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Speech-Language Pathology Interns' Perceptions of What Supervisors Value Most During Clinical Practicum

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SPEECH-LANGUAGE PATHOLOGY INTERNS' PERCEPTIONS OF WHAT SUPERVISORS VALUE MOST DURING CLINICAL PRACTICUM

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Karin Angelly Cardozo

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To: Dean Ora Strickland
College of Nursing and Health Sciences

This thesis, written by Karin Angelly Cardozo, and entitled Speech-Language Pathology Interns' Perceptions of What Supervisors Value Most During Clinical Practicum, having been approved in respect to style and intellectual content, is referred to you for judgment.

We have read this thesis and recommend that it be approved.

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Date of Defense: November 13, 2015

The thesis of Karin Angelly Cardozo is approved.

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DEDICATION

I dedicate this thesis to my parents. Mom and dad, you are a wonderful example to follow. Mom, when you were working on your own thesis, you translated the articles for your literature review from English to Spanish with an old school dictionary. That would have been simple if you spoke English, but you only had a basic understanding of the language at the time. You spent numerous hours at the computer, and many times lost saved work from your floppy disks. You spent sleepless nights creating an improved version of you and a better future for our family. On 1993, you obtained your Bachelor's Degree in Bacteriology from one of the best universities in Colombia. As if that was not enough, on 1995 you won a Latin American award for your research regarding colibacillosis in broilers. Dad, you placed mom first when it came to obtaining a higher education. You supported her through school with your modest salary while she obtained her degree and while you both raised four daughters. Dad, you taught me attention to detail, optimal organizational skills, and resilience in life.

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(Le dedico esta tesis a mis padres. Mami y papi, son un gran ejemplo a seguir. Mami, cuando hiciste tu tesis tradujiste los artículos que necesitabas del inglés al español con un simple diccionario. Esto hubiera sido sencillo si hablaras inglés, pero en ese entonces sólo tenías las bases del idioma. Estuviste muchas horas frente al computador y en muchas ocasiones perdiste información de tus diskettes. Gastaste muchas horas sin

dormir creando una mejor versión de ti y un mejor futuro para nuestra familia. En 1993 obtuviste tu título en Bacteriología de una de las mejores universidades en Colombia. Y como si fuera poco en 1995 ganaste un premio latinoamericano por tu tesis de colibacilosis en pollos de engorde. Papi, le diste prioridad a mami para obtener una educación profesional. Le ayudaste a salir adelante con tu modesto salario mientras ella iba a la universidad y mientras los dos criaban a cuatro hijas. Me enseñaste a fijarme en los detalles, en ser sumamente organizada, y a ser perseverante en la vida.

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ABSTRACT OF THE THESIS

SPEECH-LANGUAGE PATHOLOGY INTERNS' PERCEPTIONS OF WHAT SUPERVISORS VALUE MOST DURING CLINICAL PRACTICUM

by

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Professor Jean Mead, Major Professor

The purpose of this investigation was to analyze interns' perceptions of what supervisors considered important supervisory behaviors and to compare those perceptions with what the supervisors considered important. Participants consisted of 33 interns and 23 supervisors. Results of two surveys collected in previous studies were compared and analyzed. Tihen's (1983) "Tihen's Student Expectations of their Clinical Supervisor(s) Scale" was used for the intern group. A modified version of the same scale was used for the supervisor group. The scale rated five domains: passive, evaluative, active, cooperative, and affective.

Results revealed that interns ranked perceptions of what supervisors considered important supervisory behaviors as less important than what supervisors rated them. Supervisors rated all domains significantly higher than interns. Both groups considered the active domain to be the most important category and the passive domain to be the least important. Groups differed in their rankings for the affective, evaluative, and cooperative domains.

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CHAPTER I

REVIEW OF THE LITERATURE

Introduction

Supervision in speech-language pathology (SLP) is an essential component of the preparation and development of graduate students in this field. In order to develop clinical competence, the American Speech-Language-Hearing Association (ASHA) requires students to complete a minimum of 400 clinical clock hours – 375 are direct client contact, and the remaining 25 are observation hours (ASHA, 2008a). In order to obtain the hours of direct client contact, graduate students work under the mentorship and collaboration of certified clinical supervisors. Supervisors prepare students in diagnosing and implementing treatment for a variety of disorders across the human lifespan. Supervisors mentor students based on the tasks and responsibilities in their areas of employment across a variety of settings (i.e. hospitals, private practice, schools, and clinics). Supervisors typically have diverse styles of teaching as well as differing sets of expectations.

The purpose of this research study was to investigate (a) what interns believe supervisors consider to be the most important supervisory behaviors during internship rotations; (b) what supervisors actually consider to be the most important supervisory behaviors; and (c) what differences exist between both groups.

To support this investigation, a review of the literature will include a general definition of supervision. Similar definitions from the perspective of the nursing profession, physical therapy, occupational therapy, and speech-language pathology also will be provided. This will be followed by a discussion of students' perceptions

regarding supervisory behaviors, including discussion of research studies relevant to the current investigation. The literature review will conclude with a summary and rationale as well as the plan of study and specific experimental questions for the current investigation.

General Definition of Supervision

Supervision is of critical importance for the growth and development of student interns. Bernard and Goodyear (1998) identified three components of supervision: 1) it is conducted by a senior member of a profession; 2) it allows for relationships to develop over time; and 3) it allows supervisors to act as gatekeepers. The first component indicates that supervision is offered by a senior member of a profession who must have advanced knowledge compared to the supervisee (Bernard & Goodyear, 1998; Duncan, Brown-Rice, & Bardhoshi, 2014; Hudspeth, 2015). The second aspect explains that the relationship between the supervisor and supervisee strengthens as the supervisor and supervisee share responsibilities on the supervisory process (Haynes, Corey, & Moulton, 2013; Keintz, 2014; McCarthy, Kimble, & Turner, 2012). The third aspect in supervision suggests that supervisors serve as gatekeepers in the profession and have the ethical obligation to monitor whether supervisees are providing quality care to their patients (Barnett & Molzon, 2014; Bernard & Goodyear, 1998; Johnson, Skinner, & Kaslow, 2014).

Supervision in the Nursing Profession

Clinical supervision in the field of nursing requires supervisors to determine nurse mentees needs and how to best meet these needs in terms of professional development (Begat, Ellefsen, & Severinsson, 2005; Butterworth & Faugier, 2013; Fowler, 1996;

Salimi & Dehghani, 2013). Clinical supervision for the nursing student is designed to serve as a peer-educative function (Browning & Pront, 2015; Cutcliffe & Sloan, 2014). During clinical supervision, nursing supervisors reflect on their own experiences in order to better understand the needs of their mentees (Butterworth & Faugier, 2013). Through reflection, supervisors' recall their own clinical experiences as mentees to deepen their understanding of what can be improved (Salimi & Dehghani, 2013). Reflection is crucial for the field of nursing because their professional growth and knowledge depend on experience (Salimi & Dehghani, 2013).

Supervision in Physical Therapy

According to the American Physical Therapy Association (2012), both direction and supervision are crucial for ensuring the quality of physical therapy services. The degree of supervision necessary for ensuring quality physical therapy services depends on various factors, such as education, experience, and the duties of the parties involved (Dawson, 2013). The organizational structure of the institution where physical therapy services are delivered must also be taken into consideration. The American Physical Therapy Association stipulates that the supervisory process should adhere to certain requirements. First, a physical therapist should be accessible to the assistant at all times while the assistant works with patients. In addition, regularly scheduled and documented conferences with the physical therapist assistant are indispensable (American Physical Therapy, 2012). The frequency of such conferences and meetings depends upon both the needs of the client as well as of the assistants. In situations where an assistant is assigned to care for the patient/client, a supervisory visit by the physical therapist is also necessary (American Physical Therapy Association, 2012).

