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SUPERVISORY FEEDBACK IN SPEECH-LANGUAGE PATHOLOGY:
PREFERENCES AND PRACTICES

A Thesis

Presented to

the Faculty of the Department of Communicative Disorders

East Tennessee State University

In Partial Fulfillment

of the Requirements for the Degree

Master of Science in Communicative Disorders

by

J. Michelle Gurley

May 2000

APPROVAL

This is to certify that the Graduate Committee of

J. Michelle Gurley

met on the

10th day of March, 2000.

The committee read and examined her thesis, supervised her defense of it in an oral examination, and decided to recommend that her study be submitted to the Graduate Council, in partial fulfillment of the requirements for the degree of Master of Science in Communicative Disorders.

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ABSTRACT

SUPERVISORY FEEDBACK IN SPEECH-LANGUAGE PATHOLOGY: PREFERENCES AND PRACTICES

by

J. Michelle Gurley

Research in the area of clinical supervision has historically been limited, especially in the field of speech-language pathology. Furthermore, those few studies that do exist were primarily published during the decade of the 1980's. Clinical supervision, and specifically its critical component of supervisory feedback, is crucial to all clinical training programs. However, supervision research only mentions the topic of supervisory feedback and neglects the relationship between supervisory feedback preferences and actual supervisory practices. This study was designed to identify and compare supervisor and supervisee preferences and perceptions regarding supervisory feedback, to relate these preferences to a continuum-based model of clinical supervision, and to compare the feedback preferences of all participants to actual supervisory practices.

Supervisory feedback preferences and perceptions were obtained by using a 31-item Supervisory Feedback Preferences and Perceptions Questionnaire (SFPPQ) developed for this study. Supervisory practices relevant to feedback were examined and described by collecting written feedback from participating supervisors at three different points within a six-week period of supervisory interaction. Participants included 37 speech-language pathology graduate students and 10 supervisors from two ASHA-accredited university training programs.

Results revealed that both supervisors and student clinicians prefer verbal, in-person feedback, which is provided immediately and consistently after each treatment session. Additional preferences supported the continuum-based model of clinical supervision; however, actual practices did not reflect adherence to this model. Findings regarding supervisory practices revealed that supervisors gave mainly direct feedback to their supervisees and that this feedback did not change over time, unlike that suggested by the continuum model. Although no link was found between level of supervisory experience and nature of feedback given, clinicians with advanced experience levels received a higher percentage of direct feedback. This finding again contradicts the recommended model of supervision.

This research expands and extends the limited amount of supervision literature, delineates areas for future research, and discusses implications for future clinical and supervisory training. These implications include information related to specialized supervisory training and styles of adult learning.

Monday, October 25, 1999

J. Michelle Gurley

Communicative Disorders
70643

RE: Supervisory Feedback: Preferences and Practices
IRBno: 99-033e

I reviewed the above-references study and find that it qualifies as exempt from coverage under the federal guidelines for the protection of human subjects as referenced as Title 45—Part 46.101. If you feel it is necessary to call futher IRB attention to any aspects of this project, please refer to the above-titled project and IRB number. I appreciate your bringing this project before the IRB for its concurrence of exempt status.

Sincerely,

David N. Walters, M.D., IRB Chair

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DEDICATION

To the One who makes all things possible for me (Philippians 4:13, Colossians 3:23), and to my parents, Ed and Hester Gurley, my constant source of encouragement and support.

ACKNOWLEDGMENTS

My deepest appreciation is extended to Dr. Lynn Williams, my thesis committee chair, for her endless guidance and support through all stages of this thesis preparation. I also wish to thank Mrs. Teresa Boggs, Dr. Marsh Grube, and Dr. David Shapiro for their willingness to serve as thesis committee members. A special thank you is extended to David Shapiro for serving as liaison at WCU. My sincere appreciation is extended to Dr. Leo Harvill, my “call a friend lifeline” in the area of statistical analysis. I am also grateful for my current clinical supervisor, Mrs. Jamie Henry of Kingsport City Schools, for her understanding and willingness to work with my thesis schedule. Finally, my deepest appreciation is extended to all supervisors and supervisees who were willing to offer their time, share their experiences, and make this study a reality.

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CHAPTER 1

INTRODUCTION

The goal of any medically or clinically-based training program is to prepare competent professionals in that field. Thus, the need for supervision of trainees in speech-language pathology is indisputable. Clinical supervision is a crucial part of the training process and is required for all trainees who wish to complete the Clinical Fellowship and obtain the Certificate of Clinical Competence, as required by the American Speech-Language Hearing Association (ASHA) for practice in speech-language pathology and audiology. ASHA published a position statement in 1985 delineating the tasks required in supervision, yet research in the field of clinical supervision is limited, both in number and in focus. For this reason, supervision is often referred to as the “stepchild” of the speech and hearing sciences (Villareal, 1964). Furthermore, the research that does exist is quickly becoming out-dated, with the majority appearing in the 1980’s literature. The need for additional research is highlighted by increased interest in accountability and efficacy of our training programs.

Model of Clinical Supervision

Although the field of speech and hearing sciences has been recognized as a professional discipline since the end of World War II, no one had examined the component of clinical training of students or developed a supervisory model until the 1970’s. Borrowing from Cogan’s (1973) Clinical Supervision Model for student teachers

and the work of Goldhammer (1969) and Goldhammer, Anderson, & Krajewski (1980). Anderson (1988) developed a continuum-based supervisory model for use in speech-language pathology and audiology. Anderson's model contains five components: understanding the supervisory process, planning, observing, analyzing, and integrating (Anderson, 1988).

Understanding the Supervisory Process

Understanding the supervisory process, the initial component of supervision, provides a framework in which both supervisors and supervisees discuss definitions of supervision, roles of participants, perceptions, experiences, and feelings as they relate to the supervisory process. Although this is an important beginning point in clinical supervision, this component is continuously reintroduced as changes occur. These changes may be related to settings, clients, supervisory relationships, professional growth, etc.

Planning

The planning stage in clinical supervision often is regarded as the most crucial stage because it is in this stage that the plan is created for all other stages that follow (Anderson, 1988). During planning, goals and objectives are established for the clinician and client as well as the supervisee and supervisor. Participants in the planning stage determine how these goals and objectives will be measured, how the measurements will be analyzed, and how the analysis will be integrated into clinical and supervisory

practices. Baseline measures are gathered in this stage, based on the information discussed in the initial stage of understanding (e.g., determine at which point on the supervisory continuum the supervisee is currently functioning).

Observing

Observing, the third component of clinical supervision, should include objective data collection to be analyzed at a later time. As Casey, Smith, and Ulrich (1988) point out, these observations stretch beyond technical and interpersonal skills in the clinical setting, and include observations regarding writing skills (in both reports and lesson plans), professional behavior, and supervisory interactions. Generally, the observing stage is one component in providing supervisory feedback (written or verbal).

Analyzing

In the analyzing stage, objective data collected in the previous stage are examined to determine if goals and objectives are being met. The ultimate result of observing and analyzing is feedback—a means to discern what works well and what does not. It is important that feedback highlight both strengths and areas for improvement to thwart unrealistic expectations while ensuring opportunities for growth. The analyzing stage is a second component in providing supervisory feedback.

Integrating

The final component of clinical supervision, integration, is the stage in which all other components merge. This component primarily is associated with the supervisory conference, an arena where problem-solving should occur. Although joint problem-solving may be the case initially, individual problem-solving abilities are expected to grow as supervisees progress towards self-supervision.

Supervision Continuum

To complement the five components of clinical supervision, Anderson (1988) also developed a supervisory continuum. Anderson's continuum includes three stages-- evaluation/feedback, transition, and self-supervision, as illustrated in Figure 1. Anderson emphasized that this continuum is not time-bound, nor is progression along the continuum always linear. Furthermore, although the five components of clinical supervision relate primarily to the transition stage, both supervisor and supervisee may function at any point on the continuum during any of the five stages of supervision. Surprisingly, it also is possible that supervisor and supervisee function simultaneously at different continuum points within the same component of supervision. According to Brasseur (1989), the point on the supervisory continuum at which the supervisee functions is dependent upon at least seven variables: supervisee expectations and perceptions, experience, competencies, needs, desires, psychological maturity, and commitment. Anderson's model supports the idea that less experienced clinicians (in terms of either total clinic clock hours or hours spent treating a particular disorder) are

more likely to function in the evaluation/feedback stage of supervision. In this stage, the primary focus is on the clinical process and the supervisor is the principal evaluator. As supervisees gain experience, it is expected that they begin to acquire more responsibility in the clinical decision-making process and evaluate more effectively their own skills as learning clinicians. The final stage of self-supervision becomes evident when the focus of supervision shifts to include both aspects of the clinical and supervisory processes. In this stage, feedback from supervisors is much less direct and supervisees assume the role of primary evaluator. Supervisors are more likely to function as peers or colleagues with whom the supervisee may consult when additional direction is needed. Anderson's flexible model, which is based upon individual supervisory needs, has been compared to the Individual Education Program (IEP) implemented for many of the clients served by speech-language pathologists (Brasseur, 1989).

Evaluation-Feedback Stage	Transitional Stage	Self-Supervision Stage
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Figure 1. Stages of the continuum of supervision. From: Anderson, J. (1988). *The supervisory process in speech-language pathology and audiology* (p. 50). Boston: College-Hill Publications of Little, Brown.

Studies in Supervision

Supervisory Conferences

In the field of speech-language pathology, a majority of the research completed in supervision relates to supervisory conferences or to the “integrating” component of the clinical supervision model. Many aspects of the conference have been examined, including roles of participants, conference behaviors and communication, and perceived effectiveness.

In 1982, Roberts and Smith investigated role differences and consistency of behaviors in supervisory conferences. Their findings revealed that supervisors typically assumed the ‘traditional,’ “initiator,” highly structured role and that both supervisors and supervisees use mainly “simplistic, analytic, diagnostic statements” (p. 432-33).

In the same year, Smith and Anderson (1982) sought to determine the relationship of supervisory conference interactions/content variables to perceived conference effectiveness. Results indicated that a discrepancy existed between supervisors’ and supervisees’ perceptions of conference effectiveness.

Peaper (1984) also analyzed students’ perceptions of the supervisory conference and how those perceptions might change as a result of student-developed conference agendas. Results indicated that student-developed agendas often focused on evaluation or the seeking of feedback. However, over time, these agendas focused less on evaluation, suggesting that students’ abilities to self-evaluate improved with experience. This finding not only gives value to the supervisory conference and students’ active

participation in conferences, but also lends support to the supervisory continuum that suggests students' abilities to self-evaluate increase over time.

