather to help the clinical educator understand that teaching is about sharing knowledge and helping learners (i.e., SLP student learners) navigate the processes of learning designated skills associated with speech-language therapy. Each clinical supervisor or instructor is encouraged to seek his or her own comfort level with techniques used for teaching the designated skills for speech-language therapy identified in this text.

Suggested Uses of Whole-Class Teaching: Once the clinical supervisor or instructor completes any desired presentations of topics or skills, the concept of teaching begins. In fact, it is very possible to skip formal presentations for some topics, if desired, and begin student engagement with a topic in whole-class teaching through uses of techniques previously mentioned: explanations, graphic representations, explorations, conversations, facilitation techniques, corrective feedback, and so forth. The basic construct to focus on is that, regardless of the topic, whole-class teaching is essentially just that—teaching that is done with the whole class. For example, in working with the concept of therapeutic proximity, a presentation on the topic may include handouts or other supports, as mentioned earlier. However, in whole-class teaching, the same concept may be addressed in a completely different manner. Although the clinical supervisor or instructor may, in fact, use handouts or other supports in teaching as well as in presentations, the difference in presentation and teaching becomes a matter of student engagement. Presentations are seen as passive (i.e., receptive) student engagement, whereas teaching is viewed as more interactive (or give and take) student engagement. In teaching the concept of proximity, the clinical supervisor or instructor may find conversation regarding proximity to be appropriate by leading the whole class in a discussion of the topic in the following manner:

> For example, the instructor may say, "Let's talk about your own needs for proximity and personal space for a moment. Think about a time when you felt that your personal space was a little too small for your preferences for space—for example, at a dinner party where someone may have placed an item in a space that you privately reserved for yourself. What kind of thoughts or reactions do you remember having about the situation? Think for a moment, then, let's have volunteers share experiences."

This type of whole-class teaching does not accomplish the complete goal of teaching the concept of proximity, but it does lead the entire class toward the direction of greater awareness and understanding of the concept of therapeutic proximity—and it's far less formal than what is typically seen as a presentation. Clinical supervisors or instructors may choose to use numerous other teaching strategies (e.g., explanations, graphic representations, explorations, facilitation techniques, corrective feedback), as desired, to help students further conceptualize or understand new skills for learning how to do therapy.

Whole-Class Demonstrations

Whole-class demonstrations are appropriate when the clinical supervisor or instructor wishes to be sure that everyone in the class is exposed to the same demonstrations, examples, explanations, or applications of information that support a concept being taught. For example, to continue the work on proximity, once the clinical supervisor or instructor makes a brief presentation on the subject, then teaches the subject through use of conversation or exploration, the next task in student learning might be a whole-class demonstration whereby the clinical supervisor or instructor asks one student to demonstrate effective therapeutic proximity and how to achieve proximity in various therapeutic seating positions (e.g., side-by-side seating, across-the-table seating, cluster seating). In this way, everyone in the class sees the same demonstrations at the same time so that numerous repetitions of demonstrations are not necessary in smaller-group work.

Suggested Uses of Whole-Class Demonstrations: The majority of the 28 therapeutic-specific skills highlighted in Chapters 5 and 6 of this text can be demonstrated in whole-class format, if desired. Each clinical supervisor or instructor will have his or her preferred styles and concepts of what constitutes appropriate skill levels for each therapeutic-specific skill. Whether demonstrating proximity, animation, enthusiasm, volume, or uses of therapeutic touch, each clinical supervisor or instructor brings a wealth of possibilities to the whole-class demonstration. Because each clinical supervisor or instructor will have specific ways of presenting, teaching, and demonstrating skills based on personal preferences, demonstration possibilities are boundless.

Whole-Class Scripted Models

A whole-class scripted model is simply an activity whereby the clinical supervisor or instructor literally reads a script, either a segment from this text (Chapter 6, Chart 6–2.

Detailed Therapy Progression) or from other sources, that gives students an idea of what they should sound like during therapeutic intervention. In fact, clinical educators may very well write their own script to fit specific teaching–learning needs. Regardless of the source of the script, clinical supervisors or instructors choose a skill set that students need to learn and guide the students through what that skill set sounds like in therapy by verbally modeling the skill set and having the whole class repeat the modeled segments in unison. For example, if the chosen skill set for the session is a combined animation and enthusiasm segment, the clinical supervisor or instructor reads or models a line at a time from a selected or written text (i.e., a script), and the entire class imitates or repeats the model as given—not only as given in its content, but also in its style for intonation, enthusiasm, pace, and so forth. Many students (and clinical supervisors or instructors) report feeling completely awkward in this activity. There is always a lot of laughter, sometimes a little embarrassment, and occasionally a little resistance associated with this activity at its initial introduction. However, random comments over the years, and results of the informal survey of the 18 focused activities (mentioned earlier), suggest that scripted models are among the top three critical incident experiences that help SLP students significantly in learning to do speech-language therapy. Based on the findings of several researchers (Bisland, Malow-Iroff, & O'Connor, 2006; Kollar, Fischer, & Hesse, 2006) regarding the value of scripted information for the novice learner, the power of scripted models for the student SLP is understandable.

Scripted therapy guides may be as short as one word, as in words used for verbal praise (e.g., "Awesome!"; "Wonderful!"; "Excellent!"), or they may be as long as a sentence or short paragraph, depending on the skill being taught. Scripted therapy guides, of course, are never all-inclusive, but they are typically generalizable to the therapeutic process. In fact, scripted models don't actually have to be written in that most clinical supervisors or instructors have a ready repertoire of scripts (i.e., what needs to be said or done) in their working vocabularies. For example, in a scripted therapy guide for verbal praise, the student SLP might be taught to use the phrase, "Wonderful!" in response to the client's appropriate participation in his or her turn in therapy. Verbal praise is a desirable and acceptable therapeutic skill; however, many student SLPs forget to offer verbal praise of the client's efforts during therapy, so the clinical supervisor or instructor finds it necessary to very naturally interject the unwritten script for verbal praise by modeling the praise for the student SLP: "Wonderful!" Student SLPs often simply imitate the verbal praise offered by the clinical supervisor or instructor in early learning stages of therapy, but before long, student SLPs can be observed generalizing verbal praise to include other phrases such as "Good job!" or "Way to go!" Typically, once student SLPs understand that something should be said at a certain time in therapy, for certain reasons, and in certain ways, these students first learn the given script, then move quickly to add their own personal preferences to the situation in a generalized fashion—as it should be.

The intent of a script is *not* to produce hundreds of SLPs who all sound alike or are cloned to act the same, do the same, and be the same in therapy—even though it may appear to be so in initial stages of working from a script to learn how to do therapy. Instead, the intent of the scripted therapy guides is to help with initial processing, conceptualizing, absorbing,

understanding, learning, and applying skills needed for effective speech-language therapy; in this regard, the script is simply a vehicle by which student SLPs come to understand that SLP professionals use certain processes in helping to change client behavior in communication skills. Similarly, there are processes that the student SLP must master in learning to guide the client to positive changes in communication behavior. The strength of a scripted therapy guide is that it supports the learning processes for students seeking to acquire therapy skills in simple, easy-to-grasp formats as novice learners.

Haring, Lovitt, Eaton, and Hansen (1978) presented four stages of learning that are relevant to this discussion: *acquisition, fluency, generalization*, and *adaptation*. A novice student operating at the *acquisition*, or beginning stage of learning, experiences learning that is slow and inaccurate. Haring et al. suggested the use of demonstrations and modeling (as in scripted therapy guides) for such learners. The use of scripts in early learning stages was promoted by several other researchers as well (Bisland et al., 2006; Kollar et al., 2006; Paul, 2011; Smilkstein, 1993; Youmans, Youmans, & Hancock, 2011). As the student reaches the *fluency* stage in learning, skills start to become accurate. It is important, to the best degree possible, for the learner to begin thinking about not only accuracy of skills, but also speed of performances of the new skill after accomplishing fluency for new skills. Of course, for fluency of skills, first comes accuracy in the skill, then the speed of presentation or performance of skills is added. The student in *generalization* of skills is accurate with the skill, has developed skills that show increased speed with accuracy, and is learning when to appropriately apply the new skill. Through continued practice and trial and error, the new skill becomes more accurately applied. The student in the *adaptation* stage of learning begins retaining skills over a time period, with learners showing increased accuracy in appropriately using the new skill in different settings and stimuli. As adaptation expands for the student, he/she is able to use the new skill in novel ways to solve problems across different therapeutic situations (Haring et al., 1978). The belief is that, as students move from the acquisition stage of learning, with the need for models and scripted therapy guides, into fluency, generalization, and finally to adaptation, students with solid beginnings in acquisition find it easier to move through the stages of learning to become the adapted problem solvers that we so desire in the SLP profession. Scripted therapy guides are the beginning foundations for learning to do therapy; scripted therapy guides are *not* the desired eventual outcomes.

Suggested Uses of Whole-Class Scripted Models: Whole-class scripted models are very useful for helping students find their therapeutic voice, or the pitch, animation, enthusiasm levels, and intonations students should use based on ages of clients. For example, the following greeting typically sounds completely different depending on the age (and often the disorder) of the client: "Hi. It's so good to see you today." Whole-class scripted models for this greeting are often given as if the client were two different ages to show contrasts in pitch, enthusiasm, animation, and intonation: a 3-year-old and a 40-year-old, both cognitively normal. With the clinical supervisor or instructor using a simple script to model various segments of a therapy session, such as a greeting, students are able to capture the essence of several therapeutic-specific skills very quickly.