Supervision in Occupational Therapy

Supervision is also essential in the field of occupational therapy. Von Zweck (n.d) claimed that the supervision process is integral to the effectiveness of occupational therapists. Von Zweck stated that supervision is not a comfortable task for occupational therapists because they are more prone to adopting an egalitarian approach. Supervision by occupational therapists is much more than just assigning and managing work. Von Zweck claimed that for supervision to work in the field of occupational therapy, it is necessary to see supervision as an art. Effective supervision should be an interactive process of educating, managing, and assisting support personnel. Supervision is critical in the field of occupational therapy because it leads to the development of requisite knowledge, skills, and judgment. Supervision, if done effectively, ensures the necessary workplace resources for support personnel to carry out their assigned duties (Von Zweck, n.d.).

Supervision in Speech-Language Pathology

In speech-language pathology, Anderson's (1988) definition of supervision is widely accepted. As defined in her book, *The Supervisory Process in Speech-Language Pathology and Audiology*:

> Supervision is a process that consists of a variety of patterns of behavior, the appropriateness of which depends upon the needs, competencies, expectations, and philosophies of the supervisor and the supervisee and the specifics of the situation (task, client, setting, and other variables). The goals of the supervisory process are the professional growth and development of the supervisee and the

supervisor, which is assumed will result ultimately in optimal service to clients (p. 12).

The main goal of supervision is the professional growth and development of both supervisors and interns; this is growth, in turn, will maximize patient care (Anderson, 1988). ASHA's Technical Report (2008b) expanded on Anderson's definition by adding that self- reflection (analysis and evaluation of one's behavior) enriches the clinical experience for both parties. Further, it states that effective supervisors facilitate student clinicians to employ critical thinking and problem solving skills to get the most out of the clinical experience. Anderson's definition was expanded to the following:

> Professional growth and development of the supervisee and the supervisor are enhanced when supervision or clinical teaching involves self-analysis and self-evaluation. Effective clinical teaching also promotes the use of critical thinking and problem-solving skills on the part of the individual being supervised. (p. 3)

ASHA's (2008a) position is that clinical supervision is a distinct area of practice in the field of speech-language pathology. Furthermore, clinical supervision is an important aspect of the professional development of students in the practice of speech-language pathology.

Anderson's Continuum Model of Supervision

Anderson's (1988) definition of supervision is not only widely accepted, but her continuum model of supervision (1988) is also a widely known model in SLP. The model is based on the premise that both students and supervisors will develop and enhance knowledge and skills throughout their professional careers and/or academic development (ASHA, 2008b). The continuum provides an inverse relationship between

the amount of supervision provided by the clinical supervisor and student independence. Less direct supervision means a greater level of student independence (ASHA, 2008b). The model has three stages and three types of supervisory interaction roles. The clinical supervisor will determine the stage and role type during the supervisory process based on the student's needs, skills, and knowledge (Ostergren, 2011). The three stages and interaction types as described by Anderson are (as cited in McCrea & Brasseur, 2003, p. 25):

Table 1. Anderson's (1988) continuum model of supervision

General Stages of Supervision	General Supervisory Interaction Roles
a. *Evaluation-Feedback Stage*: The student has minimal competency/knowledge.	a. *Direct-Active Role*: The clinical supervisor tells the student what to do, models, criticizes, and evaluates.
b. *Transitional Stage*: The student has achieved some level of competency, but is not yet able to operate independently.	b. *Collaborative Role*: The clinical supervisor incorporates the student in the decision making process.
c. *Self-Supervision Stage*: The student has achieved competency and is responsible for his/her personal growth.	c. *Consultative Role*: The clinical supervisor assumes a passive role. He or she listens, supports, and provides suggestions to students.

It can be inferred that clinical supervisors will exhibit different behaviors depending on the stage and role in Anderson's (1988) continuum model of supervision. In a 2013 study, Cassidy examined Anderson's (1988) continuum model of supervision. Results revealed that 48% of students enrolled in their initial clinical practicum, identified that the consultant role was emphasized the most by supervisors (Cassidy, 2013). The same students recognized the greatest change in self-efficacy compared to other students who participated in the same study (Cassidy, 2013). Furthermore, Cassidy

(2013) recommended supervisors to employ the continuum model of supervision based on students' needs, and not on practicum level.

Who Can Become a Supervisor?

ASHA states that professionals who hold an active Certificate of Clinical Competence (CCC) can become supervisors (2008a). In order to become clinical supervisors, they must be experts in their area of practice, have thorough knowledge in their field (i.e. dysphagia, fluency, aphasia) and strong clinical competence (ASHA, 2008a). There is no requirement regarding the minimum number of years that a SLP must be ASHA-certified before becoming a clinical supervisor (ASHA, 2008a).

Training in Supervision

ASHA does not require formal training in supervision or special credentials (ASHA 2008a, Geller, 2014; Geller & Foley, 2009). Professionals welcome the opportunity to become supervisors as a way to advance in their career (O'Connor, 2008). However, they often take on this task without preparation or understanding its implications (Geller & Foley, 2009; O'Connor, 2008). As per O'Connor (2008), "none of us would attempt to provide services to a client with an unfamiliar disorder without study and/or consultation– yet often we take on the job of supervisor in this way" (p. 14). In the same way one would need to prepare with a client, supervisors must also prepare. McCrea and Brasseur (2003) stated that trained supervisors are more effective than untrained supervisors are. Thus, acknowledgement of formal training is necessary for supervision (O'Connor, 2008). In 2012, an Ad Hoc Committee on Supervision appointed by ASHA submitted a proposal to develop and implement training on supervision (McCrea, 2014). ASHA's board of directors approved the proposal on January of 2014.

As reported by McCrea (2014), “it is too early to know exactly how this training will be designed and made available; however […] ASHA is committed to developing resources to enhance the training of supervisors” (p. 8). Thus far, SLP professionals can learn more about the supervisory process through the ASHA website, continuing education, conferences, workshops, books, articles (O’Connor, 2008), and the ASHA Leader magazine. Membership to Special Interest Group (SIG) 11, Administration and Supervision, provides a wealth of information in supervision through its website, the “Perspectives on Administration and Supervision” magazine, and videos (O’Connor, 2008; “Special Interest Group 11, Administration and Supervision,” n.d.).

Tasks of Supervision

In its “Knowledge and Skills Needed by Speech-Language Pathologists Providing Clinical Supervision” document, ASHA (2008c) described and explained tasks of supervision to be employed during the supervisory process. The emphasis in these tasks depend on the knowledge, skill level, and academic preparation level of each graduate student, as well as the work setting and client variables (ASHA, 2008c). Competencies for clinical supervision indicate that the clinical supervisor:

1. Prepares for the supervisory experience (ASHA, 2008c).
    a. Evaluates the supervisee’s knowledge (ASHA, 2008c).
    b. Understands the different observational methods to meet the needs of the supervisee (ASHA, 2008c).
2. Develops and demonstrates effective interpersonal communication skills to create a strong relationship with students (ASHA, 2008c).

    a. Understands the dynamics of the process of interpersonal communication (ASHA, 2008c).
    b. Demonstrates the usage of effective interpersonal communication skills (ASHA, 2008c).

3. Cultivates the critical thinking skills of the student to improve their problem solving capacity (ASHA, 2008c).
    a. Understands the importance of self-evaluation to encourage professional growth of the supervisee (ASHA, 2008c).
    b. Supports the supervisee in assessing whether the aims for the client or the supervisory process have been met (ASHA, 2008c).
4. Improves students' clinical assessment competence (ASHA, 2008c).
    a. Understands and demonstrates best practices (ASHA, 2008c).
    b. Assists the supervisee's use of best practices (ASHA, 2008c).
5. Enhances students' clinical intervention competence (ASHA, 2008c).
    a. Understands best practices in the development of a treatment plan for intervention programs for clients (ASHA, 2008c).
    b. Supports the supervisee in prioritizing applicable goals in a treatment plan (ASHA, 2008c).
6. Schedules meetings to promote an open discussion about areas or opportunity or growth for both parties (ASHA, 2008c).
    a. Understands the significance of regular meeting or supervisory conferences (ASHA, 2008c).
    b. Uses different kinds of questions to stimulate thinking (ASHA, 2008c).