In 1988, Shapiro and Anderson analyzed commitments made by speech-language pathology and audiology students during supervisory conferences. The five different noted types of commitments included those related to clinical procedures, clinical process administration, supervisory procedures, supervisory process administration, and academic information/teaching function. Results indicated that the majority of commitments related specifically to the clinical process. Few commitments were centered upon the supervisory process.

One year later, Shapiro and Anderson (1989) examined the effects these commitments had upon later clinical activities and behaviors. The authors found that clinicians were more likely to follow-through on their commitments when commitments were written early in the supervisory experience. Also, less experienced clinicians benefited more from the written commitments than did more experienced clinicians. These findings lend further support to the supervisory continuum by suggesting less experienced clinicians are likely to function best in a direct, highly structured style of supervision whereas more experienced clinicians exhibit a decreased need for a high degree of structure. These studies by Shapiro and Anderson are different from others in that they are based on one measure of actual effectiveness rather than perceived effectiveness.

Another study focusing on supervisory conferences examined aspects of interpersonal communication within the conference (Pickering, 1984). Again, results

indicated that a majority of the conference time was spent discussing aspects of the clinical process in a direct manner. Few statements were made regarding the supervisory process, and supervisors typically assumed the role of “helpers” while supervisees were often the “helpees” (p. 193). One strength of Pickering’s study and the studies by Shapiro and Anderson (1988; 1989) is that they were both experimental and descriptive.

While all of these studies offer valuable insights regarding what makes supervision effective, they neglect to include those factors related to the other components in the Clinical Supervision Model, such as observing and analyzing. These two components ultimately result in the crucial component of supervisory feedback.

Supervisory Feedback

Few studies exist which focus specifically on the component of supervisory feedback. Of those few studies which do exist, the emphasis is primarily on supervisory feedback regarding clinical report writing (Gunter, 1985; Mercaitis, 1989).

One exception to this focus is a study by Peaper and Mercaitis (1987) who examined the nature of narrative written feedback to determine if the feedback changed as a consequence of increased supervisory experience (i.e., number of years a supervisor has supervised) and if the nature of the written feedback was similar to the nature of supervisory conferences. Their findings suggest that the nature of feedback may indeed change as a consequence of supervisory experience level and that the nature of written supervisory feedback was different from that of supervisory conferences. Specifically, the nature of written supervisory feedback appeared to be more evaluative. One

important suggestion from this finding is that written feedback is a one-way method of communication whereas the conference is a two-way interaction. Thus, the nature of supervisory feedback (direct versus indirect) may change as a result of the medium of delivery.

In sum, few studies have examined the aspect of supervisory feedback, despite its vital role in the clinical training of student clinicians. These studies have been limited in focus, and none have examined students' and supervisors' preferences and perceptions as they relate to supervisory feedback.

Students' and Supervisors' Preferences and Perceptions

Several studies examining supervisee preferences/perceived needs appear in the counseling literature. Stoltenberg, Pierce, & McNeill (1987) examined the relationship between counselor trainees' perceived supervisory needs and level of experience through the development of a Supervisee Needs Questionnaire. The questionnaire included questions related to structure, instruction, feedback, support, and self-direction in supervision. The authors found that supervisees' perceived needs changed over time. As professional development increased, perceived overall needs decreased, especially the need for supervisor-imposed structure and direct feedback.

Another study targeting counselor trainees' expectations and preferences revealed that clear and specific supervisory feedback was highly valued and that supervisees expected the degree of structure and directness of feedback to decrease over time (Leddick & Dye, 1987). Allen, Szollos, & Williams (1986) further supported the idea

that feedback was highly valued by supervisees. In this study, doctoral students engaged in psychotherapy supervision reported that direct and straightforward supervisory feedback was one aspect attributed to a “best” supervisory experience.

In the field of teacher education, Copeland & Atkinson (1978) reported on student teachers’ perceptions of directive and nondirective supervisory behaviors. A Supervisor Effectiveness Rating Scale was used to assess students’ perceptions regarding supervisors’ expertness, comprehension of problem, confidentiality, trustworthiness, ability to help, sincerity, knowledge of teaching, and utility. Half of the students completed the Supervisor Effectiveness Rating Scale based upon a supervisory script predetermined to exemplify a direct style of supervision. The other half of the students completed the same scale based upon a supervisory script predetermined to represent an indirect style of supervision. Results indicated that students preferred a supervisor who used a direct style of supervision—one that used mostly declarative statements and asked few questions. The authors suggested one possible reason for this outcome was that the students need to “know what the supervisor wants” in order to obtain the desired grade. A focus on grades may be more highly associated with a preference for direct supervision whereas a focus on growth of independent, clinical decision-making skills may be more highly associated with preferences for indirect supervision and, ultimately, self-supervision.

In addition to these studies outside the field of speech-language pathology, several studies have been published within this field; however, most studies focusing on student preferences/perceived needs in the supervisory process identify only general aspects of

the process or relate specifically to the supervisory conference. Dowling & Wittkopp (1982) examined supervisees' perceived needs in five specific categories: lesson plan and report writing, supervisor observation, conferencing, professional responsibility, and general supervisory practice. An additional piece of the study investigated the relationship between academic status or training site and perceived needs. In agreement with the other aforementioned studies, students with less experience seemed to prefer more direct supervision, while more experienced students seemed to prefer a greater degree of responsibility.

At the 1989 annual conference of The Council of Supervisors in Speech-Language Pathology and Audiology, Peaper and Mercaitis presented the results of their study on contributing factors in satisfactory and unsatisfactory supervisory experiences.

Again highlighting the value supervisees place on feedback, results showed "feeling that input in clinical decision making was encouraged" and "receiving clear and consistent feedback" were the most important factors in satisfactory supervisory experiences. Likewise, the most important factor contributing to unsatisfactory experiences was reported to be the "failure to provide clear and consistent feedback" (Peaper & Mercaitis, 1989).

Two studies conducted by colleagues Cartwright and Haines (Cartwright & Haines, 1987; Haines and Cartwright, 1987) are significant in that they have examined both supervisors' and students' perceptions regarding a common topic. In these studies, both supervisors' and supervisees' perceptions regarding the use of an objective evaluation instrument were analyzed. Results, however, focused primarily upon the

acceptance of/satisfaction with the evaluation instrument and not upon the amount of agreement between supervisors' and supervisees' perceptions.

Supervisory Preferences/Perceptions in Relation to the Clinical Supervision Model

Although many of the studies regarding student preferences have examined changes in perception over time, few compare student preferences to a specific model of supervision, such as Anderson's continuum-based model (Anderson, 1988). Dowling & Wittkopp (1982) examined changes in supervisees' perceived needs as related to number of clock hours, academic status (undergraduate or graduate), and training site. Although no perceptual differences were evident in undergraduate and graduate students, perceptions of positive and negative supervisory practices differed significantly as a result of earned clock hours and site of training. Stoltenberg et al. (1987) provided further support that supervisees' perceived needs change as a consequence of experience level. Peaper (1984) found that perceptions regarding the value of the supervisory conference changed over time, and Peaper and Mercaitis (1989) again indicated that the ranking of factors contributing to positive and negative supervisory experiences changed as supervisees gained experience.

One exceptional study did compare supervisor and supervisee perceptions and relate these perceptions to the continuum-based model of clinical supervision (Wagner & Hess, 1999). These authors reported that feedback and the use of social power were two methods supervisors could use to modify their supervisees' behaviors. Their study examined supervisors' and supervisees' perceptions regarding types of social power used

with beginning graduate students (BGS) and advanced graduate students (AGS). Results indicated supervisor and BGS perceptions matched, but supervisor and AGS perceptions did not match. Furthermore, supervisors perceived their uses of social power to change with clinician experience levels, thus supporting the continuum model. However, supervisees' perceptions were that supervisors did not change their uses of social power as a consequence of supervisee experience level. The study presented many interesting ideas regarding supervisory perceptions, yet did not address actual supervisory practices.

Supervisory Practices

Few studies in supervision have examined the realities of supervisory practices, especially as they relate to supervisors' or supervisees' perceptions or preferences. Of the few studies that do examine these practices, the focus is limited to supervisory conferences, while practices involved in other components of the supervisory process (e.g., Observing and Analyzing) have been ignored.

For example, Roberts and Smith (1982) examined the consistency of supervisor and supervisee behaviors in supervisory conferences. Results indicated that, although the Clinical Supervision Model supports the idea that change can occur within a six-week period, the supervisory behaviors/practices remained relatively the same for both supervisors and supervisees throughout the studied 6-week period of supervisory interaction. While this study suggests that daily practices do not always reflect the accepted models of practice, it did not address the issue of supervisor/supervisee perceptions of their behaviors.

In a second study, Smith and Anderson (1982) examined the relationship between perceived effectiveness and verbal interaction/content variables in supervisory conferences (i.e., the supervisors' and supervisees' perceptions of which practices constituted a conference perceived to be effective). While results revealed a discrepancy between supervisors' and supervisees' perceptions, they did not reveal whether or not supervisors' perceptions of what constituted an "effective" conference actually influenced daily supervisory practices.

Although both of these studies offer valuable insights into the practices and perceptions of effective supervision, neither study explored the relationship between supervisors' perceptions/preferences and daily supervisory practices.

Supervisory Perceptions Related to Supervisory Practices

One study has both compared supervisor and supervisee perceptions and addressed how each group's overall perceptions fit with the perceptions of everyday practices (Henderson, Cawyer, & Watkins, 1999). This study employed the Supervisory Behaviors Questionnaire, a 45-item, Likert scale-based questionnaire, to identify supervisor and supervisee perceptions of what constitutes effective practicum supervision. Information was obtained through interviews based on 12 open-ended questions, two of which were related to feedback. Interestingly, supervisor and supervisee perceptions based on the interviews seemed to match, with the exception of one topic—feedback. While feedback emerged as a major category for supervisees'

perceptions, supervisors barely mention this aspect. The study also compared supervisor and supervisee perceptions based on the interviews with their perceptions of incidents in weekly supervisory conferences. Supervisors' perceptions during the interviews did match their perceptions during the conferences. Supervisees' perceptions during interviews also matched their perceptions during conferences, with the exception of one topic (ethics), which emerged only during the conferences. Although this study did attempt to make the connection between perceptions and practices, the "practices" portion was still based upon the participants' perceptions and not objective data. The study did, however, raise the question of "from what methods/styles of supervisor evaluation [or feedback] can students benefit most" (p. 63)?

