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CONTENTS

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The Transition from Graduate Student to School SLP: Student Clinicians Discuss their Work with Disfluent Children

Allison is tall and pretty with long brown hair. She is twelve years old and in the sixth grade. She is in the gifted and talented program at her school. According to my supervising SLP, Margaret, Allison is a perfectionist. She is involved in several activities including dance and orchestra and she is a straight-A student. Margaret believes that much of Allison's fluency disorder is caused by the pressure she puts on herself. Because she knows the family so well, Margaret feels comfortable saying that she doesn't believe the parents place excess pressure on Allison. Margaret feels that the problem is more psychologically based than physiologically based.

On Monday of this week I met the other member of our two-person fluency group. He is in fifth grade. I went up to his classroom to bring him down to the therapy room. He was very quiet and responded to my questions and attempts at conversation with one or two words. He has not been working with Margaret nearly as long as Allison has and he was obviously less comfortable in the therapy setting than she is. We spent time in the session just talking and getting to know one another a little bit. 'Mark' was very quiet and reluctant to answer. I heard several part and whole word repetitions while we were talking. I think Mark was on guard about his speech the minute I went to get him from his classroom. He knows that my job is to monitor how he is talking and I get the feeling he is very self-conscious about it. I did my best to put him at ease and be friendly and approachable, but I think my role as the "speech teacher" prohibits him from being really comfortable with me.

Kristin wrote this entry in her journal after her third day as a graduate student clinician in a public school. Is there a speech-language pathologist who cannot remember the feelings of promise coupled with overwhelming nervousness that accompanied his/her first days of practicum? These feelings of trepidation may be even greater when the clinician in training is faced with providing fluency therapy. Research studies (Sommers and Caruso, 1995; St. Louis and Durrenberger, 1993) reveal that even experienced clinicians may have mixed feelings about working with persons who are disfluent. Clinicians have reported a lack of confidence in this area of communication disorders that generally arises from a lack of preprofessional preparation and little continuing education in fluency therapy.

Kristin, Patty, and Diane were all students in my fluency course at Cleveland State University during the term when they each experienced their first school placement and their first childhood disfluency cases. Kristin is the young mother of a school age son, Patty is a second career student, and Diane is a traditional college student. The purpose of this article is to describe how each student clinician enhanced her practicum experience by keeping a journal that documented her own work with her fluency clients. It is my contention that the transition from graduate student to clinician is brought about not only by the acquisition of technical knowledge and practical information but by careful reflection as well. Times of transition force us to question and reappraise ourselves and our circumstances (Froman, 1994). I think that a clinician at this important stage of her career must heed the inscription at the Delphic Oracle, "know thyself." I also agree with what has been said by the Booker Prize winning novelist A.S. Byatt (1990) and maintained by the Pulitzer Prize winning journalist Donald Murray (1990) as well: "When I write I know." (Byatt, 1990, p 185). To try to facilitate heightened self-awareness, I asked Kristin, Patty, and Diane to keep a journal of their practicum experiences and of their ongoing thoughts and feelings. In this way I attempted to document a small sample of the perceptions of student clinicians during this important transitional period. While not intended as a controlled study, this information may provide both university educators, student clinicians and practicing speech-language pathologists (SLPs) with examples of how self-reflection can serve an educational function.

CLINICIANS' APPREHENSIONS ABOUT TREATING DISFLUENCY

It is well documented that many clinicians are apprehensive about treating adults and children who are disfluent. This apprehension may be due to a lack of knowledge and experience as well as to pessimistic attitudes about persons who are disfluent.

In numerous studies, both historic and more current, (e.g., Ainsworth, 1974; Cooper and Cooper, 1985; Cooper and Rustin, 1985; Mallard, Gardner, and Downey, 1988; St. Louis and Lass, 1981; St. Louis and Durrenberger, 1993; Brisk, Healey, and Hux, 1997; Kelly et al. 1997) clinicians report that they are unclear about the nature of disfluency, do not have a sufficient repertoire of therapy techniques, and may not know which techniques to apply to given manifestations of disfluency. Results of a 1983 survey by Matkin, Ringel, and Snope showed that only 48% of SLPs surveyed felt highly competent in treating children who were disfluent. Three of every 10 respondents to the ASHA Omnibus Survey (Shewan, 1991) reported that they believed themselves to be unqualified to treat disfluency. Forty-eight percent of the 149 school SLPs surveyed by Kelly et al. (1997) disclosed that they did not feel that they possess adequate skills to work with children who are disfluent. In the Brisk, Healey, and Hux (1997) study of nearly 300 clinicians, over half of those surveyed felt prepared to *evaluate* children and adolescents with disfluent speech but only half felt prepared to provide therapy.

