

# Art, Meet Science: An Evolution of Clinical Reflection in Communicative Disorders

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## **Abstract:**

*This essay outlines my journey as a new professor of clinical education. I describe the importance of student reflection in clinical education within the discipline of communicative disorders and I outline the evolution of developing reflective practices for my students. As a neophyte clinical supervisor I had my students write weekly reflective papers with the same questions as prompts each time. Finding that these papers were lacking in insight and deep reflection, I devised a method of asking reflective questions very specific to each student clinician-client dyad. I found that this means of scaffolding students to deeper reflection was much more instructive and resulted in better self-reflection. Eventually I added a more aesthetic type of reflection by encouraging my students to write 17-syllable haikus to cover the essence of their clinical learning experience with one particular client over an entire semester. The use of other creative reflective practices borrowing from the arts and humanities and being infused into medical clinical education are also reviewed.*

## **Key Words:**

haiku, poetry, reflection, clinical practice, communicative disorders.

## **Introduction**

*Poetry is the breath and finer spirit of all knowledge; it is the impassioned expression which is in the countenance of all Science.*  
*Williams Wordsworth.*

In the early 1990s when I began my clinical education in speech-language pathology, the medical model was the prevailing mindset of all healthcare practitioners and educators. The people we evaluated and treated were patients, we were the omniscient clinicians who knew what was best, and we said so. A typical diagnostic session ended with "This is your problem and here's how I'm going to fix it." Over the past couple of decades, the practice of speech-language pathology has evolved into a family-centered model in which the client and caregivers are integral parts of the team.

Family dynamics, cultural background, personal preferences, and functional treatment goals that can be integrated into daily life are now part of the treatment plan. With this newer family-centered model, the clinician becomes one small piece of the bigger picture, as well as a counselor and ally of the family. That necessitates developing the habit of reflection, asking questions like: What is working? What isn't working? How do I feel about it? How are the family dynamics affecting the client and the therapy? Where are the boundaries?

I was a clinical speech-language pathologist working primarily in medical settings when I completed my Ph.D. and entered the world of academia. I intentionally chose to be at a comprehensive versus a research intensive university so that I could not only teach and do research, but also continue my clinical work, evaluating and treating clients. As an assistant professor and clinical supervisor, my weekly routine involves teaching three courses and supervising about six students in their on-campus clinical practica (each student with two therapy sessions per week), as well as a diagnostic team of three students. Being inundated with the new academic jargon and acronyms as well as syllabi construction, I was overwhelmed when my first clinical students were thrust upon me. Someone in my department let me copy a syllabus, which included a form for weekly reflection. I took it and hit the ground running.

For my first semester or two I used this same skeleton form for reflections. It included thought-provoking questions and prompts, such as:

- Discuss your client's positive and negative behaviors. How can you respond to these negative behaviors?
- What went well and didn't go so well in your session? As a result, what will you do differently?
- What clinical skills are improving? What clinical skills do you need to improve?

Those questions were all perfectly fine. However, the reflections that I was getting from my students were not. The reflections focused on objective information without attaching it to feelings and values. The writing focused on surface issues versus pithy insights and discussed individual components of speech and language versus the complex gestalt of communication. Quite frankly, reading the reflections was boring and repetitive from week to week. The reflective process was not insightful and contemplative; rather it was busywork for the students writing it and for me, reading it. I also realized that by staying at the factual content level and not digging into the bigger issues, questions, and mistakes that should naturally happen in a therapy session, that they didn't actually know how to reflect. I had to come up with a better way to get at these meatier issues, while providing a safe arena to make mistakes and ask hard questions.

I decided to start asking very specific reflective questions instead. As I observed a student clinician's therapy session, I jotted down notes and looked for exciting things that were happening that the student might not even be aware of, such as this:

**Supervisor:** When you were making (pretend) cookies, there was no spoon so you used a pen instead. How did M respond? Why is that so great?

**Student clinician:** *She pretended it was a spoon! This is great because she didn't need it to be so concrete. She didn't need a pretend spoon to pretend to use a spoon—(the pen) served the same function.*

The student realized that her young client used object substitution (a pen for a spoon) which is a crucial step in developing play skills. Pretend play is very symbolic, as is language, so play and language are developmentally and cognitively quite interconnected. Sometimes students get so focused on the goal of language that they forget to notice the little, but important steps necessary along the way. By using a reflective question to draw this student's attention to a very small event in the context of the session, she was able to reflect upon its importance.

I also used reflective questions to get students to apply academic knowledge to their clinical thinking.