Summary

In summary, many aspects of the supervisory conference (the integrating component of the Clinical Supervision Model) have been studied, but few studies have examined the crucial component of supervisory feedback (derived from the observing and analyzing components of the Clinical Supervision Model). The studies that do focus on supervisory feedback neglect to account for student and supervisor preferences in regard to supervisory feedback, how those preferences may change over time, and how those changes fit with the Clinical Supervision Model's supervisory continuum (Anderson, 1988). In addition to the lack of information on both supervisor and supervisee preferences and perceptions regarding feedback is the lack of information that

compares these preferences and perceptions to the realities of supervisory practices.

Thus, the following research questions were developed for the present study.

Research Questions

Preferences for Supervisory Feedback

1. What are supervisors' and supervisees' preferences regarding feedback?
2. How do supervisor and supervisee feedback preferences compare?
3. Do supervisees' and supervisors' preferences for feedback coincide with Anderson's continuum-based model of supervision (i.e., direct feedback preferred by/for less experienced clinicians and indirect feedback preferred by/for more experienced clinicians)?

Practices Regarding Supervisory Feedback

4. What is the nature of feedback supervisees most often receive from supervisors (direct versus indirect)?
5. Does the nature of written feedback (direct versus indirect) change as a result of clinical/supervisory experience levels?
6. Does the nature of written feedback change over time (i.e., as a clinician gains experience), as Anderson's continuum-based model suggest?
7. Is there a relationship between supervisory preferences and practices regarding nature of feedback?

CHAPTER 2

METHODS

Participants

Participants in this study were speech-language pathology graduate students and clinical supervisors from two universities: East Tennessee State University (ETSU) and Western Carolina University (WCU). Both universities offered American Speech-Language Hearing Association (ASHA) accredited graduate programs in Human Communication Disorders, with a concentration in Speech-Language Pathology. Although ETSU also offered a graduate program in Audiology, due to the variability of supervisory feedback in audiology and speech-language pathology programs, only speech-language pathology students participated in the present study.

Supervisors

Each institution's program utilized both on- and off-campus clinical supervisors, and both groups were eligible to participate in this study. The only requirement for supervisor participation in the present study was that the supervisor hold the ASHA Certificate of Clinical Competence (CCC). Off-campus supervisors included those who supervised in the public schools, nursing homes, hospitals, rehabilitation centers, and other places not directly affiliated with the university, but where graduate clinical practica may take place. Of the 19 supervisors contacted regarding this study, 10 chose to participate; 6 of these supervisors were on-campus supervisors, 3 were off-campus

supervisors, and one supervisor provided supervision both on-campus and in the public schools. Three off-campus supervisors worked in a hospital setting, while one of these supervisors also traveled to a nursing home and a rehabilitation center to supervise student clinicians. The supervisor who worked in the hospital/nursing home/rehabilitation setting chose to participate in only the first part of the study (i.e., the questionnaire). Of the nine supervisors who completed both parts of the study (i.e., the questionnaire and written feedback), five were from ETSU and four were employed by WCU.

Supervisors ranged in experience level from 1 to 5 year(s) experience in supervision to more than 20 years experience in the field. Almost half of the supervisors (40%) had more than 20 years experience in clinical supervision. Five of the 10 supervisors reported that they had received special training in supervision, with two supervisors being trained in clinical supervision during doctoral studies. One of these two supervisors has taught numerous courses/workshops on clinical supervision.

Three of the supervisors reported that they primarily supervise beginning graduate clinicians (i.e., those supervisees who have earned 1 to 25 clock hours). Two supervisors reported supervising primarily early intermediate level supervisees (i.e., those students with 26 to 100 earned clock hours), and two supervisors reported that late intermediate clinicians (i.e., those students with 101 to 200 earned clock hours) comprised the majority of their supervisees. Two supervisors indicated that they could not choose just one category, because they supervised a variety of student clinicians. Another supervisor did not choose a category, perhaps due to this same reason.

To better understand participants' overall perceptions of who "supervisors" and "supervisees" were and the meaning of the term "supervision," participants were asked to provide three synonyms for each of the three terms on the Supervisory Feedback Preferences and Perceptions Questionnaire (SFPPQ) demographic data sheet. Supervisors' responses revealed that most supervisors view "supervision" as a process of "teaching" or "providing guidance." Supervisors primarily perceive themselves as "mentors" to their supervisees, while viewing supervisees as "students" or "learners."

Supervisees

Graduate students who participated in the study were in their first or fourth semester(s) of graduate study. Eligibility for this study required only that these graduate students be currently involved in clinical practica. Of the 78 graduate students who were invited to participate in the study, 37 responded, 18 from ETSU and 17 from WCU.

Although supervisees had varying levels of clinical experience, most (54%) had earned in excess of 201 clinical clock hours. All responding supervisees had experience with child speech and language disorders. Approximately 68% reported experience in adult speech and language disorders, while 54% reported experience with dysphagia clients. A majority of supervisees indicated having worked with four to six different supervisors, and three supervisees indicated that they had taken a course in clinical supervision.

Supervisees' responses on the SFPPQ demographic data sheet revealed that, similar to supervisors, most supervisees view "supervision" as a forum for "guidance" or

“feedback.” Other synonyms for “supervision” provided by supervisees included “observation,” “teaching,” “managing,” “clinical experience,” and “colleagueship.” These descriptors were indeed similar to those provided by supervisors. A majority of supervisees perceived “supervisors” as “teachers” or “managers,” while viewing their own roles as that of “student” or “learner”—the exact synonyms provided by supervisors to describe “supervisees.” Similar perceptions were reported in an earlier supervision study (Henderson et al., 1999). Interestingly, both supervisors’ and supervisees’ responses ranged from those which reflected a greater need for “direct” supervision (e.g., “needs guidance/support,” “inexperienced,” “listener,” “accepts feedback,” “sometimes inferior,” “impressionable”) to those which reflected a need for less direct or “indirect” supervision (e.g., “confident,” “organized,” “self-evaluation,” “seeker of knowledge,” “enthusiastic,” “willing to grow”). It is important to note that comments that indicated a “direct” style of supervision were those in which the supervisees’ role was passive, while those comments which reflected an “indirect” style of supervision portrayed the supervisee as an active participant in the supervisory process.

Procedures

To address the questions posed in this study, two different types of data were collected, as noted in the description of participants. First, a questionnaire that collected data on supervisor and supervisee preferences and perceptions regarding supervisory feedback was distributed. Then, for purposes of determining the realities of supervisory practices, actual written supervisory feedback from supervisors to their supervisees was

obtained. This process of data collection involved the investigator sending a letter (see Appendix A) explaining the two-fold purpose of the study to all clinical supervisors and first and fourth semester graduate clinicians at the two universities. The project's two-fold purpose was: 1) to examine preferences and perceptions of both supervisors and supervisees regarding supervisory feedback, and 2) to examine one aspect of actual supervisory practices regarding feedback.

The Questionnaire

The Supervisory Feedback Preferences and Perceptions Questionnaire (SFPPQ) was developed for the present study (see Appendix B). This questionnaire was adapted from the Stoltenberg, et al. (1987) Supervisee Needs Questionnaire (SNQ). Like the SNQ, the questionnaire developed for the present study was based upon a seven point Likert scale used by participants to indicate how often they agreed with each statement. The SFPPQ developed for this study was comprised of two parts—Part A for supervisors and Part B for Supervisees. Each part contained 31 statements regarding supervisory feedback preferences and perceptions. The statements for each part (A and B) were identical, with only the wording being changed to address the given audience. SFPPQ items were divided into eight categories, as will be discussed further in Chapter 3.

Questionnaires were sent with the cover letter to each of the two universities and were distributed to a total of 19 supervisors and 78 supervisees. A supervisor at each university served as liaison between the investigator and that particular institution. Both supervisors who filled this role have a special interest in clinical supervision research and

practice and have received specialized training in this field. The two universities were chosen partially for this reason, since having a contact person known to the investigator often yields a greater return rate of questionnaires (Peaper, 1989). Indeed, the return rate for questionnaires was 53% for supervisors and 47% for supervisees.

Written Supervisory Feedback

To understand the realities of supervisory practices, supervisors were asked to provide written supervisory feedback at three different points, at 2-week intervals, within a 6-week supervisory interaction with one of their supervisees. Data were collected in this fashion so that representative samples of feedback would be obtained, noting that an adherence to Anderson's continuum-based model of clinical supervision would require a variation in nature of feedback, specifically direct to indirect, across time. Supervisors were assured that all names would remain anonymous to the investigator. This confidentiality was maintained by assigning code numbers and asking supervisors to remove names from feedback forms before returning data. After all written supervisory feedback was collected, the supervisory comments were coded by the investigator as "direct," "indirect," or "neutral," and is discussed in the following chapter.

Reliability. To ensure inter-coder reliability, a supervisor trained in the clinical supervision process also coded each written supervisory comment. Agreement between the primary coder and the secondary coder was .92 (206/224).

Analysis

Data were analyzed both qualitatively and quantitatively. Research question 1 was answered in a descriptive fashion by reporting notable supervisor and supervisee responses in each of the questionnaire's eight categories. Research question 4 was answered by reporting percentages of "direct," "indirect," and "neutral" supervisory comments, obtained through the collection of actual written supervisory feedback. All other questions were addressed with chi-square analyses. The analysis for each of these questions is delineated in Chapter 3.

CHAPTER 3

RESULTS

The two-fold purpose of this project—to determine the supervisory feedback preferences of supervisors and supervisees and to identify the realities of one dimension of supervisory feedback practices—was addressed by seven research questions. The reported results will follow the outline of each of the research questions by category of supervisory preferences versus supervisory practices.

Supervisory Preferences

Question 1. What are supervisors' and supervisees' preferences regarding feedback?

To determine supervisors' and supervisees' preferences for supervisory feedback, participant responses on the SFPPQ were organized based on the questionnaire's eight categories, which are summarized in Table 1. The category of "type" examined preferences for vehicle of feedback delivery (e.g., written, verbal, etc.). The category of "timing" questioned participants on the most preferable time to give/receive supervisory feedback. The categories of "frequency" and "nature" examined preferences for how often feedback should be given and how direct or indirect that feedback should be. The category of "setting" asked participants for their preferences regarding *where* feedback is given. The categories related to the "goal" of supervisory feedback asked participants to indicate their perceptions regarding the role of supervisory feedback in a clinician's

professional and personal growth. Finally, the category of “interpersonal aspects” allowed participants to indicate what they believed demonstrated sensitivity and trust to a student clinician in supervisory feedback.