Clinical supervisors or instructors may choose to use scripts at any given stage of learning, depending on circumstances. Due to the vast amount of skills student SLPs need to learn, maintain, generalize, and adapt, it is not always easy for the student SLP to learn skills in a linear fashion, nor is it always possible for clinical supervisors or instructors to assess skills in a linear fashion. For example, although any given skill may proceed linearly from point A to B to C in a uniform and desired manner, the student SLP may, at the same time, also be learning another skill that is not progressing as smoothly. Thus, a student SLP may be performing as an adapted learner in the first skill but may still be in the acquisition stages of the second or even third skill. In this instance, the clinical supervisor or instructor may find it necessary to interject a script or model for the second or third skill, even though the student SLP is an adapted learner for the first skill. To this end, while clinical supervisors or instructors are encouraged to monitor student progress for learning any given skill, (a) it is not always necessary to insist on linear progress in learning each skill before moving to or introducing an additional skill, and (b) it is not necessary to establish a strict 1:1 relationship between the stages of learning or skill acquisition and the student SLP's need for scripted therapy guides or models. Instead, clinical supervisors or instructors should be prepared to offer scripted therapy guides or models for the development of any given therapy skill regardless of where a student might be in the stages of learning other skills. This will become especially evident when working with students in small interactive groups.

Whole-Class Guided Practice of Therapy Skills, One to Two Skills at a Time, Then Chaining Together

Several researchers (Bisland et al., 2006; Haring et al., 1978) suggested that guided practice is a common teaching strategy. During guided practice, the teacher uses step-by-step instructions, demonstrations, or models to lead students through a sequence of learning events that comprise part-to-whole or whole-part-whole learning (Backus & Beasley, 1951). For example, in this text, the introduction section of therapy is composed of three different elements: *greeting and rapport, previous session's work*, and *collection of homework*. The closing segment of therapy in this text consists of four different elements: *review of the objectives of the session, report of correct productions, mentioning/assigning homework*, and *rewards and dismissal*.

The clinical supervisor or instructor may find it advantageous to guide the whole class through the greeting and rapport segment of the introduction and, once proficiency is achieved by the whole class, add on the next segment of the introduction, then the last segment, systematically adding on or chaining skills in a whole-class guided practice event until the entire section of therapy is more comfortable for student learners. Similarly, when guiding students through the closing of the session, clinical supervisors or instructors may choose to guide the whole class through the first element of the closing, then the second, third, and finally fourth until the whole class achieves proficiency and feels (and sounds) more comfortable with the way a typical speech-language therapy session may be closed. This sequential way of managing the verbal behaviors that accompany learning is often

referred to as *chaining behaviors*. Chaining in learning was reported by Hulit, Howard, and Fahey (2011) to be an effective way to help students acquire and maintain larger volumes of information such as the large amounts of information SLP students are required to learn and retain when learning how to do basic speech-language therapy.

Suggested Uses of Whole-Class Guided Practice of Therapy Skills, One to Two Skills at a Time, Then Chaining Together: The sequences the SLP student needs to learn for both the introduction and closing of a therapy session serve as good segments for initial uses of whole-class guided practice in that these segments are seen as less threatening and more fun for the novice learner. As clinical supervisors and instructors essentially use step-by-step instructions, demonstrations, or models of what various elements of therapy might look or sound like, it becomes easier for SLP students to begin to form a foundation for learning large amounts of materials quickly, one to two skills at a time. Once information is learned in small chunks, or as segmented skills, then chained together within larger whole-class guided practices, students quickly become comfortable with practicing skills individually, or in smaller groups. Eventually, even the more demanding sequences of the body of therapy become more easily learned and absorbed when the elements of the body of therapy are taught in whole-class guided practice of therapy skills, one to two skills at a time, then chained together.

Small-Group Guided Practice Through Teaching, Modeling, and Coaching

Small-group guided practice through teaching, modeling, or coaching is accomplished by dividing classes into groups of four student SLP learners, as mentioned earlier in this chapter. Early in the training cycle (e.g., semester, quarter, year) the clinical supervisor or instructor allows students within the class to form cooperative groups of four that will become the interactive learning groups through which small-group learning and interactions occur for the remainder of the training cycle. Note that the interactive learning group has its own place in student learning for a large portion of the 18 learning-focused activities as a stand-alone focused cluster. However, in this portion of the discussion, the central focus is on the clinical supervisor or instructor's work with the interactive learning group. Although occasionally there will be a learning group of three or five members, based on the number of class members, groups of four are recommended for the basic interactive learning group for the following reasons:

- Forming groups of four allows student learners to better understand the interactive nature of the therapeutic process. Four members of a group allow students to more easily study all possible roles encountered in group therapy: (a) therapist, (b) target client, (c) peer model, and (d) peer evaluator.
- With one group member serving as the SLP, of the three members serving as clients for various learning experiences, one client is always the target client, the one who is being taught specific objectives of the session, while the remaining

two clients serve as peer models and peer evaluators to support the target client's learning. In this way, all clients are always engaged in the therapy learning process, either as client learner, peer model, or peer evaluator. No client is idle, as the interactive nature of the therapy session requires each client to attend and focus such that when called upon, he/she is ready to model correct structures, following the SLP's lead, or is ready to evaluate the productions of the peer client upon the SLP's request.

In situations when it is necessary to form alternate groups of three or five (rather than groups of four student SLP learners), it is preferable to form groups of five so that students more easily see the interactive nature of what therapy looks and sounds like when there are at least two peer models or evaluators, as would occur in groups of four (and possibly three peer models or evaluators, as would occur in groups of five), rather than only one peer model or evaluator, as would occur in groups of three.

During small-group guided practice through teaching, modeling, or coaching, each member of the small interactive group of four is assigned a group member number: 1, 2, 3, or 4. Following whole-group work on any given topic or skill, the clinical supervisor or instructor directs groups to gather and assigns the task that group members will practice within the session. For ease in classroom management, typically all groups within the class are assigned to work on the same clinical skills (for example, *closing of the session*), with a designated group member (by number) asked to begin the work of the session. A typical directive from the clinical supervisor or instructor to accompany this example might sound like this:

"Everyone, please get into your interactive work groups of four. Group members #3, you will serve as the SLP for the beginning of the class today. Please arrange the appropriate seating for your clients and begin the small-group practice session today by practicing the closing of the session. Everyone, once members #3 have practiced and feel comfortable with the close of the session, group members #4 will become the SLP for the session. Members #4, please begin your practice time for the close of the session once members #3 have finished practice times. I will come around to all groups to observe members #3 for the close of the session, and I may be able to see some members #4 for the close of the session today as well. For all group members #4 not observed today, I will begin our next class session by observing your work. Group members #3, begin your practice and I'll come around for observations, teaching, modeling, coaching, and corrective feedback as quickly as possible. If there are no questions, members #3, please begin your practice for the closing of the session."

The clinical supervisor or instructor in the above scenario waits a few minutes for designated group members to practice the assigned skill(s) or sequence(s), then begins systematically moving among the various small groups of four within the classroom. The clinical supervisor or instructor listens, observes, teaches/reiterates, models, coaches, and demonstrates as needed for not only the learning and development of the designated SLP, but also for the benefit of every member in that particular small group. In this way, learning becomes more interactive in that all group members help each other learn the

assigned skills. They all see and hear the same model, get the same coaching, and get answers to the same question(s) at the same time and in the same way. In helping each other understand the work of the clinical supervisor or instructor in small groups, each group member literally becomes the teacher of others in the group, depending on what each hears, understands, applies, and shares with others within the small interactive group format. For example, as the clinical supervisor or instructor leaves a particular small group to observe another small group, it is not uncommon to hear a member of the former group say to peer members something similar to the following: "No, no, she said we need to change . . ." At that moment of explanation or reiteration, that student learner literally becomes the teacher of his or her peers.

Suggested Uses of Small-Group Guided Practice Through Teaching, Modeling, and Coaching: Once the clinical supervisor or instructor has presented and taught information and has used whole-class demonstrations, whole-class scripted models, and whole-class guided practice, small-group guided practice through uses of teaching, modeling, and coaching (and other teaching/learning strategies) will become the foundational activity through which the student SLP learns most of the skills of how to do basic speech-language therapy. Whether learning data collection, therapeutic touch, or corrective feedback, it is possible to learn all of the identified 28 therapeutic-specific skills for basic speech-language therapy within the confines of the small-group guided practice opportunities.

Each clinical supervisor or instructor will determine the best ways to keep track of individual student SLPs' progress and development during work within small-group guided practice sessions. Some clinical supervisors or instructors choose more formal ways of recording or grading student progress in developing skills within the small-group guided practice sessions, whereas others simply make mental notes or jot down information that serves as indicators for the next skills that need to be addressed within the small-group guided practice session. Regardless of how formal or informal the evaluation of a student SLP's development might be in the small-group guided practice sessions, the major objective for the clinical supervisor or instructor during this type of group work (other than student learning, of course) is to determine the degree to which students are achieving proficiency in demonstrating desired therapeutic skills for appropriate decision making regarding moving the small groups on to the next desired skill set. Although students often report feelings of nervousness when clinical supervisors or instructors come to work with them in small groups, these same students continue to report interactive small-group learning to be a very powerful and sometimes fun way for student SLPs to learn the basic concepts of speech-language therapy.

