

Issues and Directions for the Future-
Training in Aphasiology: Windows
in the Crystal Ball

Leonard L. LaPointe
Arizona State University, Tempe, Arizona

INTRODUCTION

The focus of this paper will be on training and preparation of those who would deliver services to people with aphasia. In our initial contact on the matter, Dr. Duffy requested a statement that would address issues considered important to the status of preparation and training several years from now. By implication, such a statement would allow inferences about the adequacy of current preparation.

Blunders of Forecasting. Through the ages, the exploration of future possibilities and the making of decisions that are designed to influence the future have been carried out in a casual, intuitive way, and not without blunder. When questions were raised about the future, people consulted relatives, friends, and various authorities in hope of understanding or predicting what might happen (Cornish, E., 1977).

This is not without peril. Cornish (1977) gives some instructive examples of forecasting blunder (p. 107). Let me tell you about three. In 1486, about 500 years ago, (It seems like only yesterday . . .) a committee was organized at the command of King Ferdinand to study the plan of a young Italian to sail west to the Indies. After four years of work, the committee, headed by Fra Hernando de Talavera, reported that such a voyage was impossible for the following reasons:

- 1) The Western Ocean is infinite and perhaps unnavigable.
- 2) If he reached the Antipodes (the land on the other side of the globe from Europe) he could not get back.
- 3) There are no Antipodes because most of the globe is covered with water, and because Saint Augustine said so.

Forecasting blunders also include the conclusion by Thomas Tredgold, a British railroad designer, who declared in 1835, "Any general system of conveying passengers -- at a velocity exceeding 10 miles an hour, or thereabouts -- is extremely improbable."

In another example two years later, the surveyor of the British Navy, Sir William Symonds, declared the screw propeller useless for driving steamboats. "Even if the propeller had the power to propel the vessel," Sir William argued, "it would be found altogether useless in practice, because -- the power being applied in the stern -- it would be absolutely impossible to make the vessel steer" (Cornish, 1977, p. 107).

These examples, and additional historical evidence, lead one to approach the task of forecasting on tiptoe; therefore, I will confine my speculation simply to illuminating issues that may well undergo revision in the future.

PAST CLINICAL APHASIOLOGY CONFERENCE
ATTENTION TO TRAINING ISSUES

A bit of attention has been given to the issue of training in aphasiology at past Clinical Aphasiology Conferences. But not much. In 1975 Leutenegger presented his views on training aphasiologists. He outlined what he perceived as major training problems in the areas of neglect in the basic curriculum,

case availability for practicum experience, currency of teaching skills at the university level, limitations of traditional degree systems, and the broader issue of whether or not aphasic adults were getting appropriately trained clinicians.

Two subliminal questions that permeated Leutenegger's paper and subsequently a discussion of student training chaired by Lemme in 1977, seemed to be:

1. What does the student need to know?
2. Does the profession know what the student needs to know?

The discussion chaired by Lemme (1977) grappled with several ideas; the "generalist-specialist" debate; innovative training models that seemed to work; and a few possible solutions to our training dilemma. This discussion concluded with the observation that the Clinical Aphasiology Conference, despite its rather informal organizational structure, would be the most appropriate group to develop models, criteria, requirements, and guidelines for training aphasiologists. A specific recommendation included formation of an ad hoc CAC committee to apply for a grant to develop a position paper on training needs. In apparent realization of the fears of Lemme and her colleagues about the gossamer organization of the CAC, so far that grant has remained unfunded, the position paper is in a state of pre-conception, and the committee charged with the task is unaware of its appointment.

A final nod to training was attempted in 1979 and summarized by Lewis. Discussion emphasized shortcomings of clinical practice provided in university speech and hearing clinics; revamping of university-based clinical preparation in favor of an "environmental" model; and limitations of current methods of competency assessment.