St. Louis and Durrenberger (1993) discovered that when more than 100 clinicians ranked thirty disorders to show which disorders they prefer to work with, disfluency was one of the most disliked disorders. Some reasons for their dislike of disfluency therapy (which were also given as reasons for disliking therapy for other disorders) were related to a lack of knowledge and experience. Notably, other reasons were related to feelings of frustration, anger, fear, sorrow, being out of control, or being unsuccessful.

Sommers and Caruso (1995) surveyed nearly 200 supervisors of school programs for children with communication disorders and directors of speech pathology graduate training programs and found that increasing clinicians' preparedness to treat disfluency was viewed as the number one training need of graduate directors and the second highest training need of school supervisors. Continuing education opportunities in the area of fluency were characterized by supervisors as weak and were found by Sommers and Caruso (1995) to represent only 1% of all continuing education opportunities (see also Kelly et al. 1997). The training need reported by the graduate directors partially was attributable to the fact that students may complete a master's program without any practicum hours in fluency diagnosis or treatment. Similarly, directors of community speech and hearing centers who responded to Henri's (1994) survey indicated that new graduates applying for employment were rated as having only a fair level of preparation in fluency (on a scale of poor, fair, good, or excellent).

Several studies have disclosed that some SLPs and graduate students may have negative beliefs and attitudes that influence their perceptions of both persons who are disfluent and of disfluency as a disorder (Yairi and Williams, 1970; Woods and Williams, 1971; Cooper, 1975; Woods and Williams, 1976; Turnbaugh, Guitar, and Hoffman, 1979, 1981; Silverman, 1982; Horsley and FitzGibbon, 1987; Lass et al. 1989; Brisk, Healey, and Hux, 1997). Most of the authors of these studies report that some clinicians hold beliefs that persons who are disfluent are timid, nervous, frustrated, avoidant, introverted, and otherwise socially inept and insecure. This type of stereotyping may be widespread. For example, responses to several different questions posed by Cooper and Rustin (1985) show that from 33% to 66% of the clinicians surveyed confessed the belief that persons who are disfluent have particular attributes, such as psychological problems or feelings of inferiority. Such beliefs are sometimes nothing more than projection on the clinician's part. Kelly et al. (1997) suggest that a clinician may retain unsubstantiated beliefs if he/she does not acquire sufficient academic knowledge and clinical experience to dispel misconceptions. Clinicians who responded to the survey conducted by Kelly et al. (1997) indicated that they sometimes have trouble managing their personal feelings as well as helping clients deal with their own feelings. As a result, many SLPs would prefer to treat persons with disorders other than disfluency.

Dopheide (1987) and Brisk, Healey, and Hux (1997) suggest that a prepared clinician would know how to individualize disfluency therapy for each client and would approach therapy as a collaboration between the client and the clinician. The client and clinician could both develop feelings of confidence that would be borne out of their collaborative attainment of several milestones: confronting and working through the client's negative feelings; desensitizing both the client and clinician to the client's problem; developing a sense of being an authority on the problem of disfluency; and accepting the degree of resolution of the client's disfluency problem that is achievable. S. Louis and Lass (1981) assert that a disfluent client should be able to expect his clinician to offer empathy, honesty, caring, authenticity, open-mindedness, and advocacy.

These affective qualities are separate from and in addition to the technical competencies in diagnosing and treating disfluency that should be learned by a successful graduate student. How might it be possible to teach the graduate student clinician to learn to recognize any negative feelings that they may harbor about disfluency, confront any feelings of inadequacy that they may bring to the fluency practicum, and learn to recognize the specific strengths and skills that they possess that will help them develop competence, confidence, empathy, and authenticity?

REFLECTIVE WRITING: WRITING TO ENCOURAGE THINKING, CONNECTING, DISCOVERING

Reflective writing, which is often done in a journal, is a well-known technique for facilitating personal growth and self-expression (Baldwin, 1991). When used in the context of a practicum, the journal can supplement the students' learning process by pro-

viding a forum for critical thinking about clinical experiences and course material. Journals provide an outlet for documenting observations, posing questions, speculating, developing self-awareness, and gaining insights for problem solving (deAcosta, 1995). Journaling is popular in the fields of teacher education (Isakson and Williams.1996) and English education (Fulwiler, 1987) as a technique for helping learners organize their thoughts and analyze and synthesize ideas. Its use is documented in the preparation of SLPs (Cluver, 1988). Journals may form an important component of student portfolios as well.