Percentages for low, neutral, and high ratings for each questionnaire item are reported in Table 2. A “low” response was classified as 1-3 on the rating scale, “neutral” was represented by a score of 4, and “high” responses were determined as those ratings 5-7. Data are reported categorically because the investigator could not ensure the rating scale represented true intervals.¹ The data will be summarized in the following paragraphs based on “high” responses in each of the eight categories.

Type. Both supervisors and supervisees preferred mainly verbal, in-person feedback, although both groups were also satisfied with written feedback. Only a small percentage of each population (10% for supervisors and 11% for supervisees) preferred audio-recorded feedback, and no supervisors preferred to use checklists. A small percentage (16%) of students rated checklists as a preferable type of supervisory feedback.

Timing. Both supervisors and supervisees preferred to give/receive feedback immediately after the treatment session (90% and 84%, respectively). Feedback provided during the supervisory conference was also a popular choice (70% and 76%, respectively). Although supervisors’ preferences were equivocal regarding in-vivo

¹ The reader should note that all items, although described categorically, stand alone and were analyzed individually. Furthermore, all response percentages were rounded to the nearest whole number.

Table 2

SFPPQ Responses in 8 Categories

<u>Category</u>	Key Words	<u>Supervisor</u>			<u>Supervisee</u>		
		Low	Neutral	High	Low	Neutral	High
<u>Type</u>							
Item 1	written	30%	10%	60%	22%	5%	73%
Item 2	checklists	100%	0%	0%	68%	16%	16%
Item 3	verbal	10%	10%	80%	5%	11%	84%
Item 4	audio	90%	0%	10%	86%	3%	11%
<u>Timing</u>							
Item 5	after session	0%	10%	90%	14%	3%	84%
Item 6	during conf.	30%	0%	70%	22%	3%	76%
Item 7	in-vivo	40%	20%	40%	68%	5%	27%
<u>Frequency</u>							
Items 8, 17	100%	25%	15%	60%	23%	16%	61%
Items 9, 18	25-50%	65%	15%	20%	36%	23%	42%
Item 10	on request	100%	0%	0%	92%	3%	5%
Item 19	tapering	0%	20%	80%	16%	24%	59%
<u>Nature</u>							
Item 11	direct	20%	40%	40%	16%	27%	57%
Item 12	indirect	20%	40%	40%	49%	32%	19%
Item 13	tapering	10%	20%	70%	5%	16%	78%
<u>Setting</u>							
Item 14	1 to 1	0%	0%	100%	5%	11%	84%
Item 15	group	90%	0%	10%	62%	24%	14%
Item 16	case present.	60%	30%	10%	57%	16%	27%
<u>Goal</u>							
<u>Prof. Devmt.</u>							
Item 20	interp.comm.	20%	20%	60%	27%	16%	57%
Item 21	clinical skills	0%	0%	100%	0%	5%	95%
Item 22	prof skills	60%	0%	40%	32%	14%	54%
<u>Goal</u>							
<u>Personal Devmt.</u>							
Item 23	<anxiety & fear	10%	10%	80%	19%	14%	68%
Item 24	>self-confidence	0%	10%	90%	8%	5%	86%
Item 25	motivation	0%	10%	90%	11%	5%	84%
<u>Interpersonal</u>							
<u>Aspects</u>							
Item 26	colleagues	0%	0%	100%	8%	0%	92%
Item 27	learning styles	0%	10%	90%	5%	3%	92%
Item 28	efforts	20%	0%	80%	8%	11%	81%
Item 29	input/opinions	0%	0%	100%	3%	5%	92%
Item 30	not all the answers	0%	0%	100%	11%	5%	84%
Item 31	strength/weak.	0%	0%	100%	3%	11%	86%

demonstration feedback (40% rated high and 40% rated low), most supervisees (73%) did not rate this option very highly.

Frequency. Most supervisors (80%) preferred to provide frequent feedback initially (75-100% of the time), then taper off to providing feedback 25-50% of the time, as clinicians progressed in their clinical practice. Supervisees showed no major preference for frequency of feedback, but seemed to prefer feedback provided consistently after each treatment session (61%). Neither supervisors (0%) nor supervisees (5%) preferred feedback provided only upon request.

Nature. While almost three times as many supervisees indicated a preference for direct feedback (57%) as those who reported a preference for indirect feedback (19%), the most popular choice for nature of feedback among supervisors and supervisees was feedback which was direct initially then changed to indirect as clinicians progressed (70% and 78%, respectively). Supervisors indicated neutral preferences for direct versus indirect feedback.

Setting. All supervisors (100%) indicated a strong preference for providing feedback in a one-to-one setting with their supervisees, and the majority of supervisees (84%) agreed with this setting for feedback delivery. Providing feedback in a group setting was not a popular option for either group of respondents; however, 27% of supervisees offered support for the delivery of feedback via peer case presentations.

Goal—Professional Development. Both supervisors (100%) and supervisees (95%) agreed that feedback is most beneficial to supervisees' professional growth because it facilitates the growth of clinical skills. Respondents rated this goal of supervisory feedback higher than the goals of facilitating interpersonal communication skills and aiding in the development of professional skills.

Goal—Personal Development. Both supervisors and supervisees shared the belief that feedback is indeed beneficial to the personal development of supervisees because it increases self-confidence, motivates supervisees to continuously improve their skills, and—to a lesser degree—because it decreases anxiety and fear regarding clinical performance.

Interpersonal Aspects. Both supervisors and supervisees reported that feedback sensitive to supervisees reflects a collegial relationship, acknowledges different learning styles, and acknowledges clinician efforts regardless of session outcome. Both groups of participants also agreed that feedback that conveys trust to student clinicians encourages supervisees to offer input and opinions, acknowledges that supervisors do not have all the answers, and focuses on both clinical strengths and areas for improvement. No distinctions of “most sensitive” or “most trustworthy” could be concluded from participant responses.

In summary, the majority of both supervisors and supervisees ideally preferred verbal, in-person feedback immediately and consistently after each treatment session.

Both groups agreed that feedback that was offered frequently in the beginning and less often throughout the semester of practicum experience was the most preferable.

Supervisees preferred direct feedback over indirect, but agreed with supervisors that feedback that shifted from direct to indirect over time is the most preferable. The ideal place to deliver supervisory feedback according to both groups of respondents was in a private meeting between the supervisor and the supervisee.

Question 2. How do supervisor and supervisee preferences compare?

After both supervisor and supervisee preferences were described, comparisons were made to determine if a relationship existed between the two groups' responses. A 2x3 Chi-square analysis was completed for each item within the SFPPQ's eight categories. No significant differences were noted between the preferences of supervisors and supervisees regarding supervisory feedback.

Question 3. Do supervisees' and supervisors' preferences for feedback coincide with Anderson's continuum-based model of supervision (i.e., direct and frequent feedback preferred by/for less experienced clinicians and indirect and less frequent feedback preferred by/for more experience clinicians)?

The third research question addressed Anderson's continuum-based model of clinical supervision (1988). Anderson's model supports the notion that less experienced clinicians need more direct and more frequent supervision than advanced clinicians who benefit more from indirect and less frequent supervision. The research question asked if

supervisors' (SORs) and supervisees' (SEEs) preferences for feedback coincided with Anderson's model. To determine experience level of clinicians, supervisees were asked to indicate on the SFPPQ's demographic data sheet their category of earned clinical clock hours. Supervisors were asked to indicate the level of clinicians they primarily supervised based upon these same categories: 1-25 hours (beginning), 26-100 (early intermediate), 101-200 (late intermediate), 201+ (advanced). Similar categories have been described in an earlier supervision study (Dowling & Wittkopp, 1982). However, due to the variability of clinicians assigned to several supervisors in this study, some supervisors were unable to specify the level of student clinicians they primarily supervised. Therefore, only supervisees' preferences were analyzed to answer this research question. Chi-square analyses were completed for each item/group of items in the SFPPQ's categories of frequency and nature. Each chi-square analysis compared supervisees' experience level with supervisees' responses for that SFPPQ item/group of items, as summarized in Table 3. Since only two responding supervisees had earned less than 25 clinical clock hours, the categories of beginning (1-25 earned clock hours) and early intermediate (26-100 earned clock hours) were combined. After completing chi-square analyses, no statistically significant differences were found among feedback preferences of clinicians with varying levels of experience. However, supervisees' responses were predominantly high on items 13 and 19, which support Anderson's model. Although not used in the analysis, supervisors' responses on items 13 and 19 were also high, indicating that they, too, theoretically support the continuum-based model.

Supervisory Practices

Question 4. What is the nature of feedback supervisees most often receive from supervisors (direct versus indirect)?

Written supervisory feedback was collected from supervisor/supervisee dyads, described in Table 4, to address the “practices” portion of the research study. The written feedback was coded as either “direct,” “neutral,” or “indirect.” Operational definitions for these categories are summarized in Appendix C. These definitions were adapted from descriptions of “direct” and “indirect” supervisory behaviors outlined by Smith & Anderson (1982) and Brasseur (1987). Brasseur’s review of the literature in this area suggests that “direct” supervisory behavior shows “supervisory dominance,” which is demonstrated by the supervisor “telling, giving opinions, giving suggestions, criticizing...[and using] a high proportion of declarative statements” (p. 57).