**Supervisor:** She's responding to your cue to say "bone," but she's prolonging the vowel more than she's putting the /n/ on. Why might she be doing this?

**Student:** *I wasn't quite sure so I went back to watch it again. Most of the final consonants she has produced have been stops such as /p, t/. The /n/ continues from the vowel differently than the /p/ where there is more of a difference between the two productions. I'm not sure if this is the reason, just a thought. The /n/ might be hard to tell when it stops and starts from the /o/.*

**Supervisor:** The second one. The /o/ carries a lot of acoustic energy and is very well co-articulated into the /b/ and /n/. Sometimes the /o/ seems the most emphasized and/or is sustained a bit longer.

The interesting thing about this written dialogue is that the student took the initiative to go back and watch video of herself and reflect upon her performance from an outside perspective. Furthermore, she felt safe enough to answer with "I'm not sure...just a thought." I could literally see her wrestling with these concepts. She knew it was okay to be unsure of her thoughts and that we would banter to back and forth to discuss possible reasons. That's the "hot spot" of learning or the Zone of Proximal Development (ZPD). Vygotsky (1978, p. 86) defined the ZPD as "the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance, or in collaboration with more capable peers." This student was thinking about concepts that were not well-developed internally, but that she could figure them out with some scaffolding and input from others. She was actively constructing meaning from reflecting on her clinical experience.

Additionally, reflective questions proved beneficial for developing the fledgling self-esteem and clinical competence of neophyte clinicians and enabling them to begin to view themselves as skilled professionals.

**Supervisor:** So...what was the difference between you reading the book and Mom reading the book? Why did they turn out so differently?

**Student:** *I feel like I had Sara's attention longer when I read the book. When she pushed the book away, I pulled it back and got her re-engaged. I also made her sit in my lap. When she left, I brought her back and kept reading. It seemed like*

*as soon as Sara was done with Mom, Mom just let it go and started show 'n tell with Sara (i.e., Can you blow kisses?). I also played in the book whereas Mom mostly labeled pictures. Sara and I popped balloons and jumped on the pillows. Mom labeled "steps" and "clock." Mom and I both used short phrases, but I felt like I exposed her to more language. I used repetitive phrases, but switched the words (pop, pop, pop; pop the balloon; yellow balloon). Mom tended to read the words in the book.*

The exciting thing about this reflection was that the student recognized that she had some skills to offer the parent. Often times student clinicians are very intimidated about teaching parents how to interact with their children and stimulate language development. Students frequently feel that because of their younger age, lack of life experience, and the fact that they are not parents themselves that they don't have much to offer. This reflection enabled this student to see herself as a competent provider of services and a suitable educator to teach the mother how to engage in more effective storybook reading activities with her daughter.

I felt that I had finally found a way to get my students thinking more deeply and reflectively about their therapy sessions in a meaningful way that evoked change. Feedback from student evaluations, as well as casual comments in clinical meetings, reinforced this Q & A method of reflection as a teaching tool. I also made sure that it wasn't busywork in that they didn't have a reflective question every session. I just wrote one for them to answer as the questions and opportunities naturally occurred. Some days there would be no reflective question and other days I would write two or three of them. They were never graded, which I think helped to encourage a more open dialogue and more reflective risk-thinking. Often the reflections were true "think-alouds" on paper.

At the 2011 Summer Institute for the Wisconsin Teaching Fellows and Scholars, Jessica van Slooten, an English professor colleague at the University of Wisconsin-Manitowoc, introduced the group to the high-impact practice of writing haikus as a means of reflection. All of the fellows and teachers begin to write haikus throughout the Summer Institute as a way to process the learning that we were experiencing. Jessica explained that haikus are reflective in their very nature because one only has seventeen syllables in which to express oneself. Therefore, the haiku writer must be very selective and thoughtful in choosing those precious few syllables and having them convey a strong message and image in just a few words. As a lover of literature and poetry I knew that I would bring this reflective practice back to my student clinicians as well. Furthermore, in my research on reflections in clinical education, mostly medical and nursing students, I learned that implementing artistic means of reflection had been done before with success. Law students engaged in the art of story-telling (Tyler & Mullen, 2011), clinical nursing students used narratives, art, and poetry to reflect upon learning (Wagner, 1999; La Brosse & Patel, 2011), poetry readings and discussions were employed in the education of general practice medical students (Foster & Freeman, 2008), and even haiku had been specifically implemented as a practice to engage health care practitioners in contemplating the practical and emotional issues involved in medical care (Biley & Champney-Smith, 2003). Biley and Champney-Smith (2003) found a strong and natural connection between the integration of the aesthetics of

poetry into science-based clinical education. The students found haiku to be an effective means of reflection on clinical practice and the personal feelings that interacting with other humans naturally evoked.