7. Assesses growth through evaluation tools (ASHA, 2008c).
    a. Understands various strategies for self-evaluation (ASHA, 2008c).
    b. Aids the supervisee in measuring the supervisee's own achievement and progress in the clinical supervisory process (ASHA, 2008c).
8. Accepts and adapts to diversity (language, culture, perspectives, learning styles) and is aware of own biases (ASHA, 2008c).
    a. Takes into consideration cross-cultural differences (ASHA, 2008c).
    b. Knows when to consult another individual who can serve as the cultural advisor during the supervisory process (ASHA, 2008c).
9. Maintains and promotes effective documentation for clinical setting and supervision (ASHA, 2008c).
    a. Understands the importance of accurate and timely documentation (ASHA, 2008c).
    b. Aids the supervisee in the maintenance of proper documentation especially regarding supervisory interaction (ASHA, 2008c).
10. Adheres to "ethical, regulatory, and legal requirements" (ASHA, 2008c).
    a. Recognizes the present standards for clinical supervision of students set by different professional organizations (ASHA, 2008c).
    b. Adheres to all the standards, regulations, and requirements mandated by ASHA, other professional organizations, and state (ASHA, 2008c).
11. Serves as mentor, based on student's knowledge and competency (ASHA, 2008c).
    a. Knows the likenesses and dissimilarities of mentoring and supervision (ASHA, 2008c).

b. Provides different types of opportunities for the professional growth of the supervisee (ASHA, 2008c).

Intern – Supervisor Relationship

Geller and Foley (2009) proposed an integrative framework for supervision including a "relationship-based learning and creating working alliances" (p. 24). Relationships between interns and supervisors are at the core of the supervisory process (Geller & Foley, 2009). The quality of those relationships will either enhance or impede progress for both interns and supervisors (Geller & Foley, 2009). As explained by McCarthy et al. (2012), the significance of the mentoring relationship is the base for the success of supervision. McCarthy et al. (2012) identified that personal and reciprocal mentor-mentee relationships affect clinical instructor supervision. In other words, the quality of relationships between interns and supervisors have an impact on the overall clinical experience of interns. Supervisors "develop an understanding of the supervisor—supervisee relationship by looking at, and understanding, both the observable as well as non-observable aspects of the interaction between supervisees and supervisors" (Geller, 2014, p. 52).

Relationships create either a positive or a negative environment. Positive environments promote working alliances in which "there is a sense of investment in the other person, earned confidence and trust, use of empathy to understand the other person's emotional reality, and mutually developed goals" (Geller & Foley, 2009, p. 26). This, in turn, invites mutual nurture and support between interns and supervisors (Geller, 2014; Geller & Foley, 2009).

Ostergren (2011) also investigated working relationships between interns and supervisors. She surveyed 115 interns in their first year of professional service as clinical fellows. Qualitative results of 109 out of the 115 participants identified supervisors' expertise (24%), supervisors' openness and approachability (19%), and nature of supervisors' feedback (9%) as the most important elements of the supervisory relationship (Ostergren, 2011). Regarding negative elements that hinder the intern-supervisor relationship, 86 out of the 109 participants identified limited supervisor interactions (29%) and negative feedback (18%) as the most harming aspects of the relationship.

Taylor, White, Kaplan, and O'Rourke (2012) conducted a survey of 23 graduate students to identify "supervisor behaviors and attributes that create a positive supervisory experience" (p. 47). The ranking of behaviors interns preferred in supervisors from most to least important were (1) knowledgeable, (2) supportive, (3) realistic, (4) organized, (5) honest, (6) timely, (7) caring, (8) flexible, (8) patient, and (9) enthusiastic (Taylor et al., 2012). These researchers also concluded that positive experiences existed when supervisors allowed interns to feel comfortable; when interns' discussed ideas regarding clients without restrictions; and when supervisors provided tactful feedback (Taylor et al., 2012). Negative experiences, on the other hand, result from when supervisors promoted their own style of intervention, when interns could not express their opinions freely, and when supervisors did not develop a collaborative relationship with interns (Taylor et al., 2012).

Feedback to Interns

Geller and Foley (2009) concluded that many entry-level interns mistrusted their supervisors when receiving positive feedback because they felt there was lack of authenticity. Novice interns wanted their supervisors to share knowledge and provide concrete feedback (Geller & Foley, 2009). However, supervisors were relying on interns to develop specific clinical skills in order to provide concrete feedback (Geller & Foley, 2009). Accordingly, following an understanding of developmental thinking of interns can assist supervisors in providing feedback at the interns' skill and knowledge level, making feedback more authentic (Geller & Foley, 2009).

Sykes described worst supervisors based on interns' feedback as "unprofessional, unapproachable, no communication, unclear expectations, only gave negative feedback, authoritative/controlling, never acknowledged improvement, and never returned calls" (as cited in Keintz, 2014, p. 6). In addition, Sykes described best supervisors as "good listeners, supportive/approachable/available, experienced and willing to teach, positive, good role models, enthusiastic, good organizers, gave clear expectations of performance, and allowed independence but with guidance for success" (as cited in Keintz, 2014, p. 6).

Ostergren (2011) surveyed interns regarding supervisory behaviors. Quantitative results of 115 participants revealed that interns placed highest importance to the following survey items: "my supervisor welcomes my exploration about a client's behavior" and "my supervisor is tactful when commenting about my performance" (Ostergren, 2011, p. 66). When addressing feedback, interns preferred positive feedback as concrete suggestions, excellent written feedback, constructive feedback, and feedback on report writing (Ostergren, 2011). Regarding negative feedback, interns disliked

critical appraisals, feedback that did not take into account interns' views, and the desire for different types of feedback (Ostergren, 2011).

Ho and Whitehill (2009) also addressed feedback. They surveyed nineteen (19) SLP interns and assigned them to two groups, one with immediate verbal feedback, and the other with delayed written feedback. Results revealed that students preferred immediate verbal feedback to delayed written feedback. "Verbal feedback allows discussion, clarification and elaboration" (Ho & Whitehill, 2009, p. 251). Participants from the delayed written feedback group sent additional emails to their supervisors asking for clarification (Ho & Whitehill, 2009). "Individual written feedback allows a more private discussion on the strengths or weaknesses of the intern and also on more sensitive issues" (Ho & Whitehill, 2009, p. 251). Furthermore, written feedback served "as permanent record to monitor progress, which is an advantage over verbal feedback" (Ho & Whitehill, 2009, p. 251).

Taylor et al. (2012) concluded that interns preferred face to face feedback from supervisors than receiving emails with feedback (p. 54). Face to face interactions felt more personable and were preferred "after each therapy session" (Taylor et al., 2012, p. 54).

Ferguson (2009) employed a descriptive approach. She analyzed audio recordings of ten (10) intern-supervisor conferences and performed a linguistic analysis to appraise these interactions. Results revealed that supervisors' feedback expressed mostly judgment. The majority of judgment was positive and direct, while negative judgment was implicit.

Supervisors' Communication Skills

Adler, Rosenfeld, and Proctor (2001) indicated that even though many individuals have an instinctive characteristic to communicate effectively, many professionals do not maximize their potential when communicating with others. Interpersonal communication is one of the 11 core areas of knowledge required of SLPs who serve as supervisors (ASHA, 2008c). As indicated by ASHA (2008b), "training in interpersonal communication is an important component of supervisory training. Growth in the interpersonal domain will enhance supervisors' proficiencies in interacting with clinicians in a helpful manner" (p. 8).

Pickering (1984) emphasized the importance of interpersonal communication skills in supervision in speech-language pathology. SLPs must "be familiar with the research on supervision in terms of developing supervisory relationships and in analyzing supervisor and supervisee behaviors" (Pickering, 1984, p. 3).