Journals allow a learner in transition to exercise a certain amount of constancy while adapting to change. Demick and Nazzaro (1994) describe how an individual adapts to a new environment. Environmental psychologists have defined three aspects of person-in-environment transitions:

1. a change in physical environment;
2. a change in sociocultural roles; and
3. a change in interpersonal roles.

The graduate student clinician finds him/herself in a new place (a school), with a new sociocultural role (a school system representative who must be responsive to parents, coworkers, and administrators), and with a new interpersonal role (clinician working with children). Student clinicians must adapt cognitively (i.e., apply the knowledge and skills they have learned at the university), affectively (put aside one's own motives and needs in favor of meeting student clients' needs), and valuatively (take on the school's rules, schedules, deadlines, priorities, and values).

All events in life occur for a specific duration but the durations of few events are within our control. The duration of a transition period is often hard to alter. But journals exist for any duration that we desire. Keeping a journal can lend stability and predictability during a stressful or transitional life event—it's always there when we need it to be.

For the reflective writing and journals assigned in my course, the students were encouraged to describe what they observed and experienced when working with children who are disfluent. I asked them to analyze the client's behaviors but, more importantly, I asked them to analyze their own thoughts, feelings, and behaviors. Not only were they to get to know the child, they were to get to know themselves in relation to their work with these children. They were also to look at the importance of context in the creation of competence—both theirs and the children's (Kahaney and Heinrich, 1994). I suggested that they write about any critical incidents but not wait for something special to occur. They were to write twice each week about what they were perceiving and learning about the interactive and interpersonal nature of providing fluency therapy. They were to reflect and connect theory to practice—to apply readings and lectures to everyday life. External, formal sources of knowledge remained important but their primary task was to look within themselves to discover more about what they know (Merriam, 1994). I asked them specifically not to write any assessments of the children, any progress notes, or any outcome statements where they would need to be objective and uninvolved. The purpose of the assignment was for them to be involved and to reflect upon themselves in their new context.

STUDENTS IN TRANSITION: THEMES FROM THEIR REFLECTIVE WRITINGS

Patty, Kristin, and Diane produced a considerable amount of reflective writing during the fluency course. I have analyzed their journal entries and other pieces and discovered that their expressions centered around the following themes: thinking about the children, finding similarities between clients and themselves, connecting theory to practice, professionalism, and accepting ambiguity.

THINKING ABOUT THE CHILDREN

Often student clinicians put so much effort into thinking about how they will provide therapy for children that they seem not to consider that children spend most of their lives outside of therapy. Kristin devoted much thought to considering how Allison's and Mark's disfluencies are a part of them as individuals:

> I sat in the therapy room with Margaret (my supervisor) and Allison for about 15 minutes and I heard only two short initial sound repetitions. By far, most of Allison's speech was fluent. I wonder how disfluent Allison is in other situations and how the disfluencies affect her. ... Dr. Pershey and I discussed the possibility that she was malingering and Dr. Pershey told me some behaviors to look for ...

Later she wrote:

> I have finished going through Allison's file and I am fairly convinced that she is suffering from a true fluency disorder. For a while I considered that she might be malingering, but having seen the length of time this has been an issue and reading through evaluations of her fluency, I believe it is truly a disorder ... She knows the techniques to use to increase her fluency, the trick now is to get her to use them outside of the therapy setting.

It is important that Kristin transitioned from wondering what psychological disturbances might be behind Allison's continued disfluency to determining that carry-over of fluency enhancing speech behaviors was actually Allison's need. Rather than holding on to psychological stereotyping, Kristin was able to look at the child's current behavioral status and make recommendations on how intervention should proceed. Would it be poetic justice that she later wrote:

> Margaret told me that she would really like me to push Allison ... I am considering having her keep a journal of her experiences with her fluency. She tends to deal with the disfluencies by barreling right through them without using any of the strate-

gies she has been taught. I think that a journal might force her to be more conscious of her disfluency. I would like her to figure out what situations she has more difficulty with and what her stress levels are like when she is disfluent. Ultimately I would like her to be able to use that information to prepare herself for situations in which she might be disfluent.