During the last week of summer clinical I had a wrap-up meeting with my second year graduate student clinicians. We talked about their clinical experiences, what they had learned, what their challenges and triumphs were, and how they felt about it all. After our discussion, I informed them that I wanted them to summarize their eight week practicum experience in a haiku. I reminded them that a haiku consists of three non-rhyming lines alternating with five-seven-five syllables and instructed them to begin writing. After looking at me quizzically, they bowed head to paper and began to write. There was halted scribbling followed by fingers counting syllables on the table, pencils scratching out words and revising, and occasional sighs of “This is hard!” and “But, I’m not creative.” Alas, they were wrong. As they nervously read their haikus aloud to the group, my left-brained, logical, language-analyzing student clinicians became right-brained, creative poets.

A student who worked with a toddler who threw tantrums instead of talking wrote:

*I see the wet tears  
I hear the mad frustration  
I know there is change  
(Rachael)*

This haiku was followed by an extra, unsolicited one by the same student from the mother’s point of view. The student was considering the impact of family dynamics and the possibility that the mother was overwhelmed, caring for two children with special needs.

*Am I good enough  
To help my young children grow  
In language and love?  
(Rachael)*

One student did therapy with a child with Asperger’s syndrome. She was trying to teach him how to interact in socially appropriate ways and to develop his theory of mind. Theory of mind is the ability to consider the mental states and viewpoints of other people and realize that they may be different from one’s own and is a very difficult skill to teach. This student reflected,

*Difficult to start  
Full of questions to ask him  
Teaching me what's hard  
(Samantha)*

I was thrilled that she acknowledged the role that her client had in teaching her. The teacher became the student.

Most of the clients I supervise in therapy are children with language disorders. My theoretical viewpoint is based in social-interaction theories of language acquisition (e.g., Vygotsky), so my therapy focus is naturalistic, child-led, and play-based in nature. Most student clinicians have had more experience in structured, behavioral approaches and

therefore learning to follow the child in play “in the moment” and use toys for therapy instead of organized activities with pre-selected stimuli is difficult for many student clinicians. They have to re-learn how to play like a child and they have to give up control of the therapy session. One student reflected on the cognitive dissonance this created for her.

*Confused as I was  
Hard to find my inner child  
Baffled still I am  
(Kim)*

Another student embraced the notion of learning how to play and finished her haiku with a favorite catch-phrase of her client.

*Summer therapy  
I learned how to play with her  
“See ya later, babe.”  
(Kristina)*

And finally, a student expressed her distaste for remediating a misarticulated “r” by writing,

*Stressed about the R  
So difficult to teach it  
I didn't like it  
(Allison)*

That was a personal wake-up call to me because I dislike working with children who can't produce “r.” It is a very difficult speech sound to remediate for a multitude of reasons, plus my area of expertise is language. Frankly, I find working on “r” to be quite boring. I had expressed this to the student clinician, so her haiku made me reflect. Was I consciously or subconsciously projecting my feelings about certain types of therapy or disorders onto my students?

I have continued to use haiku as an end of the semester clinical reflection activity. One reason that I think it is such a good strategy, especially in clinical education of any type, is that clinical judgments and decisions are very logical and sequential. In my specialty area of pediatric language disorders in particular, much time and mental effort is spent analyzing the breakdown of language and sorting out morphological errors and their impact on semantics and syntax or perhaps, considering errant phonological patterns and their effect on social interactions and the acquisition of a personal lexicon. These are very left-brained, analytical tasks. Writing poetry encourages engagement of right-hemisphere whimsy and creativity. It marries the analysis of language with the beauty and sensuality of well-selected words. Haiku invokes the perceptual and sensory exploration of experiences and language. I am, clinically speaking, a firm believer in multi-modal instruction. Multifaceted cues, such as visual, auditory, tactile, and kinesthetic, result in more efficacious learning in the clinic. Therefore, it stands to reason that learning activities that incorporate the whole cerebral cortex, instead of focusing so heavily on one hemisphere, would lead to richer learning experiences in the clinic, as well as the classroom. I am now convinced that haiku is a worthwhile reflective

vehicle and I will continue to seek ways to bring art, poetry, music, and other creative endeavors into the clinical education of my students.

*Science, poetry—  
Logic and its muse, meshing.  
Symbiotic words.*

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