Whole-Class Evaluation

The final clinical supervisor- or instructor-focused activity is whole-class evaluation. Each clinical supervisor or instructor will determine the values and appropriateness of whole-class evaluations, depending on the nature and structure of the learning setting for

the student SLP and based on many other teaching and learning parameters. Based on teaching and learning trends in prior classes in which students learned to do therapy as addressed in this text, it was found that at least one lightly weighted whole-class evaluation covering the components of basic therapy (components of the introduction, body, and closing) may help student SLPs focus, conceptualize, integrate, and apply basic learning. However, each clinical supervisor or instructor will have his or her preferred practices in both formal and informal evaluation of students' knowledge and development related to the acquisition of basic skills for speech-language therapy.

Suggested Uses of Whole-Class Evaluation: Whole-class evaluation of student SLPs' skills may cover as few or as many aspects of student learning as desired. Each clinical supervisor or instructor will determine evaluation needs and formats based on individual preferences and teaching circumstances.

It is important to note that, although each of the above seven clinical supervisor- or instructor-focused activities are available and recommended, not all seven activities are needed for every skill that is to be taught in the processes of learning to do therapy. Similarly, not all seven activities will be needed during each class session when student SLPs are learning to do therapy. To these ends, the successes of students learning how to do therapy are still ultimately dependent on the guidance and preferences of individual clinical supervisors and instructors. It is, however, hoped that the above explanations of the roles of the above seven focused activities in supporting desired outcomes is helpful. Figure Intro–3 shows a graphic depiction of how a clinical supervisor or instructor might construct a typical class session using these seven activities for teaching speech-language therapy on a routine basis.

As clinical supervisors and instructors plan classroom experiences for student SLPs, the information in Figure Intro–3 may be helpful for designing classroom experiences for daily practical application. However, as indicated earlier, not all possible activities will be needed for each class session. Each clinical supervisor or instructor will determine specific class content and objectives based on class needs.

Textbook- or Companion Website-Focused Activity Cluster

When teaching student SLPs to do therapy, for purposes of this discussion, the textbook- or companion website-focused activity cluster is composed of three different activities centered around this textbook and/or its accompanying companion website. These three activities are shown in Figure Intro–2 (p. xxv) as the textbook- or companion website-focused activity cluster, and consist of the following tasks that are supported by the textbook or companion website as basic activities designed to help the student SLP learn how to do therapy: (a) *explanations and research-based support*; (b) *scripted therapy guides*; and (c) *web vignettes*.

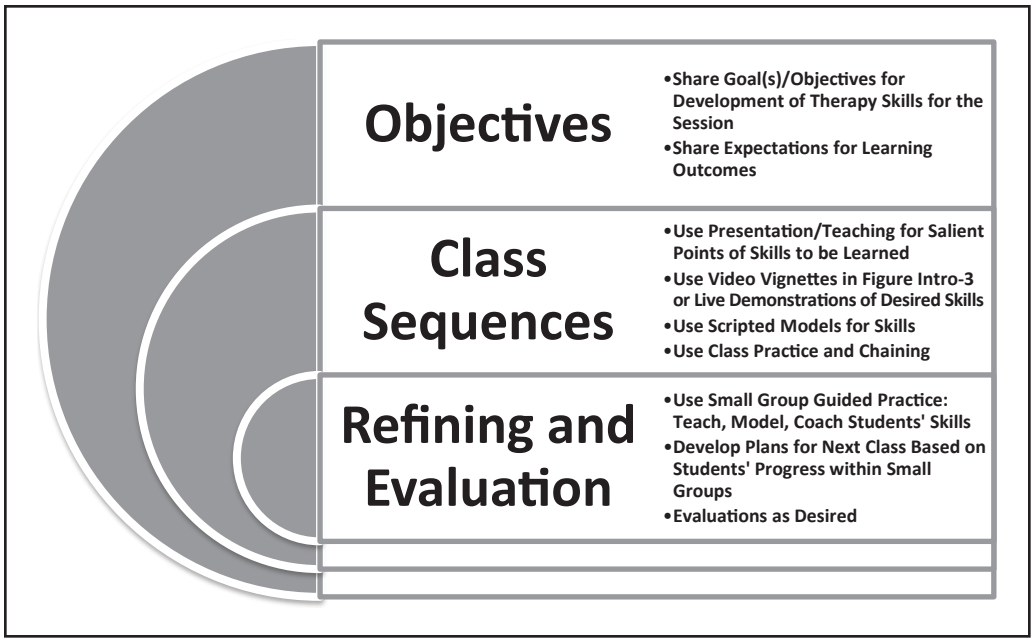

Figure Intro–3. Supervisor's routine tasks for therapy skills development.

Explanations and Research-Based Support

This third edition of the textbook is designed to assist clinical supervisors or instructors and student SLP learners by providing explanations and an organizational schema around which central themes of the textbook are founded. For example, the textbook continues to promote student learning of 28 therapeutic-specific skills associated with speech-language therapy, and the textbook continues to provide explanations and research-based support for engaging in learning and teaching of these therapeutic-specific skills. Additionally, the expansion of information in this new preface to the textbook is designed to add structure to help organize teaching and learning of the 28 therapeutic-specific skills. This is accomplished by offering 18 different learning-focused activities (see Figure Intro–2) in which the 28 therapeutic-specific skills presented in the text may be learned. (See Table Intro–1 for a complete indication of the 18 learning-focused activities suggested for use in teaching the 28 therapeutic-specific skills.)

Suggested Uses of Explanations and Research-Based Support: Skills for learning to do speech-language therapy are found in many sources: observations, conversations, direct teaching, specific training, and even creative trial and error. Typically, no one source can be attributed to addressing the breadth and depth of skills an SLP ultimately commands over the span of a professional career. This textbook is designed to be an integral part of the SLP's early training when it is important to get a student SLP from zero/very little to something credible in a short period of time. The intent of the text is to present a number of different aspects of therapy designed to help student SLPs process, conceptualize, absorb, understand, learn, and apply skills needed for basic speech-language therapy. Without elaboration on

technical or semantic differences in terms (i.e., process, conceptualize, absorb, understand, learn), it is hoped that this textbook, at the very least, contributes to the desired outcomes for teaching student SLPs how to do speech-language therapy. To that end, the clinical supervisor or instructor is encouraged to use the text in any ways credible for achieving targeted outcomes.

Scripted Therapy Guides

Scripted therapy guides are essentially written samples or examples of what the student SLP says in a therapeutic situation. Scripted therapy guides are included occasionally throughout Part I of the textbook, but they are a dominant portion of Part II of the textbook. These scripts give student SLPs parameters for what they actually say or do during the therapeutic exchange. Although scripted guides are included in the text, as indicated earlier in this chapter, clinical supervisors or instructors may also choose to write their own scripts for specific teaching and guided practice purposes. As indicated earlier, some scripted content is already a part of the clinical supervisor or instructor's repertoire and need not be actually written. Still, however, these inherent scripts need to be modeled for the student.

Suggested Uses of Scripted Therapy Guides: As indicated earlier, scripted therapy guides likely have the most power when used in the initial learning stages when, according to Haring et al. (1978), learning is slow and inaccurate (acquisition stage of learning), or when skills are accurate but slow (fluency stage of learning). Scripted therapy guides will be needed less often as student SLPs begin generalizing and adapting skills in therapy.

Video Vignettes

Video vignettes are designed to provide visual support and demonstrations of 23 of the 28 therapeutic-specific skills highlighted in this textbook and shown graphically in Table Intro–1. The exact skills captured in the companion website segments of the text are outlined in Chapter 5 of this text, with guided information for student SLP engagement in activities designed to assist learning of skills noted in Chapter 5 as well. Additionally, written workshops to assist learners are provided in the form of appendix supports entitled Therapeutic-Specific Workshops (TSW). These workshops are provided to further assist the SLP student learner with conceptualizing the processes of learning how to do therapy, and may be used in conjunction with viewing the video vignettes.

Suggested Uses of the Video Vignettes: Video vignettes and TSW forms may be used in either whole-class formats, in small-group work, or individually. However, video vignettes are not scripted to match exact content information in the book in that there is no vignette that necessarily corresponds to any given word-for-word, per-page content within the text. The video vignettes and the TSW formats are designed to help teach the concepts referenced within the text, particularly the therapeutic-specific skills noted in Chapters 5 and 6

of the text. It is hoped that the vignettes serve to illustrate possible occurrences of effective therapeutic scenarios from which student SLPs may learn to do therapy. Of course, none of the vignettes are promoted as perfect examples of therapy.

Interactive Learning Group-Focused Activity Cluster

The interactive learning group-focused activity cluster composes the third and final focused activity cluster in which student SLPs might learn the 28 therapeutic-specific skills highlighted in Table Intro–1. Interactive learning group is the name given to the smaller groups formed within the classroom when the clinical supervisor or instructor works with several students simultaneously in teaching student SLPs how to do therapy. ***Interactive learning groups*** are simply a management structure whereby students are placed in small groups to allow clinical supervisors or instructors to teach students large amounts of content and numerous therapeutic skills in a limited amount of time (see Figure Intro–2). Should the clinical supervisor or instructor find that students are best taught to do therapy on an individual basis (clinical supervisor to student), the interactive learning group will not apply to the learning structure needed to teach therapy skills in that instance. However, several subset activities attached to the interactive learning group may still prove helpful to the individual student SLP learner. For example, clinical supervisors teach, model, and coach in small groups; these activities will be applicable to the student being taught individually (i.e., clinical supervisor to student) as well.

