

**Clinical Observation
in Communication Sciences
and Disorders**

Clinical Observation in Communication Sciences and Disorders

Nancy E. Hall, PhD, CCC-SLP





5521 Ruffin Road
San Diego, CA 92123

e-mail: info@pluralpublishing.com
Web site: <http://www.pluralpublishing.com>

Copyright © 2019 by Plural Publishing, Inc.

Typeset in 10.5/13 ITC Garamond Std by Achorn International
Printed in the United States of America by McNaughton & Gunn

All rights, including that of translation, reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, recording, or otherwise, including photocopying, recording, taping, Web distribution, or information storage and retrieval systems without the prior written consent of the publisher.

For permission to use material from this text, contact us by
Telephone: (866) 758-7251
Fax: (888) 758-7255
e-mail: permissions@pluralpublishing.com

Every attempt has been made to contact the copyright holders for material originally printed in another source. If any have been inadvertently overlooked, the publishers will gladly make the necessary arrangements at the first opportunity.

Library of Congress Cataloging-in-Publication Data:

Names: Hall, Nancy E. (Nancy Edna), 1959– author.

Title: Clinical observation in communication sciences and disorders /
Nancy E. Hall.

Description: San Diego : Plural Publishing, [2019] | Includes bibliographical references and index.

Identifiers: LCCN 2017054451 | ISBN 9781635500196 (alk. paper) |
ISBN 1635500192 (alk. paper)

Subjects: | MESH: Communication Disorders—diagnosis | Observation—
methods | Professional-Patient Relations

Classification: LCC RC423 | NLM WL 340.2 | DDC 616.85/5—dc23
LC record available at <https://lcn.loc.gov/2017054451>

CONTENTS

<i>Preface</i>	<i>ix</i>
<i>Acknowledgments</i>	<i>xi</i>
<i>Contributors</i>	<i>xiii</i>
<i>Reviewers</i>	<i>xv</i>

SECTION I

Introduction to Clinical Observation

Chapter 1. The Art and Science of Clinical Observation	3
Introduction to the Process of Clinical Observation	4
<i>Using Inductive and Deductive Reasoning</i>	4
<i>Developing Hypotheses</i>	6
<i>Scientific Evidence and Intuition</i>	7
An Historical Perspective	8
<i>Clinical Observation in Medicine</i>	8
<i>Clinical Observation in CSD</i>	12
The Importance of Clinical Observation in Developing the Master Clinician	14
A Paradigm for Guided Observation	15
Chapter Summary	18
Chapter Observations and Exercises	19
Chapter 2. A Process, a Framework, and a Model for Clinical Observation	23
Setting Goals	24
Learning to Write Objectively	25
Describing the Context	26
<i>Observing the Environment</i>	27
<i>Observing the People</i>	28
Observing the Communication Behavior	28
Observing the Session	29
A Global Framework and Model	30
<i>The ICF Framework</i>	30
<i>The Biopsychosocial Model</i>	33
Chapter Summary	33
Chapter Observations and Exercises	35

SECTION II

Elements of Clinical Observation

Chapter 3. Element 1: The Observer	41
Introduction to the Observer	42
Self-Reflection	42
Reflective Writing and Narrative	49
<i>Self-Awareness and Communication</i>	49
<i>Professional Identity</i>	50
<i>Critical Thinking</i>	50
<i>Group Process</i>	52
Critical Thinking	53
Ways of Knowing with Marisue Pickering, Ed.D.	63
<i>Received Knowledge</i>	66
<i>Experiential Knowledge</i>	66
<i>Subjective Knowledge</i>	67
<i>Judgment or Expert Knowledge</i>	67
<i>Adversarial Knowledge</i>	68
<i>Modus Operandi</i>	69
<i>Theoretical Knowledge</i>	69
<i>Scientific Knowledge in the Natural Sciences</i>	70
<i>Scientific Knowledge in the Human Sciences</i>	71
<i>Co-constructed or Relational Knowledge</i>	71
Culturally Sensitive Practice	72
Professional Identity Formation	76
Chapter Summary	80
Chapter Observations and Exercises	81
 Chapter 4. Elements 2 and 3: The Clinician, The Client	 91
The Master Clinician	92
<i>Clinical Experience</i>	93
<i>Clinical Expertise</i>	94
<i>Clinician Characteristics</i>	97
<i>Openness to Experience/Change</i>	105
<i>Tolerance for Ambiguity</i>	106
Cultural Sensitivity	107
<i>In Medicine and Allied Health</i>	108
<i>In Communication Sciences and Disorders</i>	112
The Client/Patient	115
<i>The Child as Client/Patient</i>	116
<i>The Adult as Client/Patient</i>	119
Chapter Summary	121
Chapter Observations and Exercises	123