Table 3

Number of SEE Responses in 2 SFPPQ Categories by Experience Level

<u>Category</u>	<u>Experience Level</u>								
	<u>1-100 hours</u>			<u>101-200 hours</u>			<u>201+ hours</u>		
<u>Frequency</u>	Low	Neutral	High	Low	Neutral	High	Low	Neutral	High
Item 8, 17	3	3	18	2	1	7	12	8	20
Item 9, 18	13	5	6	4	1	5	10	11	19
Item 19	2	2	8	0	2	3	4	4	12
<u>Nature</u>									
Item 10	11	0	1	5	0	0	18	1	1
Item 11	1	1	10	0	2	3	5	7	8
Item 12	6	4	2	3	1	1	9	7	4
Item 13	0	3	9	0	2	3	2	1	17

Table 4

Experience Levels of Supervisor/Supervisee Dyads

<u>Dyads</u>	<u>Supervisor experience</u>	<u>Supervisee experience</u>
Dyad 1	1-5 years	1-25 hours
Dyad 2	10-15 years	1-25 hours
Dyad 3	20+ years	201+ hours
Dyad 4	20+ years	201+ hours
Dyad 5	10-15 years	26-100 hours
Dyad 6	20+ years	201+ hours
Dyad 7	5-10 years	26-100 hours
Dyad 8	20+ years	26-100 hours
Dyad 9	1-5 years	1-25 hours

Conversely, “indirect” supervisory behavior is characterized by “supportive supervisor statements, active listening, asking, and reflecting the feelings and ideas of the supervisee” (Brasseur, 1987, p. 57). Questioning has also been viewed as a characteristic of indirect supervisory feedback. Smith & Anderson’s definitions relate specifically to the supervisory conference, but can provide insight for the examination of written supervisory feedback. These authors suggest that “direct” supervisory behavior is characterized by discussion of ways to improve therapy materials and techniques, as well as discussion of weaknesses in the clinician’s clinical behavior. In this style of supervision, supervisors and supervisees function in a “teacher-student” type of dyad. “Indirect” supervisory behaviors are evident when the supervisor uses the clinicians’ ideas in discussion, uses a supportive style, encourages the clinician to set realistic goals for the clients, and encourages the clinician to verbalize his/her needs (Smith & Anderson, 1982, p. 258).

A total of 224 supervisory comments were obtained from nine different supervisor/supervisee dyads. Results revealed 165 direct comments (74%), 31 indirect comments (14%), and 28 neutral comments (12%). These results indicate that direct comments were more than five times more frequent than indirect comments. Further, indirect and neutral comments occurred with about the same frequency.

Question 5. Does the nature of written feedback (direct versus indirect) change as a result of supervisory/clinical experience levels?

To answer this question, the relationship between participant experience level and nature of feedback was explored. First, the nature of feedback comments was compared to supervisees' experience levels, which were determined by the number of clinical clock hours earned by each supervisee for whom written feedback was provided. All supervisees receiving the written feedback analyzed in this study had earned either 26-100 clock hours or in excess of 201 clock hours. A chi-square analysis, represented in Table 5, revealed that clinicians with more clinical experience received a significantly greater proportion of direct feedback than clinicians with less clinical experience, $X^2 (2, N=2)=19.47, p<.0005$. This is contrary to what was expected or predicted on the basis of the continuum model.

Supervisors' experience levels also were compared with the nature of their written feedback comments. Supervisor experience levels were defined as the number of years of experience a supervisor had in practicing clinical supervision. Again, statistically significant differences, $X^2 (6, N=4)=29.51, p<.0005$, were found between supervisor experience levels and nature of written feedback delivered by supervisors to their supervisees, as summarized in Table 6. Although results did reveal differences across experience levels of supervisors, all groups of supervisors provided mainly direct feedback across experience levels of supervisees. Interestingly, no pattern was observed with regard to nature of feedback and years of supervisory experience. That is, there was no consistent change in feedback as experience level increased. This finding suggests

that nature of feedback was related more to the individual supervisor, or perhaps to the supervisor/supervisee dyad, than it was to supervisory experience level.

Table 5

Question 5 Chi-Square Analysis for SEEs

<u>Experience Level</u>	<u>Direct Feedback</u>	<u>Neutral Feedback</u>	<u>Indirect Feedback</u>	<u>Total</u>
26-100 hours (<u>N</u> =6)	100 (65%)	25 (16%)	29 (18%)	154
201+ hours (<u>N</u> =3)	65 (93%)	3 (4%)	2 (3%)	70
	165 (74%)	28 (12%)	31 (14%)	224

Table 6

Question 5 Chi-Square Analysis for SORs

<u>Supervisory Experience</u>	<u>Direct Feedback</u>	<u>Neutral Feedback</u>	<u>Indirect Feedback</u>	<u>Total</u>
1-5 years (<u>N</u> =2)	30 (62%)	7 (15%)	11 (23%)	48
5-10 years (<u>N</u> =1)	12 (100%)	0	0	12
10-15 years (<u>N</u> =2)	28 (54%)	9 (17%)	15 (29%)	52
20+ years (<u>N</u> =4)	95 (85%)	12 (11%)	5 (4%)	112
	165 (74%)	28 (12%)	31 (14%)	224

Question 6. Does the nature of written feedback change over time (i.e., as a clinician gains more experience), as Anderson's continuum-based model suggests?

Another aspect of the continuum-based model of clinical supervision is that the nature of feedback (direct versus indirect) should change over time (i.e., as a clinician gains more experience). Written feedback was collected at three different points within a 6-week period of supervisory interaction at 2-week intervals. The number of coded comments for each supervisor at each of the three data collection times are reported in Table 7. The average number of comments at Time 1 was 9.11, (range of 3-15 total comments); at Time 2 was 8 (range of 4-14 total comments); and at Time 3 was 7.67 (range of 5-13 total comments). The number of direct, neutral, and indirect comments at each time were compared to an arbitrary "standard" that would be predicted or expected if supervisors adhered to the continuum-based model (see Table 8). Chi-square analyses were completed to determine the relationship between nature of feedback and time.

Due to the fact that persons who fill supervisory roles in our profession are each unique individuals, a separate chi-square analysis was completed for each participating supervisor at each of the three measured times within the study. Statistically significant differences were found between expected and observed nature of feedback for several supervisors, represented in Table 9. These findings suggest that most supervisors, although they may decrease their number of direct comments, still do not adhere to the continuum-based model. That is, supervisors do not shift from direct to indirect feedback, they simply give less feedback overall. Furthermore, the feedback they give either remains primarily direct or shifts to more neutral feedback.

Table 7

Number of SOR Comments Across Time by Nature

<u>SORs</u>	<u>Time 1</u>			<u>Time 2</u>			<u>Time 3</u>		
	<u>Direct</u>	<u>Neutral</u>	<u>Indirect</u>	<u>Direct</u>	<u>Neutral</u>	<u>Indirect</u>	<u>Direct</u>	<u>Neutral</u>	<u>Indirect</u>
SOR 1	4 (80%)	0	1 (20%)	5 (71%)	1 (14%)	1 (14%)	3 (43%)	4 (57%)	0
SOR 2	6 (43%)	2 (14%)	6 (43%)	5 (56%)	1 (11%)	3 (33%)	1 (20%)	0	4 (80%)
SOR 3	15 (100%)	0	0	6 (100%)	0	0	8 (100%)	0	0
SOR 4	9 (100%)	0	0	7 (100%)	0	0	6 (100%)	0	0
SOR 5	5 (83%)	1 (17%)	0	7 (70%)	2 (20%)	1 (10%)	4 (57%)	3 (43%)	0
SOR 6	6 (100%)	0	0	1 (25%)	2 (50%)	1 (25%)	7 (78%)	1 (11%)	1 (11%)
SOR 7	3 (100%)	0	0	5 (100%)	0	0	4 (100%)	0	0
SOR 8	10 (67%)	4 (27%)	1 (7%)	9 (64%)	3 (21%)	2 (14%)	11 (85%)	2 (15%)	0
SOR 9	7 (78%)	0	2 (22%)	6 (60%)	2 (20%)	2 (20%)	5 (50%)	3 (30%)	2 (20%)

Table 8

Expected Standards for Nature of Feedback Across Time

<u>Time</u>	<u>Nature of Feedback</u>		
	<u>Direct Feedback</u>	<u>Neutral Feedback</u>	<u>Indirect Feedback</u>
Time 1	60%	20%	20%
Time 2	40%	20%	40%
Time 3	20%	20%	60%

Table 9

Question 6: Statistically Significant Differences Between Nature of Feedback and Time

$\chi^2 (1, N=2)$

<u>SORs</u>	<u>Time 1</u>	<u>Time 2</u>	<u>Time 3</u>
SOR 1			8.31, $p < .005$
SOR 3	7.5, $p < .01$	5.14, $p < .025$	10.67, $p < .0025$
SOR 4	4.5, $p < .05$	6, $p < .02$	8, $p < .005$
SOR 5			6.03, $p < .02$
SOR 6			6.33, $p < .02$
SOR 7		4.29, $p < .05$	5.33, $p < .025$
SOR 8			13.07, $p < .0005$

Table 10

SORs' Patterns of Change in Nature of Written Feedback

<u>4 Patterns</u>			
<u>Direct to Less Direct</u>	<u>Direct to More Direct</u>	<u>Direct to Indirect</u>	<u>No Change</u>
SOR 1	SOR 8	SOR 2	SOR 3
SOR 2			SOR 4
SOR 5			SOR 7
SOR 6			
SOR 9			

Four overall patterns emerged from the analysis of written supervisory feedback across time, and are represented in Table 10. The majority of supervisors (56%; 5/9) shifted the nature of their feedback from direct to less direct from Time 1 to Time 3. That is, the overall percentage of direct comments decreased. However, only one of these supervisors (SOR 2) actually shifted from a majority of direct comments to a majority of indirect comments, as the continuum-based model of supervision suggests should happen. Furthermore, three supervisors actually made no change in the nature of their feedback comments—that is, all comments remained direct over time. Finally, one supervisor (SOR 8) demonstrated the pattern of direct to more direct through an increased percentage of his/her feedback directness over time.

These findings suggest that most supervisors do not adhere to the continuum-based model in terms of change in nature of feedback. Supervisors primarily gave less feedback overall, with the majority of their feedback either remaining direct or shifting to a more “neutral” nature.

Question 7. Is there a relationship between supervisory preferences and practices regarding nature of feedback?

The final research question was centered around the relationship between supervisors’ preferences and practices (i.e., Do supervisors actually do what they say they prefer to do?) Chi-square analyses revealed no statistically significant differences between supervisors’ responses on the SFPPQ items 11 and 12 (i.e., preferences for direct and indirect feedback) and actual percentages of provided direct and indirect written

feedback. This information, however, is uninterpretable since supervisors rated preferences for direct feedback and indirect feedback equally (i.e., 40% on each item). This likely reflects unclear or inappropriate wording of the questionnaire items. However, the majority of supervisors rated item 13 highly, which suggested a change in nature of feedback from direct to indirect as a clinician progresses. These data suggest that while supervisors prefer to give both direct and indirect feedback and actually do practice this preference, they have a much stronger preference for beginning with direct feedback, then moving to indirect feedback than is evident in their practices. Data analyzed for the previous research question revealed that a shift in nature of feedback from direct to indirect, in reality, does not usually occur.