It is important to offer a guide here for SLP students who will be learning to do therapy, regardless of whether learning therapy on an individual basis or in an interactive group. Figure Intro–4 presents a simplified graphic of a focus diagram of expected learning progressions associated with learning to do therapy. Student SLPs are encouraged to refer to this diagram often as a guide to the four levels of focus when learning to do therapy. Students are encouraged to focus on (a) learning the basic components of a therapy session (i.e., introduction, body, closing); (b) mastery of therapeutic-specific skills; (c) interactive nature of communication learning, and (d) client's communication skills and outcomes.

Student SLPs should begin learning therapy by focusing first on acquiring the *basic components of therapy* (e.g., introduction, body, and closing; the 28 therapeutic skills). Students continue learning by *mastering* these same skills (i.e., increasing skills for both accuracy and speed of implementation). Learning is continued through focus on the *interactive nature of communication* (roles and responsibilities of all participants in the therapeutic process [SLP, target client, peer model, and peer evaluator]). Finally, the focus is on positive impacts on the *client's communication competence and outcomes* (i.e., effectiveness of the client's communication skills). Although these levels of focus appear to be linear (and to some degree, they are), it is important for the student SLP to understand that even while learning the basic skills, the ultimate focus is always on the client's communication outcomes. (See Figure Intro–4.)

When larger groups of students are simultaneously introduced to therapy, the interactive learning group has been found to be invaluable. Eight interactive learning

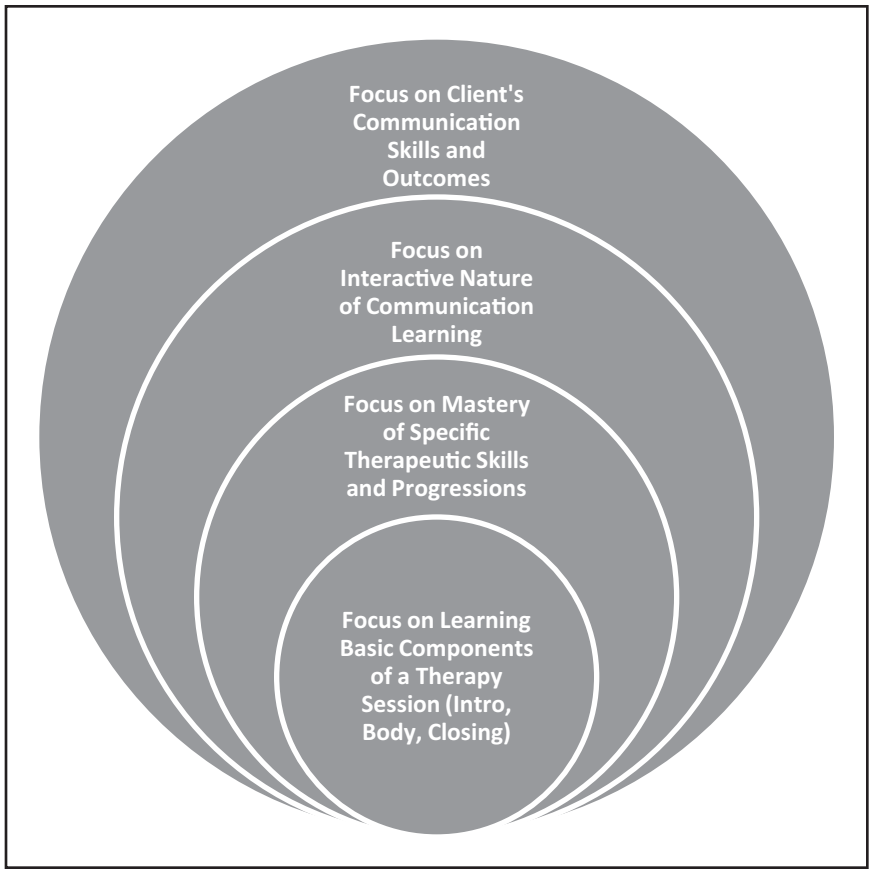

Figure Intro–4. Student SLP's focus diagram of expected learning progressions.

group-focused activities are presented for the student SLP learner: (a) *heterogeneous groups of four*; (b) *rotating roles and responsibilities of each group member (SLP, target client, peer model, peer evaluator)*; (c) *practice during class*; (d) *practice outside of class*; (e) *group members practice often as the therapist*; (f) *group members practice often as the peer model or peer evaluator*; (g) *group members self-video-record skills*; and (h) *self-analyze skills*.

Heterogeneous Groups of Four

Heterogeneous groups were discussed earlier in this chapter under the concept of cooperative learning. *Heterogeneous groups of four* in the context of the interactive group-focused activity clusters refers to the makeup of the cooperative learning group in heterogeneity of the disorders each group member represents. For example, one group member always serves as the SLP, with the three remaining group members serving as clients. It is within the makeup of the client population that heterogeneity becomes important for training purposes for this focused cluster. To expand this example, for heterogeneity in an articulation group, typically one group member will emulate a client with a specific articulation error, such as /r/. A second client presents with an /s/ problem, while the third client works on /l/. An articulation group whereby one client is working on /r/, another is working

on /s/, and a third is working on /l/ is considered a heterogeneous group with respect to target error sounds. As mentioned earlier in this chapter and as will be seen later in the text (Chapter 6), for purposes of creating a more realistic learning and communicating environment, heterogeneity within groups is preferred over homogeneous groupings. In heterogeneous groups, it is likely that if the target client is unable to correctly produce a phoneme, another client in the group is able to correctly produce that phoneme as a peer model, following the SLP's lead. However, if all clients experience difficulty producing /s/, as would be the case in a homogeneous group for /s/ errors, then no client in the group presents as a good peer model during the early phoneme learning phases of therapy.

Suggested Uses of Heterogeneous Groups of Four: Clinical supervisors or instructors are encouraged to allow student SLP learners to establish heterogeneous groups of four for purposes of learning the interactive components of therapeutic skills. This is especially important for peer modeling within the session. Often clients (especially young children) are not impressed that the SLP is able to correctly produce a phoneme. However, it becomes much more interesting (and impressive) to the young client when his or her peer is able to correctly produce the phoneme.

Rotating Roles and Responsibilities of Each Group Member (SLP → Target Client → Peer Model → Peer Evaluator)

The roles and responsibilities of each of the four group members were presented earlier as part of a discussion on cooperative learning. However, this concept needs to be reiterated here to help student SLPs focus on the roles and responsibilities as related to any small-group work that may be done outside of the classroom. Roles and responsibilities of each of the four group members within the small interactive groups rotate, depending on learner needs during practice time, both during and outside of class times. Exact structure of the small interactive groups is accomplished in the following ways:

- *Labeling of respective group members*. Once the groups of four student SLP learners are organized, each group member is assigned a group number from 1 to 4.
- *Rotating roles and responsibilities between clients and SLP*. Each group member selects a disorder that he/she will emulate during the practice session *when serving in the role of target client*. (Remember: In heterogeneous groups of four, at any given practice time, one group member serves as SLP and the other three group members serve as clients. So, at any given time, it is only necessary for three of the four group members to emulate speech-language disorders, as the fourth member of the group will be serving as SLP.) For example, in an articulation group, group member #1 may serve as the SLP for the first practice period (usually 8 to 10 minutes), whereas member #2 may choose to work on /s/; member #3 may choose to work on /l/; and member #4 may choose to work on /f/. Once group member #1 has practiced being the therapist for a designated

time, roles within the group change and group member #2 now becomes the therapist, while group member #1 now works on /s/ (as group member #1 had done previously); group member #3 continues working on /l/; and member #4 continues working on /f/. In the third practice rotation, roles change again, and now group member #3 becomes the SLP, while group member #1 works on /s/; group member #2 now works on /l/ (as group member #3 had done previously); and group member #4 continues working on /f/. Finally, in the fourth practice rotation, group member #4 becomes the SLP while member #1 continues working on /s/; group member #2 continues working on /l/; member #3 now works on /f/ (as group member #4 had done previously). Don't worry if keeping up with client role rotations becomes confusing. *As long as each SLP has an opportunity to work with a group of three clients, all of whom are working on different targets, the objective of learning to work in heterogeneous groups will be accomplished.*

In an example related to language-based therapy, group member #1 may serve as SLP, while group member #2 may choose to work on mean length utterance (MLU) expansion, group member #3 may choose to work on vocabulary for colors, and group member #4 may choose to work on the /d/ phoneme. As outlined in the client role rotations for the above articulation example, rotations of client roles occur in the same fashion when the heterogeneous groups are practicing language therapy: As each group member practices the SLP role, the remaining three members rotate client roles so that each SLP has an opportunity to practice with three clients, with one client working on MLU expansion, one client working on vocabulary expansion for colors, and one client working on the /d/ phoneme. Of course, these selected targets (phonemes and language structures) are merely examples for the sake of clarity. In actual heterogeneous group practice, clients may choose any number of other phonemes, language structure, or even voice, fluency, or resonance combinations for practice. However, in early learning and practice stages, it is recommended that language-based therapy is limited to language and articulation objectives to keep initial learning more focused and easier to conceptualize.