Chapter 5. The Client-Clinician Relationship (The Therapeutic Alliance)	125
Therapeutic Alliance in Mental Health	126
Therapeutic Alliance in Allied Health	127
Therapeutic Alliance in Communication Sciences and Disorders	130
<i>Therapeutic Alliance in Audiology</i>	131
<i>Therapeutic Alliance in Speech-Language Pathology</i>	135
A Note About the ICF and the Therapeutic Alliance	141
<i>Clinically Significant Change</i>	145
Chapter Summary	149
Chapter Observations and Exercises	151
<i>Appendix. Disability Memoirs and Stories</i>	<i>153</i>
<i>References</i>	<i>161</i>
<i>Index</i>	<i>179</i>

PREFACE

Observation is at the heart of any clinical endeavor. It is the integration of knowledge, skill, experience, and expertise within a global perspective as applied to the individual. All that we gain as clinical practitioners factors into the care with which we take to address the needs of our clients or patients—and that process begins, continues, and ends with observation. This text addresses the development of observation skills in communication sciences and disorders (CSD) with the novice clinician or student in mind. It uses a broad approach in considering what is important to learn about observation at the very beginning of a career. The book is not structured around particular speech, language, hearing, or swallowing impairments or what to look for in specific communication disorders. Instead, the focus is on observing the observer, the clinician, and the client/patient. Readers will encounter a great deal of research involving what we bring to the observation process and how our own perspectives can affect what it is we “see” or “hear.” We will explore what characteristics to look for in the clinician and the client/patient and how those features impact the therapeutic relationship. A few notes about the text and how it may be best used are in order.

- This book is primarily for undergraduate CSD students who are about to begin or are in the process of obtaining clinical observation hours. Some folks who are already providing clinical services may find it useful as a way of reminding themselves about clinical skills beyond those associated with a diagnosis or therapeutic process.
- Students (particularly undergraduates) may find some of the material and writing a bit challenging. As stated, a fair amount of research is covered in the book. It is included for a number of reasons. First, it is essential that we recognize the value of research in informing our practices. Second, students (perhaps undergraduates especially) need to develop a level of comfort with reading and understanding the literature. All of us can benefit from the practice of reading, synthesizing, and integrating the research into clinical practice. Evidence-based practice requires these skills. Third, much of the research discussed is gleaned from disciplines other than CSD. In part, this is because the CSD literature on observation is somewhat scant, but also because we can learn a great deal from the work of others. And, that brings me to my next point . . .
- The approach in the book is intentionally broad—global, you might say. Observation skills are not unique to CSD professionals, nor to North American professionals!

- Emphasis is given to medicine, nursing, and allied health disciplines, largely because these professions have similar educational and training practices to CSD. Medicine, in particular, has a rich history of explicitly examining observation as an essential skill to be developed and nurtured. Furthermore, these disciplines continue to investigate aspects of training related to interprofessional education and practice with best client/patient outcomes in mind.
- Quite a few concepts, frameworks, and models are discussed in the text. It is not expected that students at the point of clinical observation will learn and retain all of this information. Rather, the goal is to expose students just starting out to aspects of the discipline, such as some of the World Health Organization's efforts, levels of observation, the biopsychosocial model, and the therapeutic alliance. Down the road, students who continue on in CSD will recall being exposed to them and be better able to integrate them into a larger fund of knowledge and skills.
- The text is meant to be supplemental to a class on clinical observation or clinical procedures. Although examples, tables, and figures are included to assist in digesting the material, students are likely to need an instructor or clinical supervisor to help them along the way. A number of exercises are included to assist in identifying and practicing many of the important concepts and skills. It is quite likely that individuals at different stages in their academic and clinical careers will "take away" different points, ideas, and impressions from the text. Therefore, students are encouraged to hang on to the book throughout their developmental process—you may find yourselves referring back to certain concepts as you learn and grow!
- Clinical certification in audiology does not require observation hours. Still, the book addresses clinical observation in CSD as a discipline, discussing concepts, knowledge, and skills that are applicable to both audiology and speech-language pathology professions.
- Many of the exercises contained in the book are designed to be conducted with one of the videos available in the Clinical Video Library. Still, they are written in such a way that they readily can be adapted to other observation experiences.