Supervisors' Personal and Technical Characteristics

Dobbs, McKervey, Roti, Stewart, and Baker (2006) surveyed two groups of 15 participants before and after their clinical fellowship. Dobbs et al. (2006) investigated the desirable qualities clinical fellows preferred on their first year of professional practice. Results revealed that the most desired supervisors' personal characteristics were assertiveness, energetic persona, and an outgoing demeanor pre and post fellowship (Dobbs et al., 2006). Other significant results indicated that clinical fellows in both groups preferred assistance in data collection, report writing, and administrative responsibilities (Dobbs et al., 2006). Supervisor availability and therapy resources were reported important as well (Dobbs et al., 2006).

In a separate study, Taylor et al. (2012) reported that demographic characteristics did not have an impact on interns' preference regarding supervisors. On the contraty, interns indicated that assistance in clinical management, data collection, report writing, developing clinical skills, interpreting evaluation results, and writing client goals were the most important technical chharacteristics to learn from supervisors (Taylor et al., 2012). Results of the study also revealed that interns preferred supervisors who had challenging or unique caseloads (Taylor et al., 2012).

Fitzgerald (2009) surveyed interns and investigated the "importance of specific supervisory behaviors and rankings of their five highest priority supervisory needs" (p. 96). Results revealed that interns' needs for supervision decreased from novice to expert interns for the following behaviors: "modeling treatment […], providing resources and guidance for evidence-based practice […], giving encouragement […], and challenging critical thinking skills […]" (Fitzgerald, 2009, p. 99). Regarding the priority of supervisory needs, the top five supervisory behaviors for beginning, intermediate, and advanced interns differed (Fitzgerald, 2009). The ranking of the top five supervisory needs was for beginning interns was: 1) talking in times of difficulty, 2) constructive criticism, 3) assistance with specific treatment ideas, 4) resources for evidence-based practice, and 5) allowing creativity (Fitzgerald, 2009). The ranking of the top five supervisory needs was for intermediate interns was: 1) allowing creativity, 2) assistance with specific treatment ideas, 3) talking in times of difficulty, 4) encouragement, and 5) constructive criticism (Fitzgerald, 2009). The ranking of the top five supervisory needs was for advanced interns was: 1) collegial interactions, 2) exercising independent

judgments, 3) constructive criticism, 4) assistance with specific treatment ideas, and 5) allowing creativity (Fitzgerald, 2009).

Satisfaction with the Supervisory Experience

Hall, McFarlane, and Mulholland (2012) investigated how satisfied interns and supervisors were after interns' first clinical practicum. Participants consisted of 17 SLP novice interns and 4 supervisors (Hall et al., 2012). Participants were surveyed after interns completed their first 12-week clinical practicum (Hall et al., 2012). Interns completed their first clinical rotation at an in-house clinic at the University of Alberta, Canada, in a group setting (Hall et al., 2012). Supervisors mentored several students at a time; students, in turn, provided services to clients in groups of four (Hall et al., 2012). Results revealed that interns were satisfied the most with their clinical placement when they felt integrated to the team (Hall et al., 2012). For instance, when they were introduced by their supervisors to other team members, when they were treated as colleagues, and when they were shown the facility (Hall et al., 2012). In regards to the least important aspect that contributed to satisfaction with the clinical placement, both interns and supervisors rated personal space as the least important aspect (Hall et al., 2012). Qualitative data revealed that neither interns, nor supervisors, considered that their own skills or attitude had an effect on the overall outcome of the clinical rotation (Hall et al., 2012). However, the opposite was true for both groups: interns considered that supervisors' skills and attitude had an effect, and vice versa (Hall et al., 2012).

In her 2011 study, Ostergren also investigated interns' satisfaction with supervision. 86% of interns in their first year of professional service reported that they would recommend their supervisor to other clinical fellows (Ostergren, 2011). This

represents overall, positive and satisfactory experiences (Ostergren, 2011). Additionally, results revealed that satisfaction with clinical fellowship was strongly related to working alliances (Ostergren, 2011).

Students' Perceptions of Supervisors' Expectations

In a study by Mead, Young, Sakowitz, et al. (2014), researchers investigated the difference between students' expectations and their perception of supervisors' expectations in supervision. Two key aspects of supervision were investigated (Mead et al., 2014). The research investigated what students considered important supervisory behaviors and compared those views with what students thought supervisors considered to be the most important (Mead et al., 2014). Participants consisted of 33 Florida International University (FIU) graduate students in their second year of graduate school for the Masters' of Science degree in Speech-Language Pathology (Mead et al., 2014). Students had completed at least two clinical rotations under the mentoring of more than one supervisor (Mead et al., 2014). Internships took place at different clinical settings across Miami-Dade and Broward Counties in South Florida (Mead et al., 2014). Participants completed "Tihen's Student Expectations of their Clinical Supervisor(s) Scale" (Tihen, 1983) (see Appendix A) (Mead et al., 2014). The scale examines five supervisory behaviors: Passive, evaluative, active, cooperative, and affective (Mead et al., 2014). The survey comprised 62 items using a 7 point Likert scale (from 1-very unimportant to 7-very important) (Mead et al., 2014). In the Mead et al. (2014) investigation, each of the 62 items were rated twice. The first rating was based on what students considered the most important supervisory behaviors were (Mead et al., 2014). The second rating was based on what students believed supervisors considered to be

important behaviors (Mead et al., 2014). The mean Likert-Scale scores were 6.137 for the first rating (R1) and 5.351 for the second rating (R2) (Mead et al., 2014). Students perceived the behaviors to be significantly more important for them than what they considered supervisors would think important (Mead et al., 2014). Nevertheless, the order of importance of the behavioral domains were identical for both ratings (Mead et al., 2014). From most to least important the behaviors were: active (R1 M = 6.412; R2 M = 5.702), evaluative (R1 M = 6.319; R2 M =5.574), affective (R1 M = 6.179; R2 M = 5.281), cooperative (R1 M = 6.106; R2 M = 5.100), and passive (R1 M = 5.715; R2 M = 5.047) (Mead et al., 2014).

Interns' Expectations vs. Supervisors' Expectations

In another study, Mead, Marshall, Prentice, et al. (2015), the researchers examined supervisory expectations and compared the results with one of the ratings of the previous study in 2014: the rating regarding what students considered important supervisory behaviors. The supervisor group consisted of 23 active clinical supervisors who supervised students in Miami-Dade and Broward counties in South Florida (Mead et al., 2015). These field experts supervised first and second year graduate students from FIU and other local universities. Tihen's (1983) "Tihen's Student Expectations of their Clinical Supervisor(s) Scale" was modified from its original version to be completed by supervisors (see Appendix B) (Mead et al., 2015). Supervisors ranked the same five supervisory behaviors as the student scale (passive, evaluative, active, cooperative, and affective) (Mead et al., 2015). As its original version, this scale consisted of 62 items rated using a 7 point Likert scale (from 1-very unimportant to 7-very important) (Mead et al., 2015). Results revealed that the mean Likert-Scale score for supervisors was 5.516

(Mead et al., 2015). Furthermore, results revealed a difference in the order of importance between the two groups (Mead et al., 2015). As opposed to the interns, the supervisors identified the order of importance of the behavioral domains to be: active (M = 6.808), evaluative (M = 6.710), cooperative (M = 6.544), affective (M = 6.473), and passive (M = 6.228) (Mead et al., 2015). The difference in order of importance occurred on the third and fourth ranking of behaviors regarding cooperative (student M = 6.106; supervisor M = 6.544) and affective (student M = 6.216; supervisor M = 6.473) (Mead et al., 2015).