Continuing to think about the children, Kristin also wrote:

> Mark has grabbed my sympathy much more than Allison for two reasons. One is that I can already see that his disfluencies are much more severe than Allison's, and two, he is dealing with his problem by pulling into himself and not talking. He seems like such a sweet kid and I hate for him to pull back and not want to interact with people. The mother in me wants to take him and make it all OK— if only I could! This is only the beginning of his second school year seeing Margaret and I hope I will be able to see some differences in him as the semester goes on.

Diane's writing characterizes Charles:

> It has not been determined whether certain symptoms (nervousness, orderliness) cause Charles's disfluency or whether his disfluency causes him to experience symptoms of anxiety. Assessing Charles's physical habits and emotional traits was difficult. Despite Charles's history of developmental delay, he is certainly a bright, intelligent child. While he was aware of and bothered by his disfluency, and while he wanted therapy, his orderly, nervous personality characteristics often made therapy difficult and less productive. His tendency to hurry through the fluency exercises and his worries about missing regular classroom work required my constant reassurance as well as cooperation from his teachers and parents.

Patty wrote about her case:

> I have a six and a half year old male on my case load. My supervisor already tested him and determined he needed articulation therapy. During the second week of school, his mother expressed a concern that Mitchell had begun to stutter ... We agreed to observe Mitchell during therapy and in his classroom. We continued to be baffled by his inconsistent fluency. Finally, we discovered that Mitchell's parents were going through a divorce ... Mitchell's mother agreed to talk to the school psychologist.

FINDING SIMILARITIES BETWEEN CLIENTS AND THEMSELVES

Clinicians learn that therapeutic relationships cause us to walk a fine line between attachment and detachment. Without attachment, empathy, consideration, "going the extra mile" might never occur. In the worst case, the client could be viewed as "the other," someone who is so unlike ourselves that a lesser set of rights or entitlements might apply. Without detachment, counter transference could render the clinician unable to function objectively. Each student has explored her attachments. Kristin wrote:

> In many ways I identify with Allison. She reminds me quite a lot of me at that age. She always has her nose stuck in a book and she is a little awkward socially. I can remember all too well how it felt to be twelve years old ... She will have enough to deal with without having the additional worries about her fluency.

Although Diane's prose objectifies her attachment, her feelings come through nevertheless:

> Empathy is a valuable asset in a clinician's attempt to treat a disfluent client. Walking that mile makes us not only more understanding human beings, but the process better prepares us to make suggestions that might expedite and assist a client's improvement. When I met ten-year-old Miranda, I understood that stuttering affected not only her academic performance but it seriously interfered with her peer relationships, making her particularly vulnerable to the embarrassment and self-consciousness typical of the pre- and early teen years ... Personal behavior modification became easier for me when support, assistance, acceptance, and understanding were readily accessible through those around me. Miranda, too, was fortunate to receive that kind of help from her parents, other family members, close friends, and teachers ... I understand and appreciate the client's frustrations because I have experienced my own.

Patty wrote again about Mitchell:

> I cannot help but feel very sympathetic toward Mitchell and what he is going through. My parents also got a divorce when I was young. I know how hard it is for a child to watch this and try to understand what is going on. I guess this is where my life experiences will make me a better clinician. I recognized something in Mitchell that I went through when I was his age. I feel good knowing that because of my help and input Mitchell will get the help he needs to get through this traumatic situation. However, at the same time I cannot help but feel sad because I know what a long road Mitchell has in front of him.

CONNECTING THEORY TO PRACTICE

The day after our class discussed the coexistence of disfluency and atypical respiratory patterns in some individuals and the co-morbidity of disfluency and developmental motor speech disorders, Kristin wrote:

> I do want to mention that I saw some imprecise articulation in Mark that I found very interesting, and after our discussion in class yesterday I am interested in observing Mark's respiration patterns the next time we see him.

Later Kristin wrote:

> Next week we have an IEP meeting with the parents of one of the kindergarten children who is autistic. The teacher has mentioned that the mother is very concerned with the child's fluency. In the brief amount of time we have seen him, neither Margaret nor I have seen any disfluency, so this came as a surprise.

probably around three or four, so she feels he may be experiencing the normal disfluencies of a child this age. We will observe him over the next few days to see what his disfluencies are like.

