Collaborative counseling: Using course-embedded experiences to train skills and foster confidence

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CSD 725: Counseling in CSD

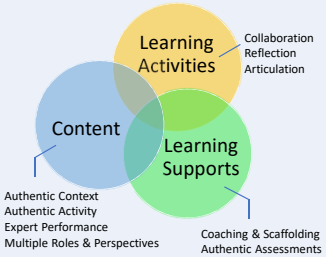
Background

Training counseling

- The American Speech-Language Hearing Association (ASHA, 2016) identifies counseling as **one of the 8 main practice domains** for speech-language pathologists (SLPs) and audiologists (AuDs)
- Counseling is in the **scope of practice** for SLPs and AuDs, (ASHA, 2016)
- ASHA (2017) **requires** Communication Sciences and Disorders (CSD) **training** programs to train counseling
- Only **59%** CSD programs have **stand alone course** in counseling (Doud, Hoepner & Holland, under revision)
- New CSD graduates **do not feel prepared** to provide counseling (Phillips & Mendel, 2008)
- Practicing **SLPs feel unprepared** to deliver counseling (Doud & Hoepner, in prep; Doud, Hoepner &Holland, In prep; Sekhon et al., 2015; Simmons-Mackie & Damico, 2011)
- SLPs may intentionally or unintentionally **avoid counseling moments** because they feel unprepared or feel compelled to get back to other communication-based interventions (Simmons-Mackie & Damico 2011)
- SLP grad students identify a **need for more training** in counseling methodology and counseling experience in their training programs (Luterman, 2001)

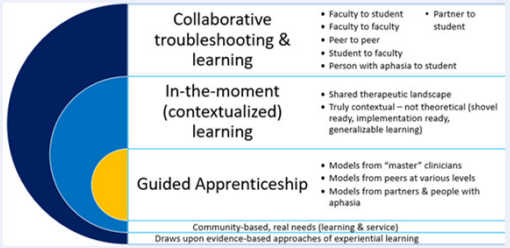
What is a course-embedded clinical experience?

- Brings an authentic intervention program into a course
- Employs an apprenticeship model where instructors deliver interventions alongside of students
- Explores service delivery models
- Exposes students to the lived experience
- Fosters reflection and collaboration



Oliver & Herrington, 2000 – **Situated Learning Model**

Core Elements of Learning



Donaldson, 2015; Feeney & Lamparelli, 2002; Glazer & Hannafin, 2006; Rueda & Monzo, 2002; Sheepway, Lincoln, & Togher, 2011; Wilson, Chasson, Jozhowski, & Mulhern, 2017

Knowing and Doing are not equivalent but also inseparable – learning (knowing) and doing (executing) happen in context

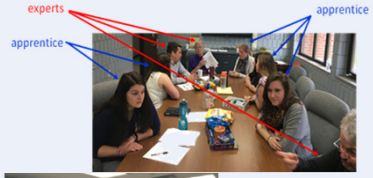
If we think of our clinical knowledge as a tool, there are multiple ways to use that tool – clinical flexibility (our goal) is dependent on using tools in context

(Brown, Collins, & Duguid, 1989; Collins, Brown, & Newman, 1989; Oliver & Herrington, 2000)

Apprenticeship Model of Instruction

(Feeney & Lamparelli, 2002)

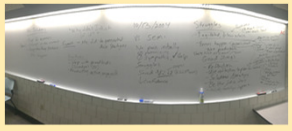
- Roles can change depending on context
- Faculty, students, and clients can be experts
- Faculty, students, and clients can be apprentices

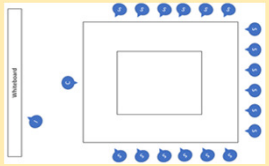


Level the disparity between expert and learner. This is a Vygotskian principle – participation in authentic interactions, the role of zone of proximal development, and vicarious learning (needs to be an achievable model) – if we create a knowledge divide, the chasm is harder to cross

Collaborative counseling as a clinical course embedded experience

- 3-4 sessions per semester
- Follows training and competency assessment
- Instructor present, alongside of students
- Instructor scaffolds interaction and techniques
- Clients start at more straightforward and move to more challenging