A group of our colleagues recently reviewed preparation and training in our profession in considerable depth; and their deliberations were published in the Proceedings of the National Conference on Undergraduate, Graduate, and Continuing Education (Asha Reports #13, 1983). This meticulous introspection lasted three years, and over 120 professionals deliberated on major phases of the problem that focused on needs identification, needs analysis, and discrepancy identification. The climax of this work was the convening of a national conference to recommend educational strategies for the future. My views are influenced heavily by results of this conference, with the additional specific evaluation of needs unique to aphasiology. This undertow of emphasis toward aphasiology is colored by the opinions, criticisms, longstanding gripes, and needs, articulated by some of you, the practitioners and trainers in clinical aphasiology. What I shall attempt to do is extract those issues considered at the national conference that are bound to our unique concerns.

Time restrictions will not permit complete analysis of each issue, but I believe that the identification of aspects of preparation that deserve analysis and possible revision is worth effort.

Undergraduate Education. One of the criticisms of undergraduate education in our field is that we have moved toward a vocational training orientation at the expense of strong education in liberal arts and sciences. This is evident not only in our self-study reports (Ericson, 1983, p. 20) but in our nomenclature. Our frequent references to "training institutions," "training programs" and to some students as "trainees," may be responses to the developing and widespread cry for "immediate relevance" and the development of job skills, at the expense of emphasis on educational breadth. The risks inherent in this trend are great. We may be preparing undergraduates who are undereducated. There is a great deal of sympathy for the belief that a fundamental objective of undergraduate education must retain the goal of ensuring that students

acquire a balanced knowledge base regardless of the area of specialization. In an applied behavioral science such as ours, there is no doubt that technique-oriented preparation deserves a place in the curriculum, but if we are to graduate thinking, roundly- and soundly-educated people at the undergraduate level, we must focus a little more on Plato and a little less on Play-Doh.

Graduate Education. The national conferees arrived at a number of conclusions regarding graduate education that would be easy for aphasiologists to endorse; for example, the need for strengthening the theoretic and scientific base of graduate education. Few would disagree with this endorsement, given the concern by some regarding the decline of the overall quality of typical graduate students enrolling in our programs (Kent, 1983); and given the desire to avoid turning out a profession of kit-users and recipe-followers. Preparation of generalists rather than specialists at the graduate level was strongly favored by participants at the national conference, but this concept may not be embraced as fervently by the group in this room.

How do students in our field select a graduate school? A recent survey by Conden (1983) contains a few surprises. In a list of twenty-nine factors, the number one ranked reason for selection was the perception of practicum facilities. This should tell us something about the importance of clinical training in attempts to market our graduate facilities.

Specialty Training. Specialty training is an issue that cuts more to the core of what is right or wrong with preparation of clinical aphasiologists, than just about any other single topic. While we endorse broadly educated generalists, no one denies the information explosion or denies the need for a concentrated area of specialty study in order to deliver quality service to people with aphasia. We, as a group, must nurture and advocate the critical need for specialty training for those who would work with the dyssemantic and the dyssyntactic. This is not an area for undertrained moon-lighters or part-time dabblers. In my view, the issue is not whether or not specialty training is necessary, but rather the appropriate time, vehicle, location, and amount of such preparation. Alternatives to practicum training and specialty preparation are sorely in need of analysis. Formal recognition of specialty training is a more complicated matter. National conference participants expressed general support for the endorsement of specialty recognition for disorder areas rather than setting; for continuing education as the primary means for developing specialty skills, and for the evaluation of clinical competencies in areas of specialization. This is an area that I believe will be much more clearly in focus a few years from now. Clinical aphasiologists can provide a strong impetus toward changing our national standards on specialty training. I believe we have a strong obligation to do so; but so far our unified voice has been silent.

Clinical Training. Little doubt seems to exist that current minimal requirements for clinical training are inadequate. In an oft-quoted essay on what he perceived as the neglected obligation of clinical training for full time clinical service, Darley (1969) estimated that the average physician has had first hand experience with about 35,000 patients before becoming an independent practitioner. In comparison, one of our master's degree graduates can get by with 300 hours of clinical practice, none of which are required to be in the area of adult language disorders.