A similar study by Mandel (2015) compared expectations regarding supervision between novice supervisees on their first and second year of clinical rotations and their supervisors. The study evaluated what the expectations of the supervisees were and compared them with their supervisors' expectations (Mandel, 2015). Supervisee participants consisted of 22 students on their first semester of clinic and 32 students on their second semester of clinic (Mandel, 2015). Supervisor participants consisted of 18 supervisors who directly mentored students on their first or second semester of clinic (Mandel, 2015). Data was gathered via "Tihen's Student Expectations of their Clinical Supervisor(s) Scale" (Mandel, 2015). The original 62 question scale was rated by students using the 7 point Likert scale (from 1-very unimportant to 7-very important) (Mandel, 2015). The same scale was used for supervisors and was modified to rate the questions from the supervisors' perspectives (Mandel, 2015). The study ranked expectations of both supervisors and supervisees on the five supervisory behaviors mentioned previously: passive, evaluative, active, cooperative, and affective (Mandel, 2015). Results revealed noteworthy differences regarding expectations of students and their supervisors (Mandel, 2015). Additionally, there were differences in the

expectations of the two groups of students depending on their clinical experience (Mandel, 2015). Rating of behaviors for supervisees on their first semester of clinic contrasted with their supervisors in the active, affective, and evaluative domains (Mandel, 2015). Rating of behaviors for supervisees on their second semester of clinic contrasted with their supervisors in the active, cooperative, and passive domains (Mandel, 2015). In comparison, supervisees on their first year of clinic expected direct instruction on therapy techniques and developing clinical skills, whereas supervisees in their second year of clinic expected to assume a collaborative role with the supervisor and anticipated more passive input from supervisors (Mandel, 2015).

Summary and Rationale for Current Research

Existing literature in nursing, physical therapy, occupational therapy, and speech-language pathology highlighted the importance of skilled supervisory behaviors. Intern-supervisor relationships, interns' feedback, supervisors' communication skills, supervisors' technical and personal characteristics, and intern-supervisor satisfaction with clinical rotations were addressed indicating that the quality of relationships between interns and supervisors matter. Creating positive environments and supporting each other strengthened the intern-supervisor relationship. Interns reported that supervisors' expertise, knowledge, approachability, availability, knowledge, support, and positive dispositions made working alliances stronger. However, when supervisors were unavailable, unapproachable, authoritative, and controlling, relationships with interns were hindered. Promoting their own style of intervention, not allowing students to communicate freely, and not acknowledging improvement also affected the supervisor-intern relationship.

Feedback also had an effect on intern-supervisor relationships. Interns conveyed that concrete suggestions, excellent written feedback, immediate in-person feedback, direct feedback, and positive feedback were their preferred ways of receiving feedback. Interns disliked when supervisors did not take their views into account and when they received negative and indirect feedback.

Positive and negative types of feedback suggested that training in interpersonal communication is important; however, not all professionals communicate effectively. This skill appeared to be imperative for supervisors.

As relationships were affected by feedback and communication skills, the supervisors' technical and personal characteristics played an important role as well. Interns indicated that the most desired personal characteristics in supervisors were assertiveness, energetic persona, encouragement, and outgoing demeanor. The most desired technical characteristics were assistance with data collection, report writing, interpreting evaluation results, writing goals, administrative characteristics, clinical management, and developing clinical skills.

In addition to strong relationships, encouraging feedback, good communication skills, and positive personal and communication skills, interns reported an overall satisfaction when they were treated as colleagues. Feeling they were part of the team where they worked was an important aspect of their satisfaction in clinical rotations. As a significant aspect to highlight, it must be noted that both interns and supervisors should recognize that their knowledge and attitude affects their relationship and overall satisfaction with the clinical rotation.

The purpose of this study was to examine five domains of supervisory behaviors (passive, evaluative, active, cooperative, and affective) to understand the sets of expectations supervisors have. In order to be successful in their endeavors, interns must recognize and understand what clinical supervisors believe are important supervisory behaviors. Aside from having clear expectations as beginner, intermediate, or advanced interns, students should take an interest in developing lasting working alliances with their supervisors.

Plan of Study, Experimental Research Questions, and Hypotheses

The current investigation considered identification of, and differences between, what interns believed clinical supervisors considered to be the most important supervisory behaviors and what clinical supervisors actually considered to be the most important. This study investigated five supervisory behaviors (passive, active, evaluative, cooperative, and affective) in speech-language pathology and compared the rankings between interns and supervisors. Specifically, the following experimental questions were answered:

1. Which supervisory behaviors did interns believe that clinical supervisors' considered to be the most important in speech-language pathology?
2. Which supervisory behaviors did clinical supervisors perceive to be most important during the supervisory process in speech-language pathology?
3. Are there significant differences between the perceptions of interns and supervisors regarding the importance of supervisory behaviors during the supervisory process in speech-language pathology?

It is hypothesized that there is a difference in the perceptions of both interns and supervisors on the importance of the five supervisory behaviors in speech-language pathology:

H1 (a): There are significant differences in the perception of passive behaviors between interns and supervisors.

H1 (b): There are significant differences in the perception of evaluative behaviors between interns and supervisors.

H1 (c): There are significant differences in the perception of active behaviors between interns and supervisors.

H1 (d): There are significant differences in the perception of cooperative behaviors between interns and supervisors.

H1 (e): There are significant differences in the perception of affective behaviors between interns and supervisors.

It is believed that there will be differences between the two sets of perceptions based on the review of the literature. Several studies demonstrated that interns' expectations varied depending on their level of knowledge and clinical experience. Furthermore, interns' expectations varied between research studies.

On the other hand, according to Anderson's (1988) continuum level of supervision, supervisors' teaching style varies based on interns' knowledge and skill level.

CHAPTER II

METHOD

Participants

Participants for this study consisted of 56 individuals; 33 were speech-language pathology graduate students (known as interns) and 23 were ASHA certified clinical supervisors.

Data collected from the intern group was reported by Mead et al. (2014). Their survey consisted of 33 Florida International University (FIU) graduate students in their second year of graduate studies for the Masters of Science in Speech-Language Pathology. Students had completed at least two clinical rotations under the mentorship of more than one supervisor. Participation for the study was voluntary. All participants were females. No additional demographic data for this group was obtained.

Data collected from the supervisor group was obtained from Mead et al. (2015). Their survey consisted of 23 ASHA certified clinical supervisors who supervised students in Miami-Dade and Broward counties in South Florida. These field experts supervised first and second year graduate students from FIU and other local universities. Participation in this study was voluntary.

Demographics information for the supervisor group (table 2) were received from 17 out of 23 supervisors; that is, 74% of the supervisor population. All respondents were females. Eight (8) participants (47%) supervised interns from 1 to 5 years; five (5) participants (29%) supervised interns from 6 to 10 years; three (3) participants (18%) supervised interns from 16 to 20 years; and one (1) participant (6%) supervised interns from 11 to 15 years. Eleven (11) out of the seventeen (17) supervisors (65%) had

supervised interns at only one setting; with private practice representing the most common setting (53%). Regarding education in supervision, ten (10) participants (60%) reported training at a seminar or other continuing education unit (CEU) event; four (4) participants (24%) reported no education in supervision; two (2) participants (11%) reported other type of education at the school system; and one (1) participant reported journal readings and a university class course (<0.5%). Regarding race and ethnicity, thirteen (13) participants (77%) were Hispanic/Latino, and four (4) participants (23%) were White/Caucasian. Regarding generations, twelve (12) participants (71%) belonged to generation X (born from 1965-1983); three (3) participants (18%) were baby boomers (born from 1946-1964); and two (2) participants (11%) were millennials (born from 1984-2002).

Table 2. Supervisor group demographics information

Variable	Distribution
Gender	
Female	100%
Male	0%
Years of Experience as a Supervisor	
1-5	47%
6-10	29%
11-15	6%
16-20	18%
+20	0%
Settings of Supervision	
Acute Care	<5%
Acute In-patient Rehab	<5%
Sub-Acute Inpatient Rehab	<5%
Out-patient	41%
Skilled Nursing Facility	0%
Private Practice	53%
Educational Setting	<5%
University Clinic	0%
Other	<5%

Education	
Seminar or other CEU Event	60%
University class/course	<5%
Journal readings	<5%
Other	11%
None	24%
Race/Ethnicity	
Hispanic/Latino	77%
White/Caucasian	23%
African American	0%
Pacific Islander	0%
Native American	0%
Generations	
Traditionalist	0%
Baby Boomer	18%
Generation X	71%
Generation Y (Millennials)	11%

Materials and Procedures

Tihen's (1983) "Tihen's Student Expectations of their Clinical Supervisor(s) Scale" (see Appendix A) was the instrument used to gather data for this study. The scale is a well-known and often used assessment survey of students' expectations of clinical supervision regarding five behavioral domains (passive, evaluative, active, cooperative, and affective). Operational definitions for the five domains are provided at the end of this section. The scale consisted of 62 items that were rated using a 7 point Likert scale (from 1-very unimportant to 7-very important).