Summary

Supervisory Preferences

The supervisory feedback preferences of supervisors and supervisees appear to be congruent. Participant responses, overall, support the ideology of a continuum-based model of clinical supervision. However, feedback preferences were not dependent upon the model (e.g., feedback preferences did not change as a result of clinical experience level).

Supervisory Practices

The nature of written feedback from supervisors to supervisees, overall, was primarily direct. Most supervisory feedback practices did not fit with the continuum-based Clinical Supervision Model—that is, with the exception of one supervisor—a shift from direct to indirect feedback over time did not occur. Most supervisors shifted their feedback from more direct to less direct over time; however, fewer feedback comments were provided overall. Furthermore, several supervisors, 4/9, increased their percentages of neutral comments over time.

CHAPTER 4

DISCUSSION

As indicated in Chapter 1, research in the field of clinical supervision has historically been limited, especially in the field of speech-language pathology. Furthermore, the research that does exist is primarily circa 1980's. Few existing studies comment on supervisory feedback, and none address the relationship between feedback preferences and actual practices.

The results of this study expand on existing research in at least two ways. First, representing an effort to bridge the gap in previous literature, which omits information on the significance of the Clinical Supervision Model, the current study speaks to the Observing and Analyzing stages of the model, by addressing the aspect of supervisory feedback. Second, the present study expands upon literature in adult learning as it relates to clinical teaching. The implications of these findings are discussed in relation to the continuum-based Clinical Supervision Model and future clinical/supervisory training.

Nature of Feedback

Research in the field of supervision suggests that supervisors typically assume the dominant, more active role and that supervisees are often confined to a role of passivity in supervisory interactions (Roberts & Smith, 1982; Pickering, 1984). Indeed, results from the present study support such statements, with the majority of supervisory feedback falling into the categories of "direct" or "evaluative." Although such practices are not congruent with the Clinical Supervision Model, they appear to be readily accepted

by supervisees. This acceptance was demonstrated by supervisees' preferences for direct feedback over indirect, both in the present study and in earlier research (Copeland & Atkinson, 1978; Dowling & Wittkopp, 1982; Allen, Szollos, & Williams, 1986). However, at least one study revealed that supervisees expect feedback to decrease in directness over time (Leddick & Dye, 1987). Similarly, preferences reported in the present study indicate that both supervisors and supervisees prefer feedback that changes in nature of directness over time. These preferences/expectations, however, are in sharp contrast to the realities of supervisory feedback practices.

Although the continuum model holds that the nature of effective supervisory feedback should change from direct to indirect over time (i.e., as a clinician gains clinical experience), the present findings revealed that such a shift, in everyday practices, did not occur. In fact, results accentuated the primary usage of "direct" feedback, regardless of clinical or supervisory experience levels. These findings have several implications for the continuum-based Clinical Supervision Model and are addressed in the ensuing discussion under that heading.

Feedback Preferences and Practices

Findings in the current investigation contradict parts of existing literature, both in terms of supervisory feedback preferences and feedback practices. In terms of the interplay between supervisor and supervisee preferences and perceptions, previous studies have alluded to the fact that a "mismatch" between supervisor and supervisee

perceptions may exist (Smith & Anderson, 1982). The present study revealed that, at least with regard to feedback, supervisor and supervisee preferences/perceptions were not incongruent. However, the perceptions of participants concerning the realities of feedback practices were not examined in the present study.

Feedback and Supervisory Experience Levels

An interesting finding in the present study relevant to supervisory practices potentially qualifies the possibility of a relationship between supervisor experience levels and the nature of provided feedback. Although Peaper and Mercaitis (1987) suggested that nature of feedback could be correlated to levels of supervisory experience, the present study found no such link. Rather, it appeared to be more related to amount of special training in clinical supervision. The *only* supervisor to make a shift in the nature of his/her feedback (direct to indirect) did not have the greatest number of years of experience, but had completed coursework and supervisory practica at the doctoral level.

Feedback and the Continuum Model of Supervision

Many of the pertinent findings in this study are associated with the Clinical Supervision Model's continuum aspect, including the identified relationship between clinical experience level and nature of delivered feedback. Earlier researchers have questioned how the nature of written feedback fits with this particular model of supervision (Peaper & Mercaitis, 1987). Until the present study, however, this question has not been explored.

The Clinical Supervision Model contends that, as clinicians gain clinical experience, they require/benefit most from a less direct style of supervision (Anderson, 1988). Previous studies lend support to this ideology (Moses & Shapiro, 1996; Shapiro & Anderson, 1988; Dowling & Wittkopp, 1982). Conversely, results of the present study indicate that, in actual practice, supervisors provide a higher percentage of direct feedback to advanced clinicians than to those supervisees with levels of less experience. Several explanations for such a discrepancy may exist. Differences in supervisors' training in clinical supervision may play a larger role than either clinician experience level or amount of supervisory experience in terms of years. Individual SOR/SEE dyads may also account for such a discrepancy. Pertinent factors within these dyads may include personality differences, gender differences, differences in learning preferences, and variations in clinician skill levels (i.e., marginal versus exceptional clinicians).

Acknowledging these dyad variables and the stated limitations of studying written feedback (Peaper & Mercaitis, 1987), the current research endeavor offers another explanation for the variance in nature of written supervisory feedback, which cannot be accounted for solely by clinical experience levels. The two advanced clinicians who received exclusively direct feedback were the only supervisees, of the SOR/SEE dyads, in an acute care/hospital setting. This realization discloses that the nature of supervisory feedback may be mandated by the nature of the population being treated. Perhaps, in an acute care setting, feedback must be more direct, at times, to ensure appropriate care for patients whose needs may be deemed more "life-threatening" than those in other non-acute care clinical settings. Although written feedback may be more direct in these

settings, it may still be used effectively in such settings. A change in nature of feedback (from direct to indirect) is important in facilitating clinicians' abilities to move beyond technical skills, which are used essentially to manage acute care patients, to more problem-solving skills needed to effectively assess and treat these patients.

Adult Learning Models

Another connection between the present research and existing literature involves styles of adult learning. McAllister, Lincoln, McLeod, and Maloney (1997) presented information on adult learning styles as it related to clinical training. Their contrasts between "deep learners" and "surface learners" suggested that inquisitiveness and self-motivation are prerequisites for moving beyond "surface" learning. With regard to supervisory feedback, the more questioning or "indirect" feedback would seem to facilitate "deeper" learning while evaluative or "direct" feedback would tend to foster "surface" learning. Thus, supervisors who use only or primarily direct feedback—as results in the present study indicated—may not be using feedback to encourage their supervisees to move beyond surface learning and engage in more reflective thinking processes.

Other distinctions among teaching/learning styles appear and can be paralleled with the supervisory process. For example, McAllister et al. suggested that learners are taught based on either "pedagogy"—representing teacher-directed learning—or "andragogy," pointing to a philosophy of student-centered learning. Perhaps supervisors who seek to identify their supervisees' preferences, perceptions, and needs and act upon

such knowledge are working from a “student-centered” perspective. On the contrary, those supervisors who act upon their own preferences, perceptions, and beliefs are likely to exemplify a “teacher-directed” style of supervision. It is possible that supervisors who fail to practice a “student-centered” approach to supervision lack training in the supervisory process and act upon their past supervisory experiences. This information related to adult learning styles raises several important questions for researchers and practitioners in the field of supervision: 1) Do supervisors understand the goal of supervision and their role in facilitating supervisee growth? 2) Do supervisors understand what is meant by “nature” of feedback and the role it plays in supervisees’ growth? 3) Do supervisors understand the continuum model of supervision? Present findings suggest that the answer to these questions may be important in interpreting supervisory preferences and practices. Furthermore, these findings have important implications for future clinical and supervisory training.

Theoretical and Practical Implications

Supervisory Training

According to current regulations in speech-language pathology and audiology, a clinician needs *only* to obtain the Certificate of Clinical Competence (CCC) to be eligible for the title of “clinical supervisor” (ASHA, 1985). The present study raises the question of whether or not clinical supervisors should receive special training in the supervisory process as a prerequisite to holding such positions.

Results from this study indicate that supervisors use primarily direct feedback across clinicians and that indirect comments rarely go beyond simple, supportive statements. Furthermore, a shift in feedback over time from direct to indirect, as the continuum-based model suggests, does not occur; rather, in its place, a shift from direct comments to neutral comments is often observed. Another shift that does not fit with the continuum model, yet appears in the present results, is within the category of “direct” comments. Rather than shifting from direct to indirect comments, supervisors seemed to shift from negative evaluations to positive evaluations within their direct comments. Perhaps supervisors, who have not been trained in the supervisory process, are not fully aware of the methods and implications of providing indirect feedback to their supervisees and its impact on students’ learning to be independent self-supervisory clinicians.

Four of the nine responding supervisors reported having received special training in clinical supervision (i.e., 2/9 during doctoral studies and 2/9 through workshops, short courses or teleconferences). However, only one of the supervisors shifted his/her use of direct to indirect feedback over time, as the continuum model suggests should happen. Given that this supervisor was one of those trained in the supervisory process at the doctoral level, the question arises, “Can a one-day workshop, course, etc. alone provide a sufficient amount of training in the supervisory process to alter supervisory style and practices?”

A further implication may be that effective supervision requires consistent and repetitive examinations of supervisory preferences and practices by all supervisory participants. One advantage of periodically identifying supervisory preferences and

practices is that perhaps supervisors are made more aware of their own actions in their everyday supervision practices. This advantage is evident in that several supervisor participants, during the course of this study, remarked to the investigator that their feedback was different from their typical feedback as a result of *their awareness levels being roused* by the purpose of the study.

Although results from the present study suggest more supervisory training may be needed, it is also important to note that amount of training alone may not result in changes in supervisory style. Thus, individual personalities of each supervisor plus the dynamic interactions of various factors within SOR/SEE relationships (e.g., supervisor and supervisee personalities, learning preferences, gender differences, and skills levels) must also be considered.