- *Rotating roles and responsibilities among clients*. By now, it should be clear that at any given time, within the heterogeneous group, one student serves as SLP while the other three students serve as clients, each emulating a different disorder. Another important thing to remember is that, more fundamentally, clients have different *responsibilities* associated with the roles within the small interactive group on another level. Each client within the small interactive group serves three different roles, with accompanying responsibilities as follows:
  - Each client is, at some point, the target client—the one with whom the SLP is working to change phonemes, language, or other behavior.
  - Each client, at some point, serves as peer model, whereby the SLP asks the peer to model sounds, language, or other structures for the target client.
  - Each client, at some point, serves as *peer evaluator*, whereby the SLP asks the peer to say/tell/show verbally or nonverbally (thumbs up, for example)

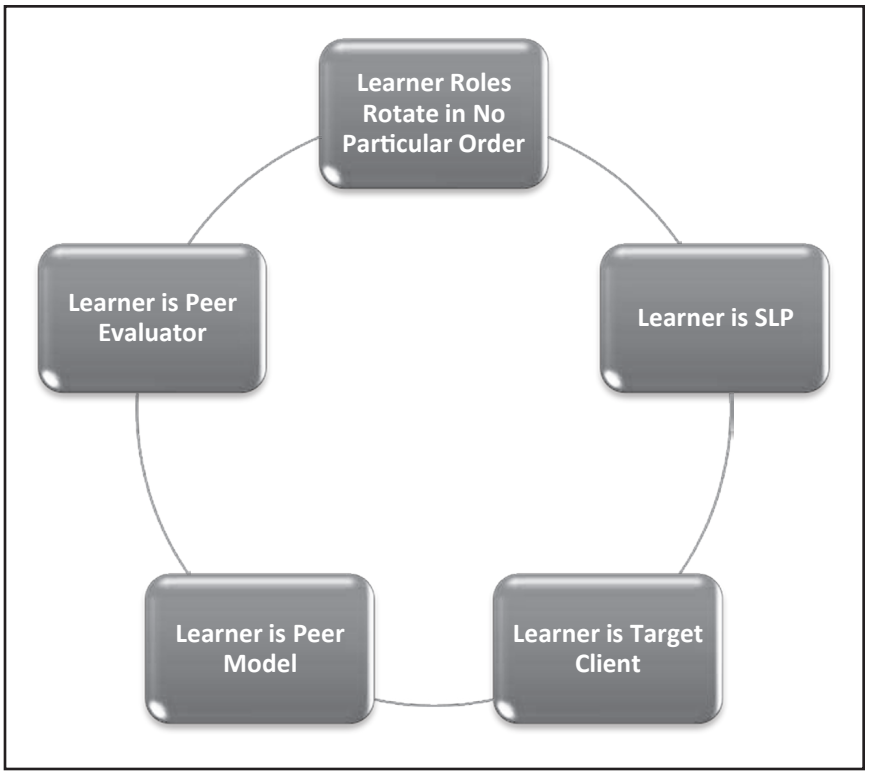

Figure Intro–5. Learner roles within the interactive group.

how well the target client performed in producing the sounds or language structures for the target client.

Figures Intro–5 and Intro–6 show graphic representations of the various rotating *roles* that the student SLP holds within the group during interactive group work, and the various *responsibilities* the student SLP holds within the group during interactive group work, respectively. Several researchers found positive results in learning when students were allowed to engage in role-playing (assuming various roles) (Howes & Cruz, 2009; Shapiro & Leopold, 2012).

Practice During Class Times as Often as Possible

Due to the large numbers of requirements of clinical management or clinical supervision courses, it is not always possible to provide student SLPs with an opportunity to practice during each class time. However, once the interactive groups of four are established, clinical supervisors or instructors are encouraged to arrange opportunities for practice during class times as often as possible. Class time practice offers students three important advantages that impact the student SLP's learning:

- Class time practice provides students an opportunity to refine skills in a more intimate and less threatening learning environment. Students tend to quickly

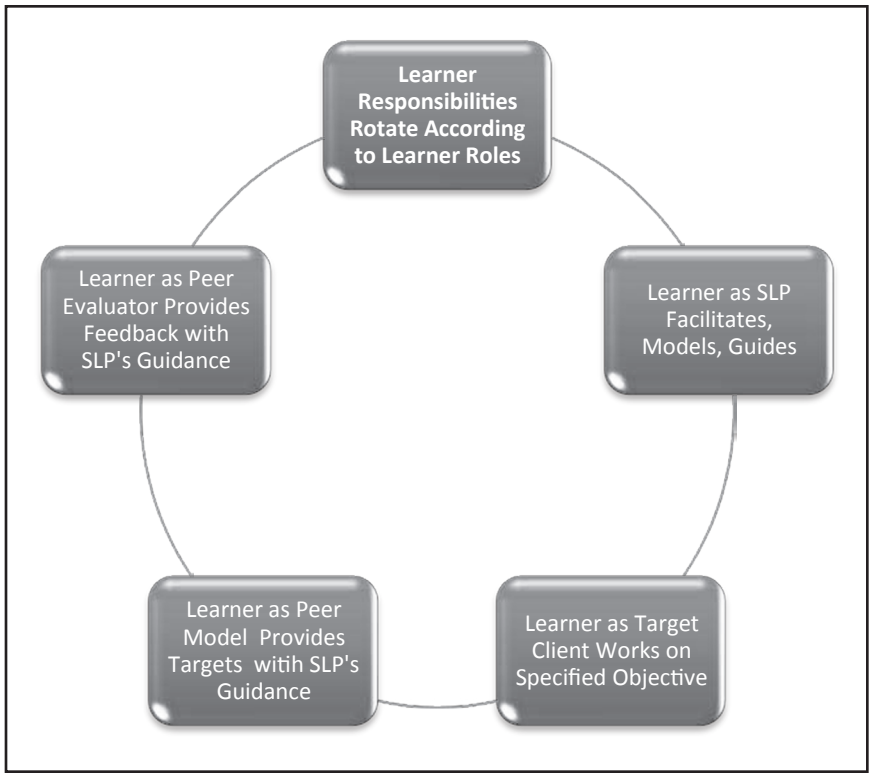

Figure Intro–6. Learner responsibilities within the interactive group.

become comfortable within the small-group learning setting, particularly when students are allowed to choose groupmates. This comfort among peers typically readily translates to students becoming more comfortable learning within small groups, especially when learning challenging tasks that require lots of repetition and often result in numerous errors and false starts, particularly in early-stage learning. Errors made within the small-group setting, rather than those made in either whole-class or individual settings, tend to be much less intimidating for student learners. Student SLPs in small groups can often be heard during small-group learning activities saying, "Wait, wait, okay. I did that wrong; let me start again," with no threats of embarrassment or other discomforts that might occur were the performances in front of the whole class, or even worse (in students' minds), in an individual exchange with the clinical supervisor or instructor. Several researchers supported small-group learning under the concept of a safe learning environment (Abiola & Dhindsa, 2012; Jones, Jones, & Vermette, 2013).

- Class time practice allows small groups of students to benefit from the clinical supervisor or instructor's directed and specific teaching, guidance, or corrective feedback needed for finer points of clarity. For example, clinical supervisors or instructors may address a misunderstanding of group member #1, but all other group members also benefit very quickly from clarity or corrective feedback

offered by the focused attention of the clinical supervisor or instructor working within the small interactive group.

- Class time practice provides student SLPs opportunities to quickly—and often accurately—submerge themselves into the therapeutic learning process by assuming mock therapeutic roles via role-playing as (a) clinician, (b) target client, (c) peer model, or (d) peer evaluator. Role-playing was reported by several researchers (Howes & Cruz, 2009; Shapiro & Leopold, 2012) to be a powerful learning experience, whereby students assumed different roles simulating real-life teaching or learning experiences. By assuming each of the possible therapeutic roles, with supporting responsibilities, student SLPs are essentially forced to engage in the various aspects of therapy both as clinician and as all possible client roles (i.e., target client, client as peer model, and client as peer evaluator). Findings of the informal survey of critical learning experiences (discussed earlier in this chapter) indicated that a number of students reported serving as peer model or peer evaluator to be less critical as learning experiences than were some of the other 18 focused learning activities. Still, it is certainly hoped that role-playing as peer models and peer evaluators helps students process concepts and perspectives of the various aspects of therapy more readily.

Suggested Uses of Practice During Class Times: Once the clinical supervisor or instructor presents a concept or skill and provides whole-class explanations or whole-class models, small-group practice times are appropriate for engaging in and learning all 28 therapeutic-specific skills associated with learning to do speech-language therapy. (See Table Intro–1.) Clinical supervisors or instructors make rounds from group to group within the classroom setting, teaching, guiding, coaching, and providing corrective feedback, but ultimately, the small groups teach themselves by working cooperatively with each other. One very nice, serendipitous result of small-group work is often a bonding or interdependence among group members. Within small interactive groups, group members not only assume responsibility for their own learning, but also often support the learning of others in the group under the concept of interdependence.

The interdependence that often emerges during focused small-group work is akin to the Backus and Beasley (1951) suggestion that "the teaching situation should be structured to provide a corrective 'emotional' experience" (p. 5). For example, in the small interactive group, each group member works to learn and habituate his or her skills, but often, each member of the group also works to help others in the group successfully demonstrate therapeutic skills as well. However, because of the strength of possible interdependence, or the possible emotional experience attached to small interactive group learning, whether during class practices, or outside of class practices, a word of caution regarding group dynamics is warranted: It is sometimes possible for one group member to carry enough influence over other group members to essentially destroy correct learning opportunities for others. Clinical supervisors, instructors, and group members themselves need to guard

against, and correct, situations whereby one group member essentially leads the other group members astray regardless of the amount of corrective feedback received from the clinical supervisor or instructor during in-class practice sessions. In situations such as this, typically a general discussion of group dynamics is sufficient. However, occasionally, groups may need to be reconfigured by the clinical supervisor or instructor to achieve proper learning balance for all group members.