Student participants (known as interns) from Mead et al. (2014) rated each of the 62 items twice. For the purposes of this study, only one rating was used; this rating was based on what interns' perceived supervisors considered important supervisory behaviors.

A response rate of 100% was achieved for this group; all interns who were asked to participate completed the survey.

Supervisor participants from Mead et al. (2015) used a modified version of Tihen's (1983) "Tihen's Student Expectations of their Clinical Supervisor(s) Scale" (see Appendix B). The scale was modified to be addressed from the supervisors' perspective. For example, item 1 "the supervisor should provide me with suggestions during the supervisory conference" was re-formatted as "the supervisor should provide suggestions during the supervisory conference." Supervisors rated items based on what they thought were important behaviors during clinical practicum. A response rate of 36% was obtained; 23 out of 64 surveys were completed.

Operational definitions for the five behavioral domains are described below:

1. Passive Domain: The supervisor takes a more active role than the intern during clinical practicum. This domain consisted of 15 items.

2. Evaluative Domain: The supervisor assesses the intern's strengths and weaknesses in areas such as organization and delivery of clinical session. This domain involved 13 items.

3. Active Domain: The supervisor takes a less active role than the intern during clinical practicum, allowing the intern to have a more active participation. The supervisor promotes student growth by assisting with clinical tasks such as goal setting and improving materials. This domain comprised 14 items.

4. Cooperative Domain: Both the supervisor and intern collaborate on tasks and responsibilities during clinical rotation. The intern is not able to operate

independently; however, the supervisor supports and values the intern's perspectives. This domain consisted of 10 items.

5. Affective Domain: The supervisor's individual affect, such as sense of humor and being sincere, is considered on this domain. This domain involved 10 items.

Research Design

A quantitative descriptive and comparative research design was utilized in this study. A quantitative study was considered appropriate for ranking the five supervisory behaviors (passive, active, evaluative, cooperative, and affective) in speech-language pathology obtained via surveys. A descriptive and comparative research design was employed to describe survey responses of interns and supervisors.

As indicated, data analyzed was collected in previous studies. Intern data was obtained from Mead et al. (2014) and supervisor data was collected from Mead et al. (2015).

General Procedures

The current study received IRB approval (ref # 103841) on July 23rd, 2015 (Appendix C)

Thirty-three student participants (known as interns) were requested to take part on Mead et al., (2014) research study verbally, in a classroom setting, in the spring of 2014. Students' participation was neither associated with a graduate course, nor it represented a grade. Graduate professors were absent from the classroom when students were asked to participate by fellow classmates. Participation was voluntary. Students signed a consent form prior to completing the survey via hard copy. The survey scale required from 10 to 15 minutes to complete and it was filled out on a one-time basis per

participant. Students were not required to write their names on the survey scale; making their responses anonymous. Response rate was 100%.

Twenty-three supervisor participants were requested to take part on Mead et al. (2015) research study via electronic mail, in the spring of 2015. Supervisors were allowed two months (January and February) to reply to the initial participation request. Prospect supervisor participants were contacted from a list of active speech-language pathology supervisors who mentored FIU students in Miami-Dade and Broward counties in South Florida in the past. Participation was voluntary. Survey and written instructions were sent via email to 64 ASHA certified supervisors. The modified survey scale required from 10 to 15 minutes to complete and it was filled out on a one-time basis per participant. Supervisors who participated printed and signed a consent form, completed the survey, and filled out a demographics form. Survey responses were received by electronic mail, regular mail, or hand delivered. A response rate of 36% was obtained; 23 out of 64 surveys were completed. Supervisors rated items based on what they thought were important behaviors during clinical practicum. None of the survey scales or demographics data were associated with its respondents.

Consent forms for both groups contained the following: purpose of the study, number of participants, duration, procedures, risks and discomforts, benefits, confidentiality, compensation and costs, right to decline or withdraw, research contact information, and IRB contact information for each study. The demographics data for the supervisor group included: years as a supervisor, settings of supervision, generation type, gender, and education received in supervision.

Data Analysis Procedures

Data collected was input to SPSS v22.0. Inferential statistics, descriptive statistics, and summary statistics were used to describe the study variables. The ranking level of supervisory behaviors were described through measures of central tendencies including the mean and range. The five domains of supervisory behaviors (passive, evaluative, active, cooperative, and affective) were categorized and analyzed. Demographic data for supervisors was described through percentages.

Parametric statistics were used to answer all research questions. Differences between group means were used to answer the first two research questions: (1) what interns believed clinical supervisors considered to be the most important supervisory behaviors; and (2) what clinical supervisors considered to be the most important supervisory behaviors. The order of ranking of behaviors from most important to least important for interns and supervisors were identified. A series of independent samples t-test were used to answer the last research question: (3) what differences existed between interns and supervisors.

CHAPTER III

RESULTS

Average Likert-Scale per Domain

The average Likert-scale per domain was calculated using all participant responses, regardless if participants missed answering one or more items in each domain (table 3). A comparison of the overall mean Likert-scale for interns (M = 5.363) and the overall mean Likert-scale for supervisors (M = 6.527) revealed that interns rated all domains significantly lower than supervisors did. In sum, what interns believed supervisors perceived was less important than what supervisors actually considered important.

Table 3. Likert-Scale mean

Domain	**Likert-Scale Mean**	
	Interns	**Supervisors**
Passive	4.957	6.103
Evaluative	5.546	6.720
Active	5.705	6.807
Cooperative	5.021	6.543
Affective	5.584	6.463
Overall	5.363	6.527

A bar graph of the mean Likert-Scale scores (figure 1) provides an illustration of the results. Both groups considered the active domain (interns M = 5.705; supervisors M = 6.807) to be the most important behavior and the passive domain (interns M = 4.957; supervisors M = 6.103) to be the least important one. Groups differed in their rankings for the affective (interns M = 5.584; supervisors M = 6.463), evaluative (interns M = 5.546; supervisors M = 6.720), and cooperative domains (interns M = 5.021; supervisors

M = 6.543). The order of behavioral domains for interns from most to least important were active, affective, evaluative, cooperative, and passive. The order of behavioral domains for supervisors from most to least important were active, evaluative, cooperative, affective, and passive. Likert-Scales data for the passive, evaluative, active, and cooperative domains was found to be closely ranked among supervisors, but not between interns.

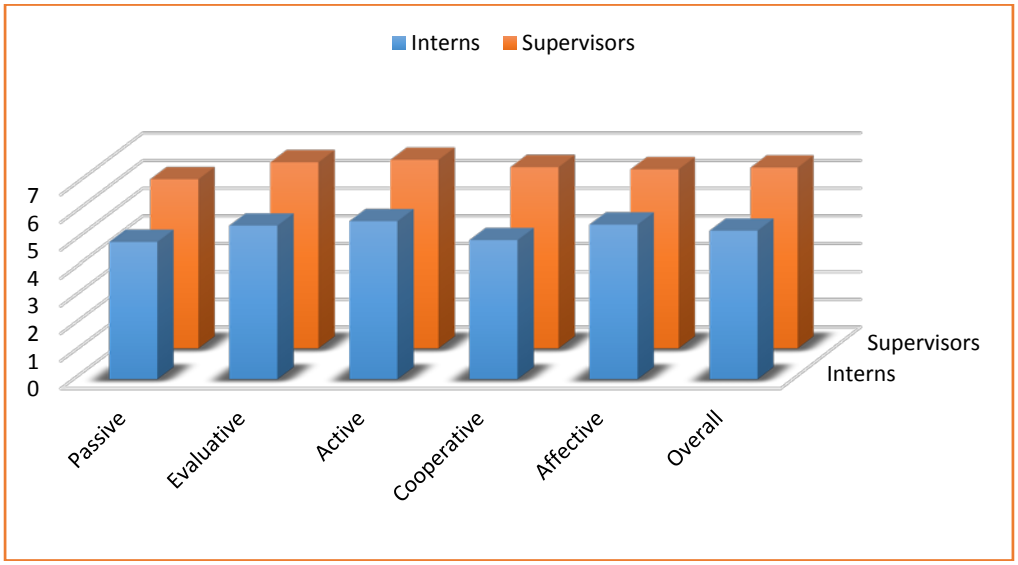

Figure 1. Average Likert-Scale scores per behavioral domain

Group Statistics

Independent samples t-tests were used to evaluate the differences between what interns perceived supervisors considered important supervisory behaviors and to compare those results with what supervisors actually considered important.