Clinical Teaching

Discovering its roots in the literature on adult learning styles, an implication for future clinical training emerges. This literature suggests that, after supervisors become aware of their supervisees' individual learning styles, they may choose either to adapt their supervision styles to best fit with supervisees' and maximize learning, or they may utilize different supervision styles to challenge supervisees and thus increase clinician flexibility (McAllister et al., 1997). One method supervisors could employ to heighten their awareness of their supervisees' individual learning styles is to poll students regarding supervision preferences. The SFPPQ items developed for this study can be a useful tool in determining preferences for supervisory feedback, and similar items

relating to general supervision practices may be created. If supervisees were given the opportunity to complete such a questionnaire prior to the commencement of each new practicum experience, supervisors would have a wealth of information from which to make critical choices that might affect the quality of supervisees' clinical training.

Continuum-Based Clinical Supervision Model

Considering the suggestion offered by Peaper and Mercaitis (1987) that the nature of written feedback is restricted to "directness" as a consequence of the one-way dialogue, an implication for the continuum-based model is that supervisors must be aware of ways to give indirect feedback via the written format, as well as knowledge of alternative methods of feedback delivery. Even though there are less opportunities for indirect feedback in the written, one-way dialogue than there are in the two-way interaction of the supervisory conference, it is still possible to facilitate more reflective, analytical processes with the clinician while using written feedback. For example, by providing objective data and asking open-ended questions, supervisors may encourage their supervisees to move beyond mere acceptance of evaluative comments and encourage supervisees to make deductions/conclusions on their own.

Areas for Future Research

As a consequence of studying a dynamic process in which all participants are unique individuals, studies in clinical supervision are difficult, to say the least. However, each investigative effort contributes a piece to the puzzle. In addition to

sharing significant research findings, each study heightens awareness of the supervisory process and identifies new unanswered questions. The present study was no exception, and the following suggestions are made for future research in the field of clinical supervision, especially with regard to the key component of supervisory feedback.

Suggestions Regarding This Study

The Questionnaire. Being the first questionnaire of its kind, the Supervisory Feedback Preferences and Perceptions Questionnaire (SFPPQ) calls for several improvements. One such improvement should be the creation/utilization of a different rating scale, one that requires respondents to report preferences in rank order for each category (i.e., preferences that are “most preferred” and preferences that are “least preferred”). Such an improvement could help clarify supervisory feedback options and present a clearer representation of supervisor and supervisee preferences and perceptions.

Studying Various Avenues of Feedback Delivery. In addition to possessing a “direct” nature in itself, narrative written feedback assumes a certain amount of shared knowledge between its presenter and its recipient. As a result of such an assumption, written comments studied in isolation often lack a context or frame of reference for an outside investigator. Furthermore, not all supervisors deliver feedback to their supervisees in the same way. For a more accurate examination of supervisory feedback practices, feedback in supervisor/supervisee dyads should be obtained via the typical mode of delivery for that particular dyad of participants, especially if feedback is delivered through combinations of written comments, conference interactions, etc.

Addressing the Variable of Training Site. Existing literature supports the idea that student clinicians may shape their preferences/perceptions upon the university training they receive (Dowling & Wittkopp, 1982). Thus, the clinical opportunities available at various universities may play a role in both supervisor and supervisee preferences and practices. The pertinence of training site was not addressed in this particular study and remains an area open for further research.

Readdressing the Relationship Between Clinical Experience Level and the Continuum-Based Clinical Supervision Model. Although the relationship between supervisee clinical experience level and nature of supervisory feedback was examined in this study, the small and unequal number of participants in the two categories of

experience levels may limit the strength of the results. Further research addressing the needs of and practices with beginning and advanced clinicians is thus warranted.

Extensions to This Study

Employing an Ethnographic Design. As the reader may have gathered by now, research pertaining to clinical supervision is hindered by the abundance of variables that constitute the supervisory process. Supervisors, who are trained at numerous institutions, possess resumes filled with various types and amounts of clinical and supervisory experiences. Likewise, supervisees are involved in clinical practica in many different locations and settings at progressive experience levels. In addition to variables relating to the mechanics of the supervisory process (i.e., where and when it occurs), researchers must also deal with fluctuations in SOR/SEE dyads (e.g., personalities, interpersonal communication skills, attitudes and feelings towards certain populations and disorders, gender differences, and clinician skill levels). A purely controlled experiment in this field is an impossibility due to one defining aspect of the supervisory process—its participants are unique, human beings. However, researchers may attempt to experimentally control as many variables as possible. Qualitative, ethnographic data obtained via interviews may best define the preferences and perceptions of both supervisors and supervisees. Supervisory practices may be most effectively assessed through in-depth studies and interviews of individual SOR/SEE dyads. Such a design, if repeated with a single supervisor over time, could be employed to answer the question

proposed by Smith and Anderson (1982) of “do supervisors maintain the same style of supervision regardless of the demographics of supervisees being trained?”

In summary, the possibilities for future research in the field of clinical supervision provide many areas of investigation. The results of these studies are vital to the advancement of all professions that depend upon clinical training for preparation of its future professionals.

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APPENDICES

APPENDIX A

Letter to Participants

Appendix A

Letter to Participants

Dear Speech-Language Pathology Supervisors and Student Clinicians,

My name is Michelle Gurley and I am a graduate student in Speech-Language Pathology at East Tennessee State University. I graduated from Western Carolina University in 1998 with my degree in Communication Disorders. I am currently working on my thesis which focuses on the supervisory process in our field. My thesis will be entitled "Supervisory Feedback: Preferences and Practices."

The two-fold purpose of my project is to identify the preferences and perceptions of both supervisors and student clinicians regarding supervisory feedback and to see if these preferences match. I am also collecting written supervisory feedback from supervisors to one of their supervisees to determine if preferences indeed match daily practices.

STUDENTS. Eligibility for the study requires only that you are in your first or fourth semester (including summer semester, so all first and second year students should be eligible) of graduate study and in good academic standing. Your participation would involve signing the Informed Consent form and filling out the attached demographic sheet and 31-item questionnaire. These questionnaires may be returned to Dr. David Shapiro at WCU or Dr. Lynn Williams at ETSU. Any information you provide will remain anonymous.

SUPERVISORS. Eligibility for the study requires only that you hold the ASHA Certificate of Clinical Competence. Your participation is requested in two ways:

1. Please complete the attached 31-item questionnaire and demographic data sheet.
2. Please choose at random (e.g., drawing a name from a hat) one student you supervise and provide actual written supervisory feedback, following an observation of a clinical session, on the provided forms.

Written supervisory feedback is needed 3 times across a 6-week period of supervisory interaction, at 2-week intervals. Since the number code provided on each feedback form is the only identification needed, please remove all names from the forms before returning them to ensure confidentiality. Feedback forms and questionnaires may be returned to Dr. David Shapiro, WCU, Dept. of Human Services, 204 Killian Building, Cullowhee, NC 28723 or Dr. Lynn Williams, ETSU, Dept. of Communicative Disorders, P.O. Box 70643, Johnson City, TN 37614.

If you choose to participate, please remember to sign the Informed Consent form and return it with the questionnaire.

All information should be returned to Dr. Shapiro or Dr. Williams no later than DEC. 10. If questionnaires can be turned in sooner, it would be greatly appreciated.

YOUR PARTICIPATION IS GREATLY NEEDED AND MUCH APPRECIATED! ☺

Sincerely,

J. Michelle Gurley, B.S.Ed.

APPENDIX B

Supervisory Feedback Preferences and Perceptions Questionnaire

Appendix B

Supervisory Feedback Preferences and Perceptions Questionnaire

Supervisor Demographic Data

1. How many years of experience do you have in clinical supervision?
Please circle one.

1-5 years 5-10 years 10-15 years 15-20 years 20+ years

2. In which setting(s) do you currently work? Please check those which apply.

university clinic
 public schools/preschool/daycare
 nursing home
 hospital
 rehabilitation center
 county health department
 other
 please specify: _____

3. What is the level of experience of the clinicians you primarily supervise?
Please circle one. Students who have earned:

1-25 hours 26-100 hours 101-200 hours 201+ hours

4. Have you had any special training in clinical supervision (i.e., attended workshops, ASHA short courses on supervision, etc.)? Please circle one.

YES

NO

Please specify: _____

Please complete the following statement: My personal definition of effective supervision is

Please list those factors which influence the amount of time you spend in supervision (e.g., work load, challenging client, clinician does not feel confident, etc.).

Please provide 3 synonyms for each of the following words:

Supervision

Supervisor

Supervisee

1.
2.
3.

1.
2.
3.

1.
2.
3.

Supervisory Feedback Preferences and Perceptions Questionnaire-Part A

Based upon your supervisory experiences at this point in your career, please answer (circle) the items below according to the following scale:

- 1= Never
 2= Rarely
 3= Sometimes
 4= Half the Time
 5= Often
 6= Most of the Time
 7= Always

1. I prefer to give written feedback to my student clinicians.

Never							Always
1	2	3	4	5	6		7

2. I prefer to use checklists when providing feedback to my student clinicians.

Never							Always
1	2	3	4	5	6		7

3. I prefer to give verbal, in-person feedback to my student clinicians.

Never							Always
1	2	3	4	5	6		7

4. I prefer to give audio-recorded feedback to my student clinicians.

Never							Always
1	2	3	4	5	6		7

5. I prefer to give supervisory feedback immediately following the treatment session.

Never							Always
1	2	3	4	5	6		7

6. I prefer to give supervisory feedback during the supervisory conference.

Never							Always
1	2	3	4	5	6		7

7. I prefer to give supervisory feedback during the treatment session (i.e., demonstration).

Never							Always
1	2	3	4	5	6		7

8. I prefer to give supervisory feedback consistently after each clinic session (100%).

Never							Always
1	2	3	4	5	6		7

9. I prefer to give supervisory feedback intermittently throughout the semester (25-50%).

Never						Always
1	2	3	4	5	6	7

10. I prefer to give supervisory feedback only upon request.

Never						Always
1	2	3	4	5	6	7

11. The nature of supervisory feedback I prefer to give is direct or evaluative.

Never						Always
1	2	3	4	5	6	7

12. The nature of supervisory feedback I prefer to give is indirect or questioning.

Never						Always
1	2	3	4	5	6	7

13. The nature of supervisory feedback I prefer to give is direct initially and then more indirect as a clinician progresses.

Never						Always
1	2	3	4	5	6	7

14. I prefer to give supervisory feedback in a one-on-one setting with the supervisor and the clinician.

Never						Always
1	2	3	4	5	6	7

15. I prefer to give supervisory feedback in a group setting with all of my student clinicians.

Never						Always
1	2	3	4	5	6	7

16. I prefer to give supervisory feedback by allowing peers to provide feedback via case presentations.

Never						Always
1	2	3	4	5	6	7

17. The frequency of supervisory feedback which *most* fosters the development of independent problem-solving clinicians is feedback provided consistently after each treatment session (100%).