The solution seems obvious; extend and intensify clinical training, but the answer is complicated by a network of growing economic and pragmatic factors. Few students are going to be willing to bury themselves deeper in student loans and stretch their stress longer, if the reward is a \$15,000 a

year job that requires the care (and these days quite literally, the feeding) of eight patients a day.

Most writers who have analyzed our clinical training needs, agree that practicum requirements must be greatly expanded. As Loavenbruck (1983) suggested, the best training for reality is probably longer stretches of reality and this translates to more extensive residency requirements and reanalysis of the clinical fellowship year, including the abolishment of CFY slave-labor. CFY's are increasingly in need of a Lincoln, and it is high time our profession considers emancipation.

Additionally, we may have to look critically at vehicles for externship training and consider reimbursement of externship supervisory personnel, if we are to expect high quality clinical environmental preparation (Ehrlich, Merten, Sweetman, and Arnold, 1983). As with so many issues, Darley (1969) seemed to capture the essence of this one as well. He stated:

Our goal is the provision of first-rate patient care. How are we to achieve it? By bolstering, enriching, and increasing experience under the watchful eye of master clinicians in settings that provide interprofessional stimulation and influence, together with making a scientific attack on real life questions that grow out of that clinical situation. . . . (p. 148).

It seems to be transition time in clinical training in our profession, and those of us in aphasiology would do well to try to shape some policy.

The Professional Doctorate. This is not the forum for a thorough exploration of the issue of the professional doctorate in our field except to indicate that it has met with mixed reviews in other professions. The debate is on, and sound arguments are heard on both sides. In the recent national conference, the Ph.D. was affirmed as the appropriate doctoral degree for the discipline of human communication and its disorders, although some interest in a professional doctorate was expressed (Rees, 1983). Some would argue that the conference was top-heavy with delegates from traditional academic environment; and therefore those who favor a professional doctorate were inadequately represented. In the ensuing years we must listen to the arguments with care, weigh the relative merits, and choose a course that will not dilute the image of our terminal degree in the minds of other professionals.

Research Preparation. The issue of the clinical or professional doctorate is vitally linked to another crucial topic, and that is research preparation of our practitioners. I would simply call your attention to the recent words of Kent (1983) on this issue, for he highlights concerns about the erosion of our scientific base, and the dangers of further dilution of research preparation. Kent's words (1983) seem as though they were spoken in a canyon, for in them we hear echoes of sentiments that have been expressed at past Clinical Aphasiology Conferences; particularly regarding preparation to conduct single subject clinical experimentation.

OTHER ISSUES: ASSURING CONTINUING COMPETENCE, EXTERNAL INFLUENCES, PREPARING FOR A CHANGING SOCIETY

A swarm of other issues that are relevant to academic and clinical preparation no doubt also could be identified and dissected. These include the tricky task of assuring continuing competence; reacting to external influences; and preparing for a changing society. These issues were not neglected by the national conference, and we must seek those aspects that directly affect preparation in aphasiology. We cannot afford to perpetuate eyebrow-raised naivete about third-party reimbursement, the unique needs of underserved special populations, or the integration of advancing technology into our clinical practice.

Surely, there are other issues as well. But our job is clear; and a bit frightening. We must engage in a protracted and relevant exercise in needs identification, needs analysis, and discrepancy identification related to academic and clinical training in clinical aphasiology. As we engage in this process we must have our fingers squarely on the pulse of the needs of the consumers, those whose lives have been wrenched by communication loss. We also must listen more to the specific needs voiced by students, recent graduates, and experienced practitioners, as expressed in this recent survey of needs of speech and language pathologists in a medical setting (Waller and Murphy, 1983). None of us knows exactly what the future holds or what our changing society will dictate to us. Crystal ball gazing is an inexact science to be sure. But certainly we can agree with the attitude of not getting stuck in traditional ways of doing and thinking (Rees, 1983). Review and the implementation of necessary changes in academic and clinical training is vital for a number of reasons; not the least of which, as someone chillingly reminded us once before, is that the students we prepare today are the clinicians destined to treat us.