Group statistical data per domain was analyzed via independent samples t-tests based on participants' responses per question. If a participant did not answer one or more question per domain, the participant was excluded from that domain. Thus, the variation

of participants (N) per group and per domain is shown on table 4. The mean data on table 3 represents the average total score per domain and per group. These data also support the fact that, on average, interns rated all behavioral domains significantly lower than supervisors. Standard deviation data indicated skewed distribution for both groups. Interns' responses indicated a large proportion of scores in the tails of the response distribution, whereas supervisors' responses indicated a large proportion of the scores located at the center of the response distribution. These results indicated that interns tended to agree less between each other per domain and supervisors tended to agree more between each other per domain.

Table 4. Mean response for each behavioral domain for the two groups

Domain	Groups	N	Mean	Mean Difference	Sig p-Value	Standard Deviation	Std. Error Mean
Passive	Interns	30	74.500	-18.921	0.000	16.205	2.959
	Supervisors	19	93.421			5.994	1.375
Evaluative	Interns	31	71.323	-15.905	0.000	15.019	2.697
	Supervisors	22	87.227			3.351	0.715
Active	Interns	32	79.594	-15.711	0.000	14.902	2.634
	Supervisors	23	95.304			3.878	0.809
Cooperative	Interns	33	50.212	-15.223	0.000	12.564	2.187
	Supervisors	23	65.435			4.491	0.936
Affective	Interns	31	55.742	-8.985	0.001	11.888	2.135
	Supervisors	22	64.727			5.522	1.177

Equality of Variance Between Groups

Levene's Test for Equality of Variance was used to assess differences in response variability on the five behavioral domains between interns and supervisors (table 5). If the distributions were similarly shaped for the groups, equal variances would be assumed. However, the distribution curves of data differed between the two groups. As a result,

the data were transformed to account for the differences in distribution between interns and supervisors. This procedure was conducted to prevent a violation of homogeneity of variance as groups must have equal or near equal variances for the significance level to be valid. Thus, this test was used to examine the differences in sample variances assuming that the variances were not equal. For each behavioral domain there was a significant difference between interns and supervisors relative to the equality of variance in the response distribution of the two groups. This indicated that sample variances were unlikely to have occurred based on random sampling from a population with equal variances.

Table 5. Levene's test for equality of variances

Domain	Levene's Test for Equality of Variances	
	F	Sig.
Passive*	14.663	0.000
Evaluative*	15.376	0.000
Active*	36.133	0.000
Cooperative*	18.035	0.000
Affective*	9.196	0.004

*Equal variance not assumed

Supporting the Hypotheses

In order to support the hypotheses, an independent samples t-test was used to calculate the equality of means (table 5). The two tailed distribution data for both groups (equal variances not assumed) represent the p-value, which is the smallest level of significance to either accept or reject the hypothesis. Results revealed that hypotheses 1(a), 1(b), 1(c), 1(d), and 1(e) were supported for the passive ($p < .05$), evaluative ($p < .05$), active ($p < .05$), cooperative ($p < .05$), and affective ($p < .05$) behavioral domains because the significance levels were below the .05 level.

Table 6. Equality of Means

Domain	T-test for Equality of Means				
	t	df	Sig. (2-tailed) P-Value	Mean Difference	Std. Error Difference
Passive	-5.799	39.883	0.000	-18.921	3.263
Evaluative	-5.700	34.118	0.000	-15.905	2.790
Active	-5.701	36.659	0.000	-15.711	2.756
Cooperative	-6.398	42.718	0.000	-15.223	2.379
Affective	-3.685	45.064	0.001	-8.985	2.438

Relationship of Survey Scores

An exploratory factor analysis was employed to determine if survey scores were correlated, regardless of their location on the scale, through a principal components analysis (table 7, table 8, table 9, table 10, and table 11). A factor analysis determines how many factors are present in the data. Because the scale rated five behavioral domains (passive, evaluative, active, cooperative, and affective), results of this test should demonstrate the presence of five factors. In other words, all scores related to the passive domain should group together on factor 1. All scores related to the evaluative domain should group together on factor 2. All scores related to the active domain should group together on factor 3. All scores related to the cooperative domain should group together on factor 4. And all scores related to the affective domain should group together on factor 5. Results revealed that 11 factors, instead of 5 factors, were present. These observations suggest the possibility of up to six (6) additional sub-types of behaviors assessed in "Tihen's Student Expectations of their Clinical Supervisor(s) Scale" (Tihen, 1983).

The presence of sub-types of behaviors are presumably due to the wording of the different items. These results may suggest a revision to the scale to ensure that only the behavioral items indicated are present in the data. It must be noted that these results are to be interpreted with caution due to small sample size per group. It is recommended to run a principal components analysis with at least double the student population used in the present study to obtain meaningful results for both scales.

Table 7. Principal component analysis: factors for passive domain

Question #	Principal Component Analysis: Factors for Passive Domain										
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
1	0.789	-0.395				-0.154	0.1	-0.206	-0.117		-0.11
2	0.594		-0.363		0.101	-0.322		-0.196	-0.422	-0.15	
3	0.771	0.165	-0.251	-0.32			0.115				-0.182
4	0.49	0.582	-0.183	-0.29	-0.283			-0.288	0.149		
22	0.477	0.558	-0.261	-0.199		0.395				0.111	
28	0.703	0.203	-0.181		0.309	-0.296	0.103			0.125	-0.183
29	0.701	-0.322	0.204				-0.224	-0.13	-0.142	0.326	
31	0.46		0.243	-0.124	0.396	-0.156	-0.191	-0.208	0.353	-0.102	0.316
33	0.767	0.203		-0.278		-0.31					-0.215
39	0.377		-0.195	-0.596		-0.31	-0.136			0.298	0.327
40	0.889		-0.228		0.22						-0.125
43	0.779	0.193	-0.178	-0.237		-0.28	-0.107			0.177	-0.161
57	0.793	-0.16	0.185	-0.283				-0.113	0.207	0.128	-0.198
59		-0.527	0.263			0.226	0.465	0.175			-0.149
62	0.655	-0.376		0.214	-0.115	0.228		-0.131	-0.359		

Extraction Method: Principal Component Analysis
11 Components Extracted

Table 8. Principal component analysis: factors for evaluative domain

Question #	Principal Component Analysis: Factors for Evaluative Domain										
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
5	0.78	-0.339						-0.266	-0.105	-0.158	
7	0.813	-0.438				0.164					
10	0.775		-0.437			0.301					
12	0.769	-0.343	-0.158		-0.118	-0.167			0.18	-0.111	
18	0.759	-0.214	-0.387	-0.163	0.252	0.232	0.101		0.142		
19	0.47	0.197		0.345		-0.132	0.533	0.259	0.22		0.199

20	0.545	0.467	-0.24		-0.502	0.124			0.258		
24	0.678	-0.506	0.122		-0.327			-0.121		0.103	
27	0.638		0.385	-0.211	-0.37		-0.139	0.245		-0.114	
34	0.71		0.206	-0.49	-0.112	0.201				-0.29	
46	0.746	-0.398	-0.114			-0.16	-0.23				0.181
50	0.852	-0.207	0.121	0.12				-0.123	0.139		0.152
56	0.755	-0.424				0.196					