ACKNOWLEDGMENTS

Thanks to Maggie Pierce, graduate assistant, for her many contributions and for juggling so many tasks, including managing clinical observations, so that I could complete this book. Thank you to the generations of students who have helped me conceptualize the teaching and learning of clinical observation and to the faculty and staff of the CSD department at the University of Maine for their support. Special thanks to Lorriann Mahan, MS, CCC-SLP, who exemplifies what it means to be a master clinician. Most importantly, gratitude is expressed to the clients, patients, and family members for all that they have taught me about observation and life. And lastly, thanks to my son, Sam, for his love and support.

CONTRIBUTORS

Patrick Finn, PhD, CCC-SLP

Professor

Communication Sciences and Special Education

University of Georgia

Athens, Georgia

Marisue Pickering, EdD

Professor Emerita

Communication Sciences and Disorders

University of Maine

Orono, Maine

REVIEWERS

Plural Publishing, Inc., and the author would like to thank the following reviewers for taking the time to provide their valuable feedback during the development process:

Katharine Blaker, MS, CCC-SLP

Clinical Instructor
Department of Speech & Hearing Sciences
University of New Mexico
Albuquerque, New Mexico

Jacqueline Busen, AuD, CCC-A, FAAA

Clinical Assistant Professor
Department of Speech and Hearing Science
Arizona State University
Tempe, Arizona

Barb Cicholski, MA, CCC-SLP

Clinical Assistant Professor
Speech, Language, and Hearing Sciences
Purdue University
West Lafayette, Indiana

Cheryl D. Gunter, PhD, CCC-SLP

Professor and Chairperson
Department of Communication Sciences and Disorders
West Chester University
West Chester, Pennsylvania

Holly S. Kaplan, PhD, CCC-A

Clinical Professor
Communication Sciences & Special Education Department
University of Georgia
Athens, Georgia

Jeanne McMillan, EdD, CCC-SLP

College of Health
Department of Speech Pathology and Audiology
Ball State University
Muncie, Indiana

Emily Patterson, AuD, CCC-A

Clinical Assistant Professor
Department of Speech Pathology and Audiology
Marquette University
Milwaukee, Wisconsin

Deborah Rainer, MS, CCC/SLP

Clinical Coordinator/Senior Lecturer
Department of Communication Sciences and Disorders
Baylor University
Waco, Texas

Gayatri Ram, PhD, CCC-SLP

Assistant Professor
Associate Director of Clinical Education
Pacific University
Forest Grove, Oregon

Bess Sirmon-Taylor, PhD, CCC-SLP

Associate Dean of the UTEP Graduate School
Associate Professor of Speech-Language Pathology
University of Texas at El Paso
El Paso, Texas

