Toward a Theory of Clinical Expertise in Speech-Language Pathology

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There have been considerable efforts in the last few years to address a common complaint among practitioners that conferences and journals do not contain enough presentations and articles on treatment issues. The result of these efforts is that we know much more now than we used to know about the appropriateness and effectiveness of different treatment procedures. Clearly, there is a great deal remaining to be learned. However, I would like to suggest that our attention and research efforts not be restricted to comparing the relative effectiveness of treatment approaches. Clinical research has tended to focus on the technical and procedural aspects of treatment. Little is known, however, about the decision-making skills, interpersonal skills, and attitudes that characterize clinical expertise in our field.

The need for a theory of clinical expertise has been recognized in fields such as medicine (e.g., Kassirer, Kuipers, & Gorry, 1982) and clinical psychology (Kiesler, 1981). With a few minor changes, the introductory paragraph in the Kassirer et al. article on clinical expertise in medicine would seem as if it were written about speech-language pathology. The changes are bracketed.

Sound clinical decisions depend upon the integration of a variety of facts regarding a patient’s condition with an extensive store of knowledge [about communication sciences and disorders]. As a result of scientific and technological advances, the knowledge that underlies the practice of [speech-language pathology] has expanded at a rapid rate. But the intellectual challenges of clinical practice are still formidable, and little is known about the mental processes that enable [speech-language pathologists] to make the diverse and difficult decisions required in the clinical setting. The intellectual abilities that form the basis of clinical expertise seem to many to be mysterious, collectively constituting the cognitive skills or wisdom of which [speech-language pathologists] are most proud but about which they have little explicit understanding. (p. 251)

In speech-language pathology, the intellectual abilities that underlie clinical expertise are not the only factors that are mysterious. We also do not know how decision-making skills, interpersonal abilities, and factors such as innovation, enthusiasm, compassion, flexibility, and sensitivity impact on treatment outcomes. Questions about such issues as the appropriate time to recommend intervention, the notion of a clinically significant change, and the length of treatment, are beginning to receive attention in the literature (Bain & Dollaghan, 1991; Campbell & Bain, 1991; Olswang & Bain, 1991). These research efforts need to be expanded, however, to examine the “on-line” decisions clinicians make during actual treatment sessions and the influence various intellectual, interpersonal, and attitudinal factors have on these decisions.

In this short article, I begin with a brief review of current conceptualizations of clinical expertise in speech-language pathology. These conceptualizations are based on models of high-quality service. In the next section, I review some claims about the impact that factors like belief, enthusiasm, and innovation can have on learning. I conclude with some suggestions for the kind of research needed to develop a theory of clinical expertise in speech-language pathology.

Defining High-Quality Services and Clinical Expertise

In recent years, there has been increasing interest in defining expertise in various clinical fields. For example, researchers in psychology (e.g., Glaser & Chi, 1988; Rock, Bransford, & Maisto, 1987) have suggested that expertise varies as a function of specific as well as general factors. General factors include number of years of experience, total number of clients seen, and number of continuing education experiences. Specific factors include types of clients seen, types of continuing education experiences, clinical orientation (e.g., behavioral, cognitive, etc.), experience using specific assessment instruments, and intervention strategies.

General and specific measures of experience are not the only factors that have an impact on clinical expertise. Cornett and Chabon (1988), in their recent book on clinical
practice in speech-language pathology, identified three “attitudes” that they believe are central to providing high-quality services: (a) a scientific attitude that represents the theoretical knowledge and scientific data base, (b) a therapeutic attitude that reflects interpersonal skills, caring, and compassionate behaviors, and (c) a professional attitude that encompasses the substantive aspects, occupational values, and economic principles of clinical work.

At the core of a scientific attitude is curiosity and skepticism about theory as well as practice. Kent (1985) has suggested that the “scientific clinician’s” primary goals are to (a) learn about new research discoveries, (b) apply selected information to clinical practice, (c) empirically evaluate intervention outcomes, and (d) conduct research in a clinical setting. Clinicians should always be asking questions about purposes, assessment procedures, goals, objectives, and treatment methods (Cornett & Chabon, 1988).