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DISCUSSION

- Q: To a certain extent there is only so much we can do, and we all have certain roles and serve certain functions. One of the things that has

begun to strike me more and more is this. We all have a certain function; we can all help each other if we're all not afraid to ask for help.

A: Sometimes it seems we spend much more time on the differences and factions of audiology versus speech pathology, traditional and experienced researchers versus neophytes, and internal debates and arguments, than we spend time in realizing that we certainly have more in common than we have differences, and your plea for communication between practitioners and people in the academic environment is well taken.

Q: You've been on both sides now. You were in the VA for a long time; you've been in a setting where students receive a lot of training; you're now in a university program training students. My question is, do you see an island of hope anywhere as the costs of education continue to go up and up and up, the knowledge base increases, the students are required to learn more in less time, and the toughest thing to face is that at the end of the road with a Master's degree is an \$18,000 job seeing eight patients a day and caring for them and feeding them. Do you see some hope, a place to begin?

A: I don't know if it's exactly related to academic preparation and education issues, but I do see a few rays of hope; one of which is the trend toward the establishment of a firmer foundation of private practice in our profession. I think with that will come the elevation of the attitude that we need to be paid for the services we render, and that we are not merely deliverers of good cheer. I see that as one ray of hope, and it should have a lot of spin-offs.

Q: What do you think about changing the entry level requirements to the Ph.D., like the neuropsychologists -- the same respect, the same pay scale, etc. Not the professional doctorate, but the entry level requirement. I realize it's a massive change, but we've talked about it at our university to some extent because we're just an M.A. program, but the kind of people we attract can't write, and are choosing between whether or not to be an OT or a teacher or a speech pathologist because it's all the same to them, so how can we expect that coming from that background that they are going to be at the same level as we are talking about here, where they are going to go out and do research and read the journals and command that kind of respect? It's an 18-month program and after that we get to be an M.A. and go out and be a speech therapist. And part of what is nice about that is that it is a short-term program for the students, so it's very hard to change that within the master's framework.

A: Yes, I have struggled with that for a long time, and am grappling with it right now. I don't know exactly how I feel about it yet. If you read the literature on these introspective issues on the elevation of our standards over the last few years, one of the issues that surfaces is the very one that you talked about. There's considerable sentiment that suggests that in our altruistic efforts to elevate standards in our profession by requiring the master's degree to be the entry level degree in our field, that the folks who decided upon that made a mistake, that they should have shot for a doctorate degree. There's a sound literature that exists debating both sides of the issue. I'm sensitive to the practicalities and the logistical problems of a change, and sensitive as well to the issues on the other side of what that would do for our profession. It will be debated for a few years.

Q: I think there's one other piece in the equation we also have to deal with, and that's the responsibility that those of us who are involved in training and educating potential clinicians have, and counseling those people who are not cut out to be clinicians to get out of the field. I've been around too many students who have been encouraged to go on when they really shouldn't, because that buck is always being passed down to somebody else, and until we're willing to stand up and say "You can't and you can and you're able to and you're not," I think we're going to have this problem around for a long time.

Q: I wondered if you perhaps would take a couple of minutes to comment personally and professionally on the merit, or lack of merit, between what you see around either the Ph.D. or the professional doctorate versus specialty certification for the field.

A: First of all, relative to specialty certification for the field; for what it's worth, my personal opinion is I think it's necessary and I'm in favor of it. I think the issues are how to implement it, and defining the relevant curriculum and training. Relative to the professional doctorate in our field, my opinion is not firm on that one yet. It's changed in the last year or so. I see the merits and the risk to the image of our profession by diluting the scientific training and the scientific base of our traditional doctorate degree. These arguments are well-debated and well-spelled out in the literature by Alan Feldman and Ray Kent and Erickson and several others. But on the other hand, I can see some advantages to a field that prides itself as being primarily interested in helping folks recover from problems, of training people with a clinical doctorate who can practice and who may or may not have the traditional training in research strategies and techniques. My opinion on this issue is evolving right now.