Practice Outside of Classes as Often as Possible

Groups should practice together outside of classes as often as possible—but ***not*** *until therapeutic skills have sufficiently developed within the group members during in-class practices and demonstrations*. This caution is added because it becomes easy—and often detrimental—for group members to practice *incorrectly* outside of the clinical supervisor's or instructor's guidance. Clinical supervisors or instructors are, therefore, cautioned to be aware of the negative practice effect of small interactive group work and guard against groups rushing to prematurely practice as a group outside of class to accomplish an assignment.

Suggested Uses of Practice Outside of Classes: Small groups should practice outside of classes only when overall proficiency in group skills supports *correct* practice. To this end, group members should become comfortable with the idea of asking clinical supervisors or instructors to evaluate *group readiness* for practicing outside of the classroom.

Group Members Practice Often as the Therapist

The concepts of both *heterogeneous groups of four* and the *roles and responsibilities of interactive groups* were presented earlier in the discussion of the interactive learning group-focused activities. However, there is a need to practice as the therapist as often as possible. Ideally, this practice is done in conjunction with other group members serving as clients. However, it is possible for any individual group member to actually practice his or her therapy script alone, without the benefit of clients, once the individual group member understands the therapist's roles and responsibilities. Using the scripted language from Chart 6–2 of the textbook (Detailed Therapy Progression), the individual group member is able to practice the therapist's part of an intervention session based on imagined client responses, similar to the way an actor/actress might practice his or her part in a stage or film production.

Suggested Uses of Group Members Practicing Often as the Therapist: It is suggested that group members practice the role and responsibilities of the therapist as often as possible, both with and without the group. Practicing with the group was discussed in the section on *Rotating Roles and Responsibilities of Each Group Member* (above). However, individuals may practice separately from the group by standing in front of a mirror (or other feedback mechanisms) and verbally reading aloud through the Detailed Therapy Progression

(Chart 6–2). Student SLPs are reminded that practicing alone often yields the same effect as working in small interactive groups in that similar feelings of awkwardness and sometimes frustration are often present when first attempting to practice alone. Still, however, student SLPs are encouraged to try this method of practice to increase opportunities to practice as the therapist as often as possible.

Group Members Practice Often as the Peer Model or Peer Evaluator

Peer models are clients who are called upon by the SLP to give models of how sounds or other structures are produced. Peer models, themselves clients in the therapy session, work to support the target client's learning—upon the therapist's command. ***Peer evaluators*** are clients who are called upon by the SLP to give the target client feedback regarding the accuracy of his or her productions. Peer evaluators, themselves clients in the therapy session as well, work to support the target client's learning—upon the therapist's command. All clients in the therapy session rotate between serving as the target client (i.e., the client who is the direct/immediate recipient of the therapist's intervention), peer model, or peer evaluator. In all instances, the objectives of the peer model and peer evaluator are to support the learning of the client serving as the target client. In helping other clients learn, however, peer models and peer evaluators are still engaged in communicative learning.

Suggested Uses of Practicing as the Peer Model or Peer Evaluator: In that the therapist guides the responses of the peer model and peer evaluator during the therapy session, the greatest value of practicing the roles of peer model or peer evaluator is in helping student SLPs further understand the processes of the interactive nature of therapy: One client works on his or her targets or goals, while the remaining clients serve as either peer models or peer evaluators, on a rotating basis, to help support learning for the client working on targets and goals. This peer-shared learning also supports the learning of the peer models and peer evaluators (Savion, 2009).

Group Members Self-Video-Record Skills

Lasting impressions of therapy skills are often obtained through visual self-recordings of group work. Video recording each individual group member in the role of therapist is encouraged for its value as a good feedback mechanism to help each group member learn to do therapy.

Suggested Uses of Group Members Self-Video-Record Skills: Analysis of Table Intro–1 (Matrix of Focal Points and Activities) suggests that all of the 28 therapeutic-specific skills may be addressed through use of video-self-recording, depending, of course, on the specific nature of the therapy goals/objectives. Student SLPs are encouraged to self-record in the role as therapist to improve therapeutic skills.

Group Members Self-Analyze Skills

Interactive group members may self-analyze skills development in two ways: (a) use of cognitive processes for task analyzing skill development of each of the 28 therapeutic-specific skills (or parts thereof), and (b) self-analysis of the self-recorded video session. Once group members self-record skills, it is important to individually self-analyze the results to assess desired outcomes in skills attainment. Although it was noted above that all of the 28 therapeutic-specific skills may be addressed through use of video-self-recording, depending, of course, on the specific nature of the therapy goals/objectives, it is more feasible for the student SLP to select a subset of the 28 therapeutic-specific skills for analysis for any given video-recording effort. In this regard, the student SLP may choose to analyze skill development for selected skills rather than attempting to self-analyze all of the 28 therapeutic-specific skills at a given time.

Suggested Uses of Group Self-Analysis: Individuals within groups may benefit from self-analysis of therapy skills development for any selected therapeutic-specific skill. Once a skill is selected, student SLPs may use several sources for evaluative comparisons of skills development: clinical supervisor or instructor's feedback, textbook/companion website descriptions or demonstrations, and findings or results of self-recorded video sessions. Mistakes are a common part of the therapy learning process; mistakes are expected. Whether using cognitive processes for task analyzing skills development of selected therapeutic-specific skills, or self-analyzing self-recorded video sessions, the value of self-analysis is, ultimately, in the information gathered from the processes of scrutiny of performances, both subjective and objective, for skills development for student SLPs learning how to do therapy.

Overview of the 28 Therapeutic-Specific Skills

Although the 28 therapeutic-specific skills were presented earlier in this chapter (see Table Intro–1), an additional treatment of these skills needs to be highlighted. The list below contains the 28 therapeutic-specific skills from Table Intro–1, grouped together in ways that are easy to teach and easy to comprehend. The skills in bold print represent the skills addressed on the companion website accompaniment to the textbook. Notice that on some lines, several skills are not only listed together on the line, but several are also in bold print, indicating that these skills are grouped together and demonstrated in respective video vignettes. More discussion of the 28 therapeutic-specific skills follows in Chapters 5 and 6; however, the following list for indicating the skills is offered simply to help with clarity of thinking as student SLPs begin preparations for learning the skills. The 28 therapeutic-specific skills include:

- Motivation
- **Communicating Expectations**

- **Enthusiasm**, **Animation**, and **Volume** in the Therapeutic Process
- **Seating Arrangements**, **Proximity**, and **Touch** in the Therapeutic Process
- **Preparation**, **Pacing**, and **Fluency** for Therapeutic Momentum
- Antecedents: **Alerting Stimuli**, **Cueing**, **Modeling**, and **Prompting**
- Direct Teaching: **Learning Modalities**, Describing/Demonstrating, **Questioning**, and **Wait Time**
- Stimulus Presentation: **Shaping (Successive Approximations)**
- Positive Reinforcers: **Verbal Praise**, **Tokens**, and **Primary Reinforcers**
- **Corrective Feedback** in the Therapeutic Process
- **Data Collection** in the Therapeutic Process
- Probing in the Therapeutic Process
- Behavioral Management in the Therapeutic Process
- Troubleshooting in the Therapeutic Process

Each of the above skills is further presented in discussion and applications in Chapter 5. As student SLPs work to accomplish the 28 therapeutic-specific-skills, the list above serves as a quick review of skills, the possible grouping of skills, and shows skills that are presented in companion website format (indicated by the media symbol).

Welcome to This Text

The suggestions offered in this Introduction should help with the application of the information presented in this text. A final note related to the use of cooperative learning and interactive groups is important here. Cooperative learning and interactive group arrangements for student learning have been successfully used for more than 20 years with several hundred students, with approximately 16 inadequate student presentations in culminating demonstrations using these techniques. Interestingly, in each of the poorer-performing student presentations, each student in respective groups presented therapy in the *same incorrect manner*, using the same incorrect techniques and therapy sequences, with the same incorrect degree of details, thereby, with each poorer performing student demonstrating the power of cooperative learning within interactive groups, but doing so in *negative* rather than *positive* student outcomes. Additionally, in each instance of poorer-performing student SLP learners, it was easily determined that lack of student successes stemmed from identifiable faults: (a) students did not receive enough corrective feedback during small interactive group class time practice from the clinical supervisor or instructor, (b) students began practicing outside of the classroom *before* obtaining enough skills to *practice correctly* outside of the classroom, or (c) there was one group member who wielded enough persuasive power as to essentially lead the other group members astray regardless of amount of corrective feedback received from the clinical supervisor or instructor during in-class practice sessions.

Regardless of prior experiences in teaching/learning therapy skills, the concepts presented in this text should support continued successes and gratification in SLPs interested in learning more about basic therapy skills. So, to all students and practicing clinicians, welcome to this book and to its encouragement for your continued best performances in a career as an SLP professional. "Showtime!"

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PART

Introduction

Speech-language pathologists (SLPs) most often are exposed to a strong curriculum addressing the broad parameters of the profession (e.g., language, articulation/phonology, voice, fluency, resonance, swallowing). SLPs spend many hours addressing the specifics of therapy associated with these areas of the profession. However, several other areas of child and adult functioning found in speech-language therapy clients receive less attention during formal training for SLPs. For example, there is often little space in training programs for SLPs to address concepts related to early child development or the specifics of various recognized disability areas. SLPs who are exposed to child development and disability categories often receive that training early in undergraduate education when little relevance of these areas to the specifics of speech-language therapy is possible. Fortunately, many SLPs come to understand the relationship of child development and various disability categories to the speech-language pathology profession over the years as they engage in professional practices. For those not exposed to related areas of the profession as much as desired, Part I of this text can help.