At the core of a therapeutic attitude is a caring and compassionate attitude, enthusiasm, and the ability to develop a rapport with clients. Sarason (1985), for example, found that the most helpful professional service providers were “typically recalled as being ‘interested,’ ‘concerned,’ ‘understanding,’ and ‘sensitive,’” while the least helpful professionals were described as “‘discouraging,’ ‘insensitive,’ ‘cold,’ and ‘businesslike’” (pp. 100–101).

The professional attitude in clinical practice encompasses six somewhat diverse areas: (a) expertise: the requisite knowledge and specialized skills/techniques attested to by educational and certification requirements, (b) professional norms: codes of professional conduct and clinical accountability, (c) professional identity: collegiality and professional memberships, (d) legal identity: state licensure laws that regulate professional practice, (e) business acumen: the management and financial aspects of professional practice, and (f) personal traits: one’s professional style.

Frattali (1991), in a recent article on the pursuit of quality, pointed out that quality may be defined differently by practitioners and clients. Practitioners, Frattali noted, often define quality by the level of their technical skill, whereas clients define quality in terms of humanistic characteristics. To illustrate the divergent perspectives of quality, Frattali cited a recent article by Dorothy Wender, a person with aphasia, who offered the following description of a “good therapist”:

He spoke to me as an intelligent adult, who needed special information concerning aphasia, but who also knew things which he didn’t know, like the classics. He smiled often, was warm and gentle. He talked to my daughters. . . . This mattered very much. (p. 43).

Ms. Wender proceeded to describe a “bad therapist,” again in terms of the clinician’s interpersonal skills and treatment style.

Frattali (1991) uses these comments to argue that both interpersonal and technical aspects of treatment influence quality and that the absence of either likely would have a negative effect on the treatment outcome. It should come as no surprise to clinicians that clinical expertise and quality of services are influenced by interpersonal factors, or by what Cornett and Chabon (1988) have called the therapeutic attitude. I am not familiar with any studies, however, that have examined the actual impact interpersonal factors and other nontechnical factors have on the treatment outcome of children with speech and language disorders. A few old studies exist in the aphasia literature (e.g., Stoicheff, 1960; see Darley, 1982, p. 231) that have documented the importance of attitudes of acceptance, patience, encouragement, and optimism in treatment outcomes with aphasic individuals. To illustrate the potential impact of such factors on children’s learning, in the next section I review some claims about the influence that innovation, belief, and enthusiasm have on learning to read and teaching English to deaf students.

The Role of Innovation, Belief, and Enthusiasm in Teaching and Learning

One would assume that it matters what approach one uses to teach reading, given the almost century-long debate between meaning-based (now called whole language) and phonics approaches. This does not seem to be the case, however. In a recent book on how children learn to read, Marilyn Jager Adams (1991, pp. 34–36) reviews some of the seminal work of Jean Chall (1967, 1983) on the effectiveness of different reading approaches. Although Chall has been a strong supporter of phonics approaches, her early research actually found that the reading approach a teacher used had less of an impact on teaching young children to read than other factors.

Chall (1967) set out to study the effectiveness of different reading programs in teaching young children to read. She visited more than 300 kindergarten, first, second, and third grade classrooms in wealthy, middle-class, and poor districts across the United States, England, and Scotland. Chall was prepared to find large differences in children’s responsiveness to their reading lessons. What she actually found surprised her, however. Whatever the prevailing mood of the classroom—excitement, boredom, enthusiasm, apathy—this mood seemed independent of the philosophy or objectives of the particular program or materials used. The level of children’s interest was not related to the content of the stories or the emphasis on phonics rules. Children’s interest also was not related to class size or organization. More than anything else, student involvement depended on the atmosphere (momentum, support, and expectations) created by the classroom teacher. Pace was a key variable. Chall defined pace as the teacher’s ability to stay tuned to the delicate interval between ease and difficulty and to stay within this interval for different students.

With respect to the specific reading programs or approaches used, Chall found that the success of a program seemed to be due less to its nature than to its newness in the schools. Innovators tended to be believers. They involved parents, confronted difficulties, and did so regardless of the particular philosophy of the program. An important finding, however, was that teachers presenting new programs maintained their old practices. For exam-
ple, teachers who were switched to phonics programs did not engage in less book reading and meaning-based activities.