Never						Always
1	2	3	4	5	6	7

18. The frequency of supervisory feedback which *most* fosters the development of independent problem-solving clinicians is feedback provided intermittently throughout the semester (25-50%).

Never						Always
1	2	3	4	5	6	7

19. The frequency of supervisory feedback which *most* fosters the development of independent problem-solving clinicians is feedback provided more frequently at the beginning of the semester, then tapering off as the semester progresses (75-100% tapering off to 25-50%).

Never							Always
1	2	3	4	5	6		7

20. Supervisory feedback is *most* beneficial to student clinicians' professional growth because it facilitates development of interpersonal communication skills.

Never							Always
1	2	3	4	5	6		7

21. Supervisory feedback is *most* beneficial to student clinicians' professional growth because it facilitates the development of clinical skills.

Never							Always
1	2	3	4	5	6		7

22. Supervisory feedback is *most* beneficial to student clinicians' professional growth because it facilitates the development of professional skills (i.e., obtaining funding for services, client advocacy, etc.).

Never							Always
1	2	3	4	5	6		7

23. Supervisory feedback is *most* beneficial to student clinicians' personal growth because it aids in reducing anxiety and fear regarding clinical performance.

Never							Always
1	2	3	4	5	6		7

24. Supervisory feedback is *most* beneficial to student clinicians' personal growth because it facilitates the development of self-confidence in clinical skills.

Never							Always
1	2	3	4	5	6		7

25. Supervisory feedback is *most* beneficial to student clinicians' personal growth because it motivates them to continuously work to improve their clinical skills.

Never							Always
1	2	3	4	5	6		7

26. Supervisory feedback which *most* demonstrates sensitivity to the student clinician includes wording which reflects a collegial interaction as opposed to a superior-subordinate interaction.

Never							Always
1	2	3	4	5	6		7

27. Supervisory feedback which *most* demonstrates sensitivity to the student clinician is that which acknowledges different learning styles/preferences.

Never							Always
1	2	3	4	5	6		7

28. Supervisory feedback which *most* demonstrates sensitivity to the student clinician is that which acknowledges clinician efforts regardless of session outcome.

Never						Always
1	2	3	4	5	6	7

29. Supervisory feedback which *most* demonstrates trust to the student clinician is that which encourages the clinician to give input and opinions.

Never						Always
1	2	3	4	5	6	7

30. Supervisory feedback which *most* demonstrates trust to the student clinician is that which includes the supervisor's acknowledgement that s/he does not have all the answers.

Never						Always
1	2	3	4	5	6	7

31. Supervisory feedback which *most* demonstrates trust to the student clinician is that which includes a balance in discussion of clinical strengths and areas for improvement.

Never						Always
1	2	3	4	5	6	7

Supervisee Demographic Data

1. How many clinical clock hours have you completed at this point in your training?

Please circle one.

1-25 hours 26-100 hours 101-200 hours 201+ hours

2. Please circle your academic status.

1st Year Graduate 2nd Year Graduate

3. Please check any of the following disorder areas which you have served in your clinical training experiences:

- child language
 child speech
 adult language
 adult speech
 dysphagia

4. How many different supervisors have you had at this point in your training?

Please circle one.

0 1-3 4-6 7-9 10+

5. Have you ever taken a course in clinical supervision? Please circle one.

YES

NO

Please complete the following statement: My personal definition of effective supervision is

Please provide 3 synonyms for each of the following words:

Supervision

1.
2.
3.

Supervisor

1.
2.
3.

Supervisee

1.
2.
3.

Supervisory Feedback Preferences and Perceptions Questionnaire-Part B

Based upon your supervisory experiences at this point in your training, please answer (circle) the items below according to the following scale:

- 1= Never
- 2= Rarely
- 3= Sometimes
- 4= Half the Time
- 5= Often
- 6= Most of the Time
- 7= Always

1. I prefer to receive written feedback from my supervisor.

Never							Always
1	2	3	4	5	6		7

2. I prefer to receive supervisory feedback through the use of checklists.

Never							Always
1	2	3	4	5	6		7

3. I prefer to receive verbal, in-person feedback from my supervisor.

Never							Always
1	2	3	4	5	6		7

4. I prefer to receive audio-recorded feedback from my supervisor.

Never							Always
1	2	3	4	5	6		7

5. I prefer to receive supervisory feedback immediately following the treatment session.

Never							Always
1	2	3	4	5	6		7

6. I prefer to receive supervisory feedback during the supervisory conference.

Never							Always
1	2	3	4	5	6		7

7. I prefer to receive supervisory feedback during the treatment session (i.e., demonstration).

Never							Always
1	2	3	4	5	6		7

8. I prefer to receive supervisory feedback consistently after each clinic session (100%).

Never							Always
1	2	3	4	5	6		7

9. I prefer to receive supervisory feedback intermittently throughout the semester (25-50%).

Never						Always
1	2	3	4	5	6	7

10. I prefer to receive supervisory feedback only upon request.

Never						Always
1	2	3	4	5	6	7

11. The nature of supervisory feedback I prefer to receive is direct or evaluative.

Never						Always
1	2	3	4	5	6	7

12. The nature of supervisory feedback I prefer to receive is indirect or questioning.

Never						Always
1	2	3	4	5	6	7

13. The nature of supervisory feedback I prefer to receive is direct initially and then more indirect as I progress.

Never						Always
1	2	3	4	5	6	7

14. I prefer to receive supervisory feedback provided one-on-one with the supervisor and the student clinician.

Never						Always
1	2	3	4	5	6	7

15. I prefer to receive supervisory feedback provided in a group with other student clinicians and the supervisor.

Never						Always
1	2	3	4	5	6	7

16. I prefer to receive supervisory feedback provided by peers via case presentations.

Never						Always
1	2	3	4	5	6	7

17. The frequency of supervisory feedback which *most* fosters my development as an independent problem-solving clinician is feedback provided consistently after each treatment session (100%).

Never						Always
1	2	3	4	5	6	7

18. The frequency of supervisory feedback which *most* fosters my development as an independent problem-solving clinician is feedback provided intermittently throughout the semester (25-50%).

Never						Always
1	2	3	4	5	6	7

19. The frequency of supervisory feedback which *most* fosters my development as an independent problem-solving clinician is feedback provided more frequently at the beginning of the semester, then tapering off as the semester progresses (75-100% tapering off to 25-50%).

Never							Always
1	2	3	4	5	6		7

20. Supervisory feedback is *most* beneficial to my professional growth as a clinician because it facilitates the development of my interpersonal communication skills.

Never							Always
1	2	3	4	5	6		7

21. Supervisory feedback is *most* beneficial to my professional growth as a clinician because it facilitates the development of my clinical skills.

Never							Always
1	2	3	4	5	6		7

22. Supervisory feedback is *most* beneficial to my professional growth as a clinician because it facilitates the development of my professional skills (i.e., obtaining funding for services, client advocacy, etc.).

Never							Always
1	2	3	4	5	6		7

23. Supervisory feedback is *most* beneficial to my personal growth as a clinician because it aids in reducing my anxiety and/or fear regarding clinical performance.

Never							Always
1	2	3	4	5	6		7

24. Supervisory feedback is *most* beneficial to my personal growth as a clinician because it facilitates the development of self-confidence in my clinical skills.

Never							Always
1	2	3	4	5	6		7

25. Supervisory feedback is *most* beneficial to my personal growth as a clinician because it motivates me to continuously work to improve my clinical skills.

Never							Always
1	2	3	4	5	6		7

26. Supervisory feedback which *most* demonstrates sensitivity to the student clinician includes wording which reflects a collegial interaction as opposed to a superior-subordinate interaction.

Never							Always
1	2	3	4	5	6		7

27. Supervisory feedback which *most* demonstrates sensitivity to the student clinician is that which acknowledges different learning styles/preferences.

Never							Always
1	2	3	4	5	6		7

28. Supervisory feedback which *most* demonstrates sensitivity to the student clinician is that which acknowledges clinician efforts regardless of session outcome.

Never						Always
1	2	3	4	5	6	7

29. Supervisory feedback which *most* demonstrates trust to the student clinician is that which encourages the student clinician to give input and opinions.

Never						Always
1	2	3	4	5	6	7

30. Supervisory feedback which *most* demonstrates trust to the student clinician is that which includes the supervisor's acknowledgement that s/he does not have all the answers.

Never						Always
1	2	3	4	5	6	7

31. Supervisory feedback which *most* demonstrates trust to the student clinician is that which includes a balance in discussion of clinical strengths and areas for improvement.

Never						Always
1	2	3	4	5	6	7

APPENDIX C

Written Feedback Categorization Guidelines

Appendix C

Written Feedback Categorization Guidelines

Direct

- questions which have a specific answer (e.g., yes/no questions) or ask clinician simply to report on an event/action
“Did you try the approach we discussed last week?”
“When have you observed the pt informally during the day, perhaps at PT or OT?”
- all evaluative comments, including affirmations which are evaluative in nature
“When you told your client to put her tongue up to her teeth, then move it back, you really helped her recognize placement.”
“You asked the pt to make an inference on Task #1. This skill is not an appropriate goal for him at this time.”
“I like the way you model the /r/ sound.”
“Nice job with presentations.”
- declarative statements—supervisor tells supervisee what to do or gives opinions
“Use more descriptive terms when modeling language.”
“I believe you could have the pt sit in the chair during trial feedings.”

Indirect

- questions which do not have an obvious answer and encourage the clinician to think
“What do you think about moving the tx session to am vs. pm?”
“Have you thought about discussing this case with the nursing staff?”
 (NOTE: Although this is a yes/no question, it is indirectly asking the clinician to think about the implications of discussing the case with the nursing staff.)
- general, non-evaluative comments which offer support
“Keep trying.”
“Don’t give up.”
- objective data is reported which clinician must manipulate/compute to make a conclusion (e.g., tally marks)

Neutral

- comments on client’s behavior/performance which do not provide feedback to supervisee
“This client seems really interested in therapy.”
“He has almost met his goals.”
- clinical “housekeeping” comments
“Our supervisory conference will be at 1:30 this week.”
“The diagnostic materials are located in the file cabinet next door.”

VITA

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