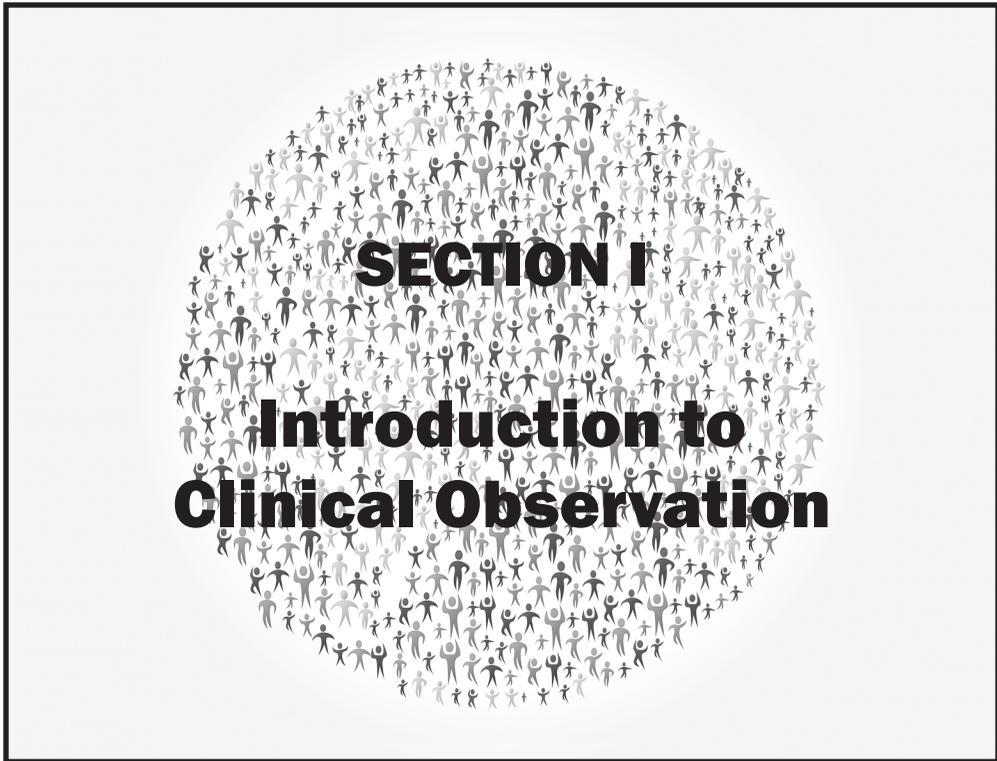
Caterina Staltari, MA, CCC-SLP

Director of Clinical Education
Department of Speech-Language Pathology
Duquesne University
Pittsburgh, Pennsylvania

Denise Stats-Caldwell, MA, CCC-SLP

Clinical Associate Professor
Speech and Hearing Science
Arizona State University
Tempe, Arizona

*To my father, the original master physician, who walked the talk—
reminding me that the provision of quality clinical care requires life-
long learning: “That’s why they call us practitioners . . . we’ll never
know it all . . . but we will always be practicing and learning.”*



Observational skills, honed through experience with the literary and visual arts, bring together in a timely manner many of the goals of the medical humanities, providing thematic cohesion through the act of seeing while aiming to advance clinical skills through a unified practice.

—Wellbery and McAteer (2015, p. 1624)

We begin with an introduction to clinical observation. This overview embraces a philosophical orientation in which observation is elevated to a process of clinical practice. We use an historical approach in which we review work conducted on the development and use of keen observational skills in health care disciplines, in particular, medicine. The rationale for looking back within the medical field is, primarily, because that is where the literature leads us. Interestingly, the history of medical education, the instruction and guidance of future physicians, includes a great deal of philosophy. And those in charge of the knowledge and skill development of future physicians have put considerable effort into conceptualizing and carrying out their responsibilities. We would be remiss not to take advantage of their work.

Second, this section scaffolds the pursuit of observation onto a framework for organizing what it is we see, hear, and touch. That organization is grounded

in a humanistic approach to understanding communication behavior and its disorders. The reader is introduced to the World Health Organization's (WHO, 2001) International Classification of Functioning, Disability, and Health (ICF) and the biopsychosocial model. We explore how to interpret what it is we observe using these lenses.

Importantly, the reader will want to make note of the author's viewpoint. As a practitioner and an educator, I feel strongly that a broad perspective on clinical matters is of great value. None of us can *know* the experience of another, but all of us can take the time to *appreciate* it. The more we seek to expand our own world views and ways of thinking, the better equipped we will be to do what is best for our clients/patients/students. Whether it is a youngster having just immigrated to my community from Somalia, a 95-year-old veteran seeking help for a hearing loss, a parent with a toddler recently diagnosed with autism spectrum disorder, a young adult recovering from a car accident, or a third-grader who is working on written language, we bring our *best* by devoting both the *art* and the *science* of our profession to each one.

1

The Art and Science of Clinical Observation

Chapter Outline

- I. Introduction to Process of Clinical Observation
 - A. Using Inductive and Deductive Reasoning
 - B. Developing Hypotheses
 - C. Scientific Evidence and Intuition
- II. An Historical Perspective
 - A. Clinical Observation in Medicine
 - B. Clinical Observation in Communication Sciences and Disorders
- III. The Importance of Clinical Observation in Developing the Master Clinician
- IV. A Paradigm for Guided Observation
- V. Chapter Summary
- VI. Chapter Observations and Exercises

Learning Objectives

- The reader will learn to view clinical observation more broadly than just looking for signs of a communication or swallowing disorder, using models and principles from medical education.
- The reader will learn four levels of observation and eight principles of observation.
- The reader will learn American Speech-Language-Hearing Association's (ASHA's) requirements for clinical observation.
- The reader will learn about humanism in clinical practice.
- The reader will learn about arts-based and visual thinking strategies for enhancing observation skills.