The next week she continued in her thinking on paper:

Today we had an IEP meeting with the parents of Cody, the kindergartner with autism. Mary quoted Wendell Johnson to me saying that in this case she felt the "disfluency is starting not in the child's mouth but in the parent's ear." ... Cody's parents and teachers have all observed the disfluencies and have observed that Cody speaks in an abnormally high pitch. Neither of these behaviors has been seen by Margaret nor by me. It was rather awkward for Margaret to try to address these concerns when she has not observed them. We left it that the parents would chart the disfluencies and high pitch for us at home ... The parents are coming back in next week to continue discussing goals and objectives for Cody ... When it comes to fluency, Margaret feels it is in large part psychological. From our discussions in class and my own experience ... it seems to me a physiological component is at least equally to blame in fluency disorders.

And two weeks later:

While I was in the classroom with Cody today, I noticed that he exhibited many more disfluencies when he was talking in his natural pitch range than when he was talking in the higher pitch. One of his teachers reported that he showed definite signs of struggle earlier in the week when experiencing a disfluency. It appears more and more that his disfluencies are not part of "normal" childhood disfluency. He exhibits several part word repetitions during an utterance and occasional silent blocks. I wonder if the higher pitch may be a compensatory strategy ... I want to take a closer look at his respiratory patterns when he is speaking in both pitches. I am wondering if he has figured out a way to talk at the top of his breath while speaking in the higher pitch.

(By "at the top of his breath" Kristin was referring to the technique of using breath support to enhance fluency.)

Diane incorporated a behavioristic perspective into her writing about Miranda:

Miranda experiences situational stuttering. Her disfluency actually serves as a stimulus that predisposes her to continued stuttering. She expects to stutter, worries about the probability of stuttering, and becomes upset and embarrassed when she is disfluent.

Diane also wrote about her approach to treating Charles:

I understood that I only had a limited amount of time to help Charles preserve his positive self-image before peer pressure and teasing became more serious issues. I suggested a program to immediately correct clavicular breathing and speech rate and speech control problems. These difficulties not only contributed [redacted] is in part dependent upon environmental supports:

Stress, anxiety, and fear can mar self-worth, making self-improvement extremely difficult. Miranda learned to anticipate stuttering. When she reacted negatively to her errors, others also reacted negatively, causing her embarrassment. As Miranda becomes more comfortable with herself and others around her become more comfortable with her fluency goals, behavior modification can effectively address habit breaking and establishing new fluency techniques. She'll be able to exercise more body control, have more self-tolerance, and develop a more positive self-image.

Patty also wrote about behaviorism in two different entries:

My rate of speech can be extremely fast. For me, speaking fast results in a type of response contingency. I often have a great deal to say and not much time to say it. When I speak fast, I get to say everything I want to in a short period of time. This reinforces this behavior for the next time I speak. I equate this with persons who stutter who try to speak as fast as they can. The quicker they speak, the faster they get done with the act of talking itself. Thus, a quick rate of speech is also reinforced for them.

I certainly have a better understanding of how difficult changing a learned behavior is. It is not something that can be done easily. Changing the way you talk involves a long, slow process of changing learned behaviors. I'll make sure my [redacted] know that this is not an easy thing to accomplish and it [redacted] does not occur overnight.

PROFESSIONALISM

Anyone who has raised or taught a child knows that children draw conclusions about adults' personalities based on their perceptions of the physical appearance of adults. Often adults react to appearances, too. Kristin wrote a physical description of Margaret before she ever saw Margaret at work with children. It is interesting that Margaret's mien impressed Kristin enough to write this:

Margaret is in her early forties and is short and sturdy. She walks purposefully and energetically and she is very confident. She is friendly, helpful, and easy to be with, and at the same time, professional with a no-nonsense attitude. Her colleagues appear to respect her a great deal, and she makes it a point to be helpful and accommodating to them.

Near the end of her journal Kristin wrote:

I have learned that it is imperative to set limits and follow through on them from the very beginning. The children need to know what they can and cannot do ... I have learned the importance of professionalism and confidence in one's own abilities. I have learned that it is more important to do what needs [redacted] done than to worry about whether or not everyone else [redacted] like

have on the people you work with. Thanking others and applauding their efforts and accomplishments creates an environment of trust and respect.