Purposes of Part I

The purposes of Part I of this text are to (a) discuss foundational information related to speech-language therapy (Chapters 1 and 2); (b) present information in related areas and global parameters of therapy to help professionals understand the impact of those areas on therapy (Chapters 3, 4, and 7); and (c) present therapeutic-specific skills and basic components of the speech-language therapy session (Chapters 5 and 6). Exercises, figures, and text boxes are used to help support information presented.

How to Use Part I of the Text

Chapters 1, 2, 3, 4, and 7 of the text are traditional in format; the reader is presented information and asked to refer to various inserts as examples or as exercises designed

to increase clarity. However, Chapters 5 and 6 take a less traditional presentation in that additional learning aids are required for completion of activities for these chapters. Accompanying Chapter 5 are two additional learning aids: therapeutic-specific workshop forms (TSW forms) and video vignettes on the PluralPlus companion website. These two learning aids are integral to the information presented in Chapter 5. For example, 28 therapeutic-specific skills are presented in Chapter 5. As an additional aid to learning the 28 therapeutic-specific skills, students are presented with information not found in the text on TSW forms for use when learning the skills presented. Also accompanying Chapter 5 of the text are video demonstrations of how 21 of the 28 skills presented in the chapter actually look when applied to therapy. The 21 skills presented in video vignettes are incorporated as students work through the TSW forms. For example, students will begin working through a selected TSW form and, if a video vignette is part of the learning for the topic presented for that form, the student will be instructed to view the video vignette prior to completing the tasks on the TSW form. The TSW forms are presented as appendices to the text and are labeled to match the skills presented in Chapter 6. Students should perform the following tasks to learn the skills presented in Chapter 5.

1. Read the information from the text in Chapter 5 for the topic selected for study.
2. Select the TSW form that accompanies the topic selected in Chapter 5.
3. Read sections A through D of the applicable TSW form.
4. View the vignette (when applicable) that accompanies the selected topic.
5. Complete sections E and F of the TSW form.

By working systematically through the information presented in Chapter 5, the TSW forms, and the accompanying video vignettes, students learn to demonstrate the 28 therapeutic-specific skills presented in the chapter. The TSW forms and the video vignettes serve as guided practice in acquiring these skills.

One learning aid accompanies Chapter 6 of the text and is foundational for learning the components of therapy presented in the chapter. Chart 6–2 presents the details of therapy progression from the beginning to the end of a session, including components, timelines, definitions, and procedures and examples of what the SLP might say in therapy. Students are encouraged to refer to this chart often, as they study the sequence of events that occur in therapy. Understanding the information presented in Chapter 6 and in Chart 6–2 is integral to success in providing speech-language therapy.

Finally, it is not necessary to proceed with learning all 28 therapeutic-specific skills in Chapter 5 before proceeding to the details of therapy in Chapter 6. Typically, students begin learning one or two of the therapeutic-specific skills at about the same time they are introduced to Chart 6–2, Detailed Therapy Progression. As students are introduced to the components, timelines, definitions, procedures, and examples of Chart 6–2, they are also learning selected therapeutic-specific skills in isolation. Soon, however, students begin merging therapeutic-specific skills into the progression of therapy, reading from Chart 6–2 as they learn the order of the session while at the same time practicing a new therapeutic-specific skill. For example, it is not uncommon for the clinical management

instructor or clinical supervisor to assign TSW skills from Chapter 5 for practice with the greeting and rapport section of the introduction of therapy in Chapter 6. Numerous configurations for learning in that fashion are possible, and Chart 6–2 lists the TSW skills likely needed for each component of the therapy session for those interested in learning skills in an integrative manner. However, also possible are more linear styles of learning and teaching whereby consecutive chapters and items within chapters are addressed in order as presented. Regardless of the choice of presentation order for learning the skills presented in Chapters 5 and 6, the content of these chapters is designed to help develop or increase skills in speech-language therapy. Let's get started!

CHAPTER 1

Basic Considerations for the Therapeutic Process

Introduction

This discussion is designed to help the speech-language pathology student and professional focus on concepts that are fundamental and foundational to service provision in the profession. Some discussions are specific to the speech-language pathology profession, but others are general and so broadly founded as to be applicable to almost any chosen profession. Students and professionals are encouraged to revisit often the concepts discussed in this chapter during professional practice.

Artistry in Speech-Language Pathology

There is something that continues to be magical in ways a good speech-language pathologist (SLP) does his or her therapy. SLPs are scientists, firmly rooted in the academics across many areas of study, yet watching a good SLP at work makes it clear that something beyond science is operational. That something can only be explained as simple artistic flair—for lack of a more creative expression. Good SLPs have somehow found effective ways to mesh, layer upon layer, the knowledge and requirements of the sciences with the caring expressions of the humanities and the skills of well-trained craftsmen to emerge as skilled artisans and masters in the art of helping clients with communicative skills. Most typically do not view speech-language therapy as being akin to artistry. Yet, SLPs daily perform the act of positively impacting clients, in some way, to improve communication. SLPs, of course, are versed in research-based knowledge in the profession, and SLPs embrace best practices in the everyday performances of duties as speech-language pathology professionals. However, at the juncture of research and practical application of basic tenets of the profession is the concept of the art of speech-language therapy.

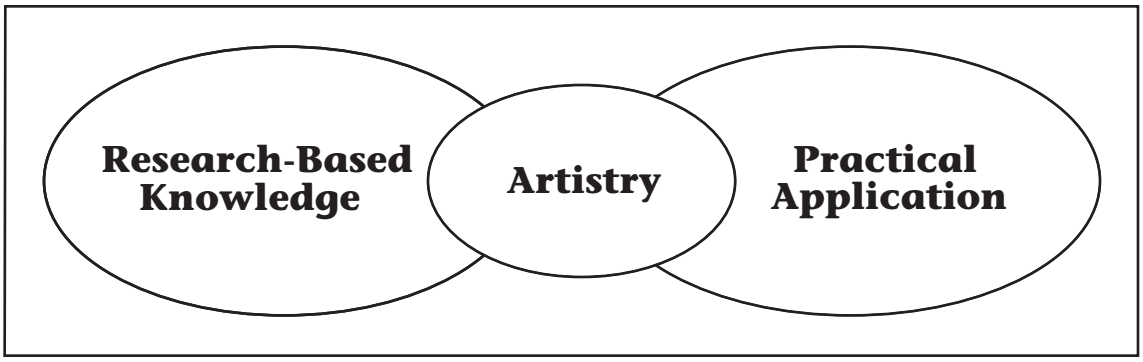

Figure 1–1. Artistry is the bridge between research-based knowledge and practical application in speech-language therapy.

Rarely have SLPs discussed the art of speech-language therapy. Typically, the focus is on knowledge, skills, techniques, competencies, models, and theories of the profession. SLPs try to ensure professional practices are firmly grounded in accepted research and best practices. Research is necessary for ensuring accuracy in understanding the anatomical, physiological, and neurological structures and functions being manipulated for positive communicative change in clients. But once these structures and functions are understood, it is up to the professional to incorporate the best information from learning theories and from physical, behavioral, and social sciences to effect appropriate change in the client's skills. Research tells us the *what* of speech-language therapy: what structures, what functions, what client goals to address in therapy. However, practical application helps us with the *how* of the profession: how best to implement techniques appropriate for a specific client's needs, and how best to attain the desired outcomes for our clients. The merging of the *what* and the *how* of our profession is, in fact, no less than artistry. This ***artistry***—the artistic quality, or effect, on workmanship (*Merriam-Webster's*, 1993) —is illustrated in Figure 1–1.

Practicing SLPs are encouraged to focus on research-based knowledge of the profession, for we need that foundation. Equally important, however, is the need for SLPs to focus on appropriate applications of techniques and methodologies for excellence in therapy. For SLPs to achieve increased levels of excellence in therapy, we must find ways to interface research with practical application; artistry is that interface. The development and execution of artistry in therapy often equates to the difference between the speech-language pathology professional assessed as "good in therapy" and one judged as "excellent in therapy." It is hoped that this text will help to promote excellence in therapy.

"Showtime!"

Showtime is an underlying guiding concept whereby clinicians come to understand the significance of excellence in providing therapy to clients. In the theatrical world, rallies of "Showtime!" or "The show must go on!" are heard often. Although the SLP's work is not designed to entertain in the way that a traditional Broadway show might, it is important

for SLPs to understand that we provide a valuable service to clients whose communicative competence depends on our professional skills. We are charged with the mammoth task of providing therapy services to clients to the best of our professional abilities at all times. Of course, there are perhaps times when SLPs feel ill prepared to provide speech-language therapy: we get sick, and sickness should be attended; we have personal traumas and tragedies, and those must be addressed. The underpinning of our work, however, should be the concept that clients receive the best possible speech-language therapy at all times. The SLP's commitment to providing the best possible therapy equates to the rally of the performing artist who, without hesitation, musters the performing troupe with the cry, "Showtime!" Similarly, when it is time to provide speech-language therapy services, SLPs are expected to perform with precision and excellence as we serve our clients. We train tirelessly to acquire skills to serve clients. We observe them, read about them, research them, and write about them. We assess them, and we analyze and interpret data on them. With the kinds and amounts of investments SLPs make in understanding client behavior and client needs, how can we be expected to offer less than our best when it comes to therapy for the client? The answer is, "We cannot give the client less than our best!" Now, how different are speech-language pathology and performing art? Certainly, different in many aspects; yet, not at all different when it comes to "Showtime!"