We need to be systematic and rigorous at the same time that we are intuitive and empathetic.

—Berger (1980, p. 356)

Introduction to the Process of Clinical Observation

Clinical observation is more than looking and listening for particular signs or symptoms. It includes more than jotting some notes or transcribing behavior. It is a process, a process that brings together personal beliefs, academic knowledge, and clinical experience with a context that includes the perspectives, values, and needs of clients and patients and their families. Because the process of clinical observation relies on the development of well-honed skills, it must be practiced again and again. And it must be grounded in a sound philosophy supporting clinical practice.

Using Inductive and Deductive Reasoning

Manton (2004) explains that being skilled at observation involves much more than having the knowledge set. When conducting clinical observation, both inductive and deductive reasoning processes, as well as intuition, are involved, and the interaction of these processes with scientific knowledge and past experience goes into describing what is observed, using inference and interpreting multiple components of the clinical picture. The process of inductive reasoning, sometimes thought of as “bottom-up” thinking, involves the bringing together of parts to explain a whole or to support a conclusion (depicted in Figure 1-1). Typically, observations are made through which a pattern may be detected and we develop a tentative hypothesis on the basis of that pattern. We then test our hypothesis within the realm of available theory. In clinical observation, this might be likened to identifying signs or symptoms, collecting data on specific components of communication, and comparing this information to what is understood to be the norm for a particular culture. In contrast, deductive reasoning, or “top-down” logic, applies theoretical knowledge to hypothesis testing, often employing a set of rules or laws (or deductions) to come to a true conclusion. Figure 1-2 presents the process of deductive reasoning.

As an example, with inductive reasoning, one might use the following observations in determining an hypothesis of possible deafness:

- a. The child is older than two years.
- b. The child has been exposed to appropriate language models in her environment.
- c. The child does not respond to her name.
- d. The child uses gestures, body language, grunts, and cries to make her needs known.
- e. The child enjoys playing interactive games.

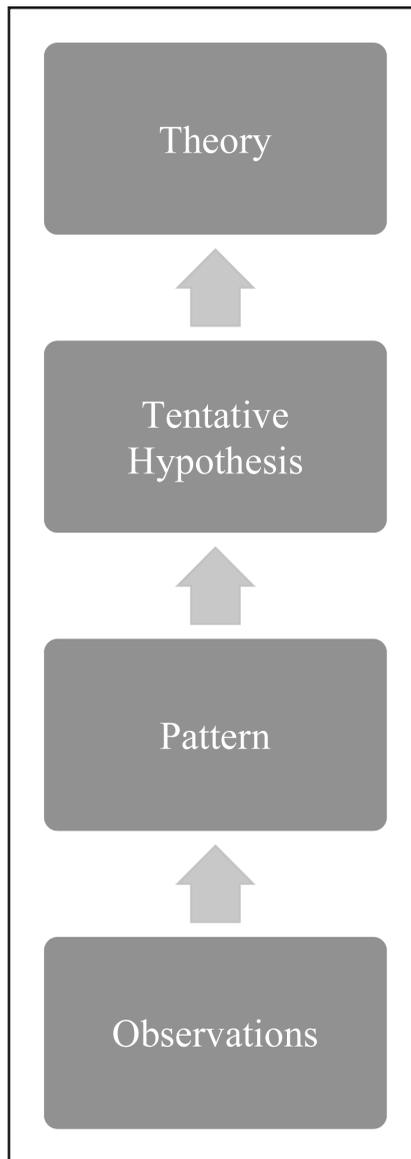


Figure 1-1. Inductive or “bottom-up” reasoning.

In contrast, a deductive process of clinical reasoning, albeit faulty, might look like this:

- a. All children with autism spectrum disorders have impairment in social skills.
- b. This child has social skills impairment.
- c. Therefore, this child must have an autism spectrum disorder.