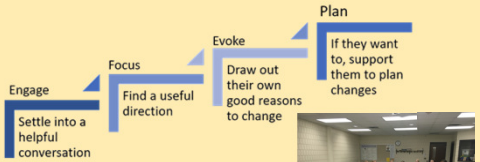


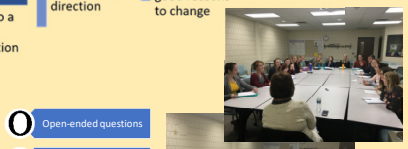


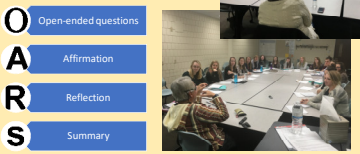
The process:

Joint review of counseling videos → Video competency and self-review → Collaborative counseling sessions

1) Client #1 – Instructor helps scaffold student interactions – focus on counseling phases (engaging, focusing, evoking, planning) and techniques (open-ended questions, affirmations, reflections, summaries)
   - Scaffolding includes writing down key information on the whiteboard, cues to shift between phases, stepping in and modeling techniques
   - Students negotiate group dynamics and collaboration (who asks and says what)
2) Client #2 – Instructor decreases scaffolding – focus on getting to planning details, focus on differentiating between techniques (OARS)
   - Scaffolding is mostly shifting to planning, eliciting details and implementing initial steps for planning, eliciting specific steps, recognizing change talk
3) Clients #3/4 – Group is fairly independent at counseling – focus on high-level skills pulling together the rambling, hodge podge of ideas into a bouquet of change talk







Research Methods

- Participants: 36 first year students (18 per cohort) across 2 years
- Individual written reflections after each collaborative counseling session
- Large-group, oral debriefings after each session (still analyzing)

Qualitative Coding

- Transcribe and segment codable statements
- Multiple rounds of open and axial, qualitative coding with consensus coding across three researchers
- Identified overarching schemes, categories, and subcategories
- Multiple sources (individual reflection, group debriefings, and field notes) to triangulate and establish rigor

Results and Interpretations

Broad

Modeling	Facilitating group interactions	Confidence/self- efficacy	Client	Implementing skills	Client or disorder specific learning
○ Peer examples ○ Instructor demonstration ○ Learning from client	○ Hard to "jump in" ○ Differed at group level ○ Talking too much ○ Hard to navigate group counseling ○ Critical appraisal of peer or self's techniques ○ Collaboration with peers	○ Enjoyed opportunity ○ Preparedness for profession ○ Decreased nerves ○ Trouble moving through phases of counseling (stuck) ○ Professional insight ○ Clinical flexibility ○ Feelings of satisfaction	○ Client temperament ○ Client feelings ○ Client input	○ Using MI or OARS ○ Recognizing or evoking client's change talk ○ More OARS or MI ○ Righting reflex ○ Active listening	○ Learned about TBI

Feelings after 1st session

Development of planning skills	Implementing counseling skills
○ Reflecting and planning for next session ○ Difficulty getting through stages of counseling ○ Debrief time	○ Moving to planning stage ○ Engaged well ○ Evoked well ○ Affirmed and summarized well ○ Challenging to reach change talk

Feelings after 2nd or 3rd session

Negotiating group/team interactions	Improved implementation skills	Improved confidence/self-efficacy	Encountering increased challenges
○ Improved collaboration ○ Increased participation ○ Plan	○ Increased use of OARS (core techniques) ○ Reached evoking and planning (core phases)	○ Increased comfort ○ Enjoyed opportunity ○ Gained client diversity experience	○ Client difficulty ○ Too much affirming (not enough evoking/summarizing) ○ Didn't help enough

Counseling notes

Client/session information
○ Subjective impressions ○ Objective impressions

Key Educational and Clinical Takeaways

- Hands-on guided practice addresses needs identified by (Doud & Hoepner, in prep; Doud, Hoepner &Holland, In prep; Luterman, 2001, Phillips & Mendel, 2008, Sekhon et al. 2015)
- Incremental learning and repeated opportunities for practice
- Students identified increased:
  - self-efficacy and confidence across three collaborative sessions
  - Ability to implement counseling skills and techniques
  - Ability to negotiate team-based counseling
    - Pertinent to IEPs daily rounds, discharge planning meetings, etc.
- Professional insights
  - Feeling prepared to address a counseling moment – addressing Simmons-Mackie & Damico, 2011
  - Being intentional about use of techniques – differentiating between what technique to use when
  - The need to scaffold communication and cognition – that's why SLPs should be doing it (ASHA, 2016 scope of practice)
  - Keeping it client directed – knowing the counseling and communication techniques to do this
  - Not settling for the first solution – exploring contingencies

Acknowledgments

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References – available upon request