Speech-Language Therapy and Task Analysis

Aspiring SLPs observing speech-language therapy for the first time often are overwhelmed with the dynamics of a typical therapy session. Within the constructs of a given group therapy session, the clinician talks to clients, clients talk to the clinician, and clients talk to each other. Clinicians lead, guide, model, direct, facilitate, collect data, encourage, and reinforce efforts, to name some of the skills used during a typical therapy session. All of these skills are demonstrated under the auspices of ***therapeutic interaction***, a highly responsive and fluid exchange between clinician and clients during therapy; often the beginning professional is not sure just what is being observed. No wonder beginning SLPs feel intimidated at the thought of eventually taking the responsibility for providing therapy services on their own! Although initially uncomfortable with the thought of providing therapy services, new professionals, through guided practice in therapy skills, become not only comfortable with taking the lead as a practicing SLP, but eventually excel in the methods and techniques of speech-language therapy.

SLPs are taught to negotiate the path from beginning-level practices to professional competence in therapy through a series of experiences designed to promote successful mastery of therapeutic skills. This mastery is accomplished through use of ***task analysis***, a behavioral concept whereby tasks, or skills, are broken down into component parts to learn the parts separately; then the parts are put back together to demonstrate the target or required tasks (Hallahan & Kauffman, 2000). Similarly, Ormrod (2012) described task analysis as the process through which the component parts of a target subject matter are identified and sequenced, going from simple to more complex. By task analyzing each

segment of therapy, developing the skills required for successful implementation of that segment, then putting those skills together to demonstrate the entire target sequence, SLPs learn the art of demonstrating or performing the basic skills of speech-language therapy. Hulit, Howard, and Fahey (2011) referred to this type of segmentation for learning new skills as *chaining*, whereby large volumes of information are broken into smaller segments for initial learning, then segments are put together to form the full sequence of the newly learned skill. Shrestha, Anderson, and Moore (2013) reported positive outcomes in using task analysis and chaining to teach a child with autism functional self-help skills.

Skills for Speech-Language Therapy

Talents, skills, techniques, and a broad knowledge base for the profession compose the constellation of proficiencies that SLPs demonstrate. Several researchers (Hegde & Davis, 2005; Low & Lee, 2011; Paul & Cascella, 2007) presented helpful information regarding the skills SLPs need in the clinical setting. Hegde and Davis (2005), for example, discussed the importance of broad-based knowledge that SLPs need regarding the profession. Additionally, Roth (2015) discussed the World Health Organization's (WHO) 2010 promotion of interprofessional collaboration as the model of health care for the 21st century. Roth concluded that training in communication sciences and disorders must ensure SLPs are adequately prepared for the changing educational terrain. For purposes of this discussion, there are two broad-based skill areas that SLP professionals must demonstrate when providing speech-language therapy: *interpersonal communication skills* and *therapeutic-specific skills*. ***Interpersonal communication skills*** are the personal behaviors or interactions used for engaging others. Interpersonal communication skills emerge in various forms during various stages of child development (Adams & Wittmer, 2001). These skills include characteristic traits such as empathy, friendliness, politeness, honesty in feedback, and appropriate nonverbal interactions (e.g., eye contact, body language, proximity). Some students are considered to be naturals for therapy because they possess interpersonal communication skills (Conderman, Johnston-Rodriguez, & Hartman, 2009) appropriate for speech-language therapy, whereas other students must be taught interpersonal communication skills in addition to therapeutic-specific skills for therapy. In fact, Klevans, Volz, and Friedman (1981) compared experiential and observational approaches for enhancing interpersonal communication of speech-language pathology students to investigate the possibility of the students learning the language of positive interpersonal skills. They found that the interpersonal skills were teachable, but that more time for teaching was required than was available for the duration of the study. More recently, Perryman, Sandefur, and Morris (2021) investigated developing students' interpersonal and counseling skills through mixed-reality simulation in communication sciences and disorders. These researchers concluded that "mixed-reality simulation may be a useful tool for teaching interpersonal communication and counseling skills for students, including undergraduates in CSD" (p. 1). In cases in which an SLP student must be taught appropriate interpersonal communication skills that are perceived as appropriate for therapy, clinical supervisors or instructors must work through training

levels to help students acquire those skills on a case-by-case basis. However, essentially every student SLP is taught therapeutic-specific skills in that such teaching is the essence of clinical training in the communication disorders discipline.

Therapeutic-specific skills are fundamental core professional skills necessary for effective speech-language therapy. Typically, because of their importance to clinical effectiveness, therapeutic-specific skills are taught and learned in relation to their applications in speech-language therapy, although many of the skills apply across other disciplines. Regardless of how well-versed students are in interpersonal communication skills, all students studying the discipline of communication disorders must be taught therapeutic-specific skills. As a point of encouragement, beginning SLPs should understand that all skills demonstrated in speech-language therapy are learned skills. Whether students must be taught both interpersonal communication skills and therapeutic-specific skills, or need only to be taught the therapeutic-specific skills related to therapy, SLPs learn all skills and eventually demonstrate them without difficulty through use of task analysis activities. The therapeutic-specific skills that should be present within the context of speech-language therapy, regardless of goals, are presented in Textbox 1–1 and are discussed in more detail in Chapter 5.

Once an SLP commands appropriate use of the skills listed in Textbox 1–1, in conjunction with the broad-based knowledge of the profession per disability area (e.g., articulation/phonology, language, voice, fluency, resonance, swallowing), excellence in therapy becomes not only possible, but probable.

Textbox 1–1. Twenty-eight therapeutic-specific skills important to speech-language therapy. Ten web companion vignettes (media symbol) highlight 23 of these skills listed in bold italics

- Motivation in the Therapeutic Process
- ***Communicating Expectations***
- ***Enthusiasm***, ***Animation***, and ***Volume*** in the Therapeutic Process
- ***Seating Arrangements***, ***Proximity***, and ***Touch*** in the Therapeutic Process
- ***Preparation***, ***Pacing***, and ***Fluency*** for Therapeutic Momentum
- Antecedents: ***Alerting Stimuli***, ***Cueing***, ***Modeling***, and ***Prompting***
- Direct Teaching: ***Learning Modalities***, Describing/Demonstrating, ***Questioning***, and ***Wait-Time***
- Stimulus Presentation: ***Shaping (Successive Approximations)***
- Positive Reinforcers: ***Verbal Praise***, **Tokens**, and **Primary Reinforcers**
- ***Corrective Feedback*** in the Therapeutic Process
- ***Data Collection*** in the Therapeutic Process
- Probing in the Therapeutic Process
- Behavioral Management in the Therapeutic Process
- Troubleshooting in the Therapeutic Process

These 28 therapeutic-specific skills were presented in Chapter 1 and are more fully explained in Chapter 5. However, they are presented here as a reminder of their importance to learned effectiveness in providing appropriate speech-language therapy to clients.

Therapeutic Mindset

Mindset is a mental disposition or attitude that predetermines one's responses to and interpretations of situations (*Webster's II*, 1996). ***Therapeutic mindset*** for the SLP is the mental disposition or attitude that predetermines the SLP's responses to and interpretations of situations that occur within therapy sessions. The therapeutic mindset guides the SLP to continuously assess stimuli, responses, and all other interactions of the therapeutic process and to act or respond accordingly. For example, when a client is asked to respond to the SLP's speech model and the client's response is correct, the SLP must be aware of and follow up with one or more of several possible options. Similarly, when the client's response to a given stimulus is incorrect, the SLP must be aware of and follow up with one or more of several possible, but different, options. The awareness of the options and the preparedness to select and implement the appropriate option for the situation is a function of therapeutic mindset.

To further illustrate the impact of therapeutic mindset, think of a family preparing for a long-anticipated camping trip. Plans must be made and implemented; dozens of details must be addressed. Safety as well as fun should be considered. Although plans are made and exacted, alternatives in cases of emergencies must be identified. The therapeutic mindset is no less requiring. Plans for therapy must be made; details of structures or concepts elicited in therapy, how they are elicited, and what is expected as acceptable client responses must be addressed. Client and clinician safety and, certainly, some element or desire for improved communication as an outcome must be considered. Finally, alternative strategies or techniques must be identified in the event therapy does not proceed as planned. This parallel between a camping trip and speech-language therapy is, of course, an oversimplification of the therapeutic process. However, it helps illustrate the idea that, for the SLP, providing speech-language therapy is, most often, much more than meets the eye. When therapy is executed well, there are so many more elements or aspects involved than can be seen by the untrained observer. The SLP gives these elements of therapy proper focus, in large part, due to therapeutic mindset—the awareness, anticipation, planning, executing, evaluating, adjusting, and readjusting of sequences of occurrences in therapy to achieve positive therapeutic outcomes are all functions of therapeutic mindset.

Developing Therapeutic Mindset

There are three important elements of therapeutic mindset: *anticipation*, *evaluation*, and *interaction*. To develop the therapeutic mindset needed to provide effective speech-language therapy, the SLP must become proficient in thinking through and anticipating the possibilities of therapy. Additionally, each phase, step, or communicative occurrence