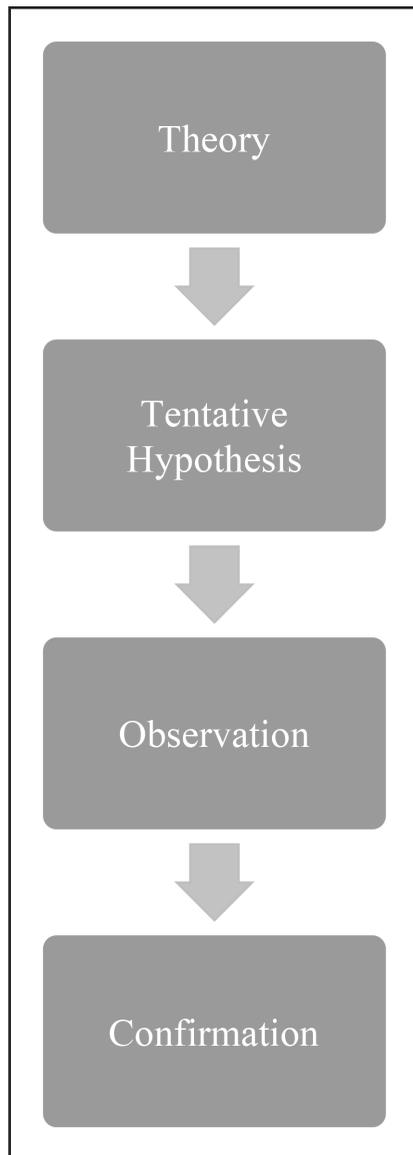


Figure 1-2. Deductive or “top-down” reasoning.

Developing Hypotheses

Using these processes in making observations allows the skilled practitioner to develop multiple hypotheses regarding the clinical picture into which she or he can integrate scientific knowledge and clinical experience. Hypothesis testing and using multiple methods of reasoning embody the “science” of communication sciences and disorders (CSD). In using the steps of the scientific method, we employ a standard practice that allows us to carefully scrutinize our

evidence in the context of what is to be expected and in comparison to appropriate normative information.

Scientific Evidence and Intuition

Intuition, on the other hand, is not rooted in the science of the discipline. It is largely an instinctive, rather than consciously reasoned, process of assigning meaning. When we use intuition as a guide, we rely on a “gut feeling” or a sense of how something “seems” to be. An example of the use of intuition might look like this: We observe a child who uses echolalia and can see that its use does not facilitate communication. Thus, we intuit something is awry with the child’s communication on the basis of the presence of the echolalia. The intuitive process may be quite familiar, and some clinicians may rely on it in decision making; however, intuition is not the same as clinical judgment. The use of clinical judgment is dependent on the development of expertise, a component of evidence-based practice. As a discipline in which best practices are expected to be evidence-based, CSD does not condone the use of intuition in clinical work. Therefore, it is important that future clinicians learn to recognize the ways in which we might approach clinical decision making, and work to hone those skills that align with best practice philosophies. In Chapter 3, we explore the various ways in which we might explain beliefs, behavior, and feelings that are developed over the course of personal and professional growth and how those “Ways of Knowing” fit into observing clinical practice.

Thus far, I have attempted to introduce the reader to the art and science of CSD. Often, it is the integration of these components that can be shortchanged, circumvented, or left out altogether, allowing the clinician to miss the mark on diagnosis and/or treatment. Although there may be truth to the adage that experienced clinicians know what they see and those with less experience may see only what they know, there is no guarantee that only with experience does one develop expert skill at observation along the way to becoming a master clinician. Certainly, experience is of considerable value, yet those clinicians new to the field may have a certain advantage in that they will be fresh from having their skills scrutinized, critiqued, and sharply honed. Thus, whether you are a clinician with many years under your belt, a student just beginning the journey, or a newly minted practitioner, your skill at observation is likely to be the most important tool in your clinical repertoire.

There is good reason why the education and training of communication disorders professionals include attention to both knowledge and skills. Practitioners in the disciplines of audiology and speech-language pathology are expected to amass a substantial amount of critical knowledge regarding human communication and swallowing processes, potential impairments, etiological factors, signs, and symptoms, as well as elements of diagnosis and intervention. And, of course, the treatment of communication impairments is not reliant solely on that knowledge. Rather, clinicians must develop and practice the myriad clinical skills essential to quality clinical care. One of the first steps toward obtaining and mastering