Diane wrote this about her growing professionalism:

> I have learned to smile when bogged down with paperwork and to check tears when children expose their feelings, fears, and inadequacies. Clinical experience has made me acutely aware of my role as a partner in the therapy process. Personal and professional challenges have helped me become a careful listener, an alert observer, and a more patient individual ... Recognizing my own interests, strengths, and weaknesses has better prepared me to consider each of these areas in my clients when designing individual therapy programs for them.

Patty wrote:

> I like working with all types of students. Children are individuals just like you and me and each is unique. I have learned to adapt my teaching styles and methods to accommodate the individual needs of my students.

ACCEPTING AMBIGUITY

One of the most difficult problems for student clinicians in transition is accepting ambiguity. At this time, the etiology of stuttering is still unknown: organic traces are at times detected, at times not; behavioristic explanations are plausible to some clinicians but not others; the semantogenic theory has passed in and out of favor in light of the success of early intervention; knowledge of family dynamics and environmental modification must be tempered in the presence of each new family that we meet (Curlee and Siegel, 1997). The student asks, "If nothing is surely known, what will I tell parents? Where will I find solid theoretical principles to guide therapeutic decision making?" Diane wrote:

> I learned cures are not always possible and perfection is infeasible.

Patty, too, seems to have come to terms with this, as she wrote:

> I have learned that often in this field there are no easy or clear-cut answers ... I have seen many clients with stuttering disorders who had numerous factors (environmental, genetic) affecting their fluency. We as clinicians need to learn how to trust our instincts and judgements about what is best for our clients.

CONCLUSIONS

Kolb (1984) has posited a four-stage model of learning from experience. In the first stage, one is confronted by an experience. In the second stage, the experience is thought about reflectively. In the third stage, a learner can form abstract concepts and generalizations that help explain the experience and put it into perspective. In the fourth stage, the learner takes these concepts to a new situation. Through this process experiences are conceptualized and are transformed into knowledge, skills, and attitudes. Too often in professional preparation we ask our students to confront experience after experience without taking time to engage them in reflection and conceptualization of experiences, either through journal writing or simply through thoughtful discussion.

Reflective writing allowed Kristin, Patty, and Diane to bring to consciousness the ideas, beliefs, values, doubts, uncertainties and questions that they were pondering as they transitioned from graduate student to student clinician. This task allowed their experiences in the field to take on additional meaning. A journal offers a personal lens through which life events and transitions can be examined (Merriam, 1994) and is a facilitative technique which supervisors may use in the preprofessional preparation of student clinicians.

REFERENCES

Ainsworth, S. (1974). The specialist in the treatment of stuttering. *Journal of Fluency Disorders*, 1(3), 52–57.

Baldwin, C. (1991). *One to One: Self-understanding Through Journal Writing*. New York: M. Evans and Company, Inc.

Brisk, D. J., Healey, E. C., & Hux, K. A. (1997). Clinicians' training and confidence associated with treating school-age children who stutter: A national survey. *Language, Speech, and Hearing Services in Schools*, 28 (2), 164–176.

Byatt, A. S. (1990). *Possession*. New York: Random House.

Cluver, L. P. (1988). Journal writing by speech-language pathology student clinicians. *Clinical Supervisor*, 6(1), 101–107.

Cooper, E. B. (1975). *Clinicians' Attitudes Toward Stutterers: A Study of Bigotry*. Paper presented at the convention of the American Speech-Language-Hearing Association, Washington, D.C.

Cooper E. B. & Cooper, C. S. (1985). Clinician attitudes toward stuttering: a decade of change (1973–1983). *Journal of Fluency Disorders*, 10, 19–33.

Cooper E. B. & Rustin, L. (1985). Clinician attitudes toward stuttering in the United States and Great Britain: A cross cultural study. *Journal of Fluency Disorders*, 10 (1), 1–17.

Curlee, R. F. & Siegel, G.M. (1997). *Nature and Treatment of Stuttering: New Directions*. (2nd ed.). Boston: Allyn and Bacon.

de Acosta, M. (1995). Journal writing in service learning: Lessons from a mentoring project. *Michigan Journal of Community Service Learning*, 2, 141–149.

Demick, J. & Nazzaro, N. A. (1994). Adult learning environments: Perspectives from environmental psychology. In J.D. Sinnott, (Ed.), *Interdisciplinary Handbook of Adult Lifespan Learning*. Westport, CT: Greenwood Press.

Dopheide, B. (1987). Competencies expected of beginning clinicians working with children who stutter. *Journal of Fluency Disorders*, 12, 157–166.