James Paul Gee (1992) takes Chall’s claims one step further. After reviewing Chall’s findings from her classroom observations, as I did above, Gee relates his experiences teaching students who were going to become teachers of the deaf. He notes that, as a linguist, he realized that many methods of teaching English to children who are deaf, such as cued speech, lip reading, various oral methods, and invented sign systems, were “unintelligent” from a linguistic point of view. However, Gee also knew from the work of Quigley and Paul (1984; cited in Gee, 1992) that a distinct result reported in the deaf education literature was that nearly any method, no matter how unintelligent it is, works if the teachers believe in it and the parents support it at home. What this means, according to Gee, is that enthusiasm, belief, advocacy, and parental support are more important than specific teaching methods and procedures. Or, stated more strongly, “people who, from a scientific point of view, don’t know what they’re doing, very often do just fine. If they strongly believe in what they’re doing, The very best methods, without this strength of belief, fail miserably” (p. 120). As additional support for these claims, Gee points out that the very best teachers of school-based literacy are middle- and upper-middle-class parents who, from the point of view of educational science, have no idea what they are doing.

Some Caveats

Although I agree with Chall and Gee that innovation, pacing, belief, parental support, and enthusiasm are important factors in teaching and learning, I think Gee goes a step too far in stating the case for the importance of enthusiasm and belief. Learning depends on more than belief and enthusiasm. For example, there are many reports involving facilitated communication of nonbelievers becoming believers only after having success with the approach (e.g., Duchan, 1993). Believers in facilitated communication also report that the approach does not work with every child who is autistic (e.g., Peterson, 1993). I think we need to be extremely careful not to overemphasize the influence belief and enthusiasm may have on learning, while at the same time recognizing that these factors may actually have a greater impact on learning in disordered populations than they do in nondisordered ones.

Toward a Theory of Clinical Expertise

The conceptualizations of high-quality service proposed by Cornett and Chabon (1988) and Frattali (1991) indicate that clinical expertise in speech-language pathology is defined not only by technical, procedural, and knowledge-based (intellectual) qualities, but by interpersonal and attitudinal qualities as well. These conceptualizations now must be supported by empirical studies that systematically examine how clinical decisions are influenced by these qualities. Clinicians and clinician characteristics (e.g., young-old, experienced-unexperienced, enthusiastic-unenthusiastic, etc.) need to become the focus of our studies. As I have noted earlier, the focus in most of our clinical research to date has been on treatment approaches and other technical/procedural aspects of treatment. How to operationalize qualities such as compassion, enthusiasm, sensitivity, flexibility, and innovation and to study the impact that these qualities have on clinical decisions and treatment outcome may not be readily apparent. However, we should be able to draw on the recent studies in medicine and psychology that have examined clinical expertise.

One procedure that has proven successful in shedding light on how clinicians think about and solve clinical problems is to obtain verbal (thinking aloud) protocols from clinicians while they observe or perform clinical activities (Kassirer et al., 1982). Verbal protocol can also include question asking and answering procedures (Graesser & Clark, 1985). For example, clinicians may be shown videotapes of actual or contrived treatment sessions and be asked to provide a running commentary (thinking-aloud protocol) of the session. Thinking-aloud protocols could be supplemented with questions that would ask the clinician to identify the factors that impact on the specific decisions being made during the session.

It is important to realize that no one study or research methodology will be able to define clinical expertise in speech-language pathology. As Gelso (1979) noted in reviewing research in clinical psychology, all research is flawed; scientific progress results from repeated empirical attacks on a problem or question. In order to construct a theory of clinical expertise in speech-language pathology, research efforts need to be initiated in which clinicians are the object of study. These research efforts should be diverse. Group studies as well as single-subject or case studies should be performed. These studies should not be restricted to any one type of measure, analysis, or procedure (e.g., rating scale, descriptive analysis, verbal protocol analysis, etc.). Through such diverse research efforts, we gradually will construct a theory of clinical expertise in speech-language pathology that addresses the impact that decision-making skills, interpersonal abilities, and attitudes have on treatment outcomes.

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References


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