Extraction Method: Principal Component Analysis
11 Components Extracted

Table 9. Principal component analysis: factors for active domain

Question #	Principal Component Analysis: Factors for Active Domain										
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
6	0.535	0.147	-0.307	0.227	0.162	0.335		-0.133	0.176		-0.146
11	0.546	0.211	-0.447	0.273	-0.188	0.453		-0.102		0.164	
13	0.52	0.215	0.268	0.401	-0.33	-0.188	0.278	-0.135	-0.106		
17	0.722	-0.284	-0.153		0.304					-0.246	0.219
25	0.321	0.13	0.214	0.487		-0.186	-0.331	-0.102	0.384		-0.311
30	0.782		0.264	-0.239	-0.261			0.111		-0.33	
36	0.798	-0.238	-0.131		0.13		-0.211	0.342			
37	0.738	-0.37	0.272			-0.112	0.194	-0.125			
42	0.782	-0.435			-0.28					0.134	
44	0.59	0.136		0.511		0.113	-0.3	0.259		0.12	0.127
47	0.685	0.298		0.157	0.193		0.315	0.228			
53	0.862		-0.177	0.132	0.158	-0.161		0.119			
60	0.762		-0.148	0.301	-0.276		0.27				
61	0.772	-0.326	0.142	0.179		0.191		0.145		-0.114	0.1

Extraction Method: Principal Component Analysis
11 Components Extracted

Table 10. Principal component analysis: factors for cooperative domain

Question #	Principal Component Analysis: Factors for Cooperative Domain										
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
8	0.827	-0.187	0.238						0.166	-0.192	0.125
15	0.684	0.185	-0.267	0.321		-0.344	0.159	0.14		-0.115	0.121
16	0.688	0.54	-0.204							-0.161	
21	0.817		-0.29		0.164	0.14		-0.144			
26	0.691		-0.49		-0.119	-0.25		0.224		0.143	
38	0.709		0.287	-0.317		-0.164				0.245	0.173
41	0.69	0.338	-0.293	-0.325	-0.126		-0.177	0.126	-0.107		
45	0.883	-0.142		-0.114				0.282		-0.111	-0.137
55	0.621	0.312	0.382	0.327				-0.354			

58	0.658	0.26	-0.176	0.205	0.129			-0.258	-0.22	0.19	

Extraction Method: Principal Component Analysis
11 Components Extracted

Table 11. Principal component analysis: factors for affective domain

Question #	Principal Component Analysis: Factors for Affective Domain										
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
9	0.668	0.511	0.308	-0.103				-0.114	-0.182	-0.192	
14	0.684		0.279	0.284		0.181	-0.188	0.144	-0.324	0.186	
23	0.572	0.501	0.334							-0.214	0.232
32	0.695	0.452	0.358					-0.155	-0.134	0.102	
35	0.61	0.189	0.423	-0.17			0.118		0.202	0.441	
48	0.589	0.164	0.391	0.422	0.224	0.14		0.11			0.164
49	0.486	0.52	0.281		-0.231	0.183	-0.254	0.18	-0.137		-0.156
51	0.44	0.26	0.159	0.342	0.412	-0.244	-0.277			-0.149	-0.212
52	0.147	0.342	0.42	-0.533	0.232	0.276	0.166	0.215	-0.14		
54	0.359	0.226	0.211		0.747	0.118	0.204				-0.197

Extraction Method: Principal Component Analysis
11 Components Extracted

CHAPTER IV

DISCUSSION

The purpose of the current study was to investigate (a) what interns' believed clinical supervisors' considered were the most important supervisory behaviors during clinical practicum; (b) what clinical supervisors' actually considered to be the most important supervisory behaviors; and (c) what differences existed between both groups. Data collected from two separate studies by Mead et al. (2014) and Mead et al. (2015) via surveys were analyzed. Both interns and supervisors, rated five behavioral domains (passive, evaluative, active, cooperative, and affective) employed by supervisors during clinical practicum rotations.

Results revealed differences in the ranking of the five behavioral domains: passive, evaluative, active, cooperative, and affective, between interns and supervisors. Interns perceived all domains as less important than what supervisors actually rated them.

Interns' Perceptions of Supervisors

The ranking of behavioral domains for interns from most to least important were (1) active, (2) affective, (3) evaluative, (4) cooperative, and (5) passive. Questions related to this domain referred to interns being able to express their own opinions, communicate freely during supervisory conferences, provide their own suggestions for therapy, ask questions, and be independent with strategies and techniques. The results are congruent with the supervision research. Specifically, these behavioral aspects are consistent with Ostergren (2011) who identified that interns' valued supervisors' openness and approachability; and the finding of Sykes (as cited in Keintz, 2014) who stated that interns liked supervisors who allowed independence.

Interns rated the affective domain as second in ranking. Questions related to this domain referred to the supervisor being patient, encouraging, warm, accepting, understanding, and considerate. Furthermore, questions for this domain also were related to interns receiving positive feedback; supervisors respecting intern's individuality; supervision free of anxiety; and supervisors having a sense of humor. These findings also are consistent with the review of the literature. Ostergren (2011) concluded that supervisors' nature of feedback affects the intern-supervisor relationship. Taylor et al. (2012) described that interns preferred face to face tactful feedback; Sykes (as cited in Keintz, 2014, p.6) described positive vs negative feedback as related by interns; and Ho and Whitehill (2009) confirmed that interns preferred immediate vs delayed written feedback. Regarding personality traits, Taylor et al. (2012) discussed that interns enjoy enthusiastic supervisors; and Dobbs et al. (2006) determined that the most desired supervisors' personal characteristics were assertiveness, energetic persona, and outgoing demeanor.

Interns rated the evaluative domain third. Questions related to this domain referred to the supervisor evaluating the intern's performance, lesson plans, clinical reports, and intern's clinical strengths and weaknesses. These findings are supported by ASHA's Technical Report (2008b) in which supervisors are accountable for intern's performance and growth during supervision.

The fourth domain as rated by interns was the cooperative domain. Questions related to this domain referred to the intern and the supervisor working together to determine therapy goals, write patients' clinical reports, develop lesson plans, determine clinical techniques, and diagnostic instruments. These are consistent with the

conclusions of Taylor et al. (2012) who indicated that interms want assistance in clinical management, data collection, report writing, developing clinical skills, and writing client goals. Furthermore, Taylor et al. (2012) indicated that negative relationships between interns and supervisors took place when there was no collaborative relationship between the two parties.

The fifth domain as rated by interns was the passive domain. Questions related to this domain referred to the supervisor taking the most active role while interns take the most passive role. In this domain the supervisor provides lesson plans to interns, tells the intern what materials and diagnostic tools to use, and takes the lead during supervisory conferences. It may be assumed that interns will take a passive role as novice inters, or during the first weeks of their clinical practicum, while they learn clinical and administrative needs of the clinical setting.

Supervisors' Perceptions

The order of behavioral domains for supervisors from most to least important were (1) active, (2) evaluative, (3) cooperative, (4) affective, and (5) passive. These results contrast with the findings of Mandel (2015). Supervisors' rating regarding novice interns from most to least important were (1) active, (2) passive, (3) evaluative, (4) affective, and (5) cooperative (Mandel, 2015). Supervisors' rating regarding intermediate interns from most to least important were: (1) active, (2) evaluative, (3) affective, (4) passive, and (5) cooperative (Mandel, 2015). It can be inferred that the differences between Mandel's (2015) and Mead's et al. (2015) ratings were due to differences in instructions given to supervisors when completing the scale. Mandel (2015) made a clear distinction to supervisors when rating supervisory behaviors needed for novice and

intermediate interns. Mead et al. (2015) did not make that distinction. Thus, it can be estimated that supervisors completed the modified scale for Mead et al. (2015) study either considering interns' skills at all levels (novice, intermediate, or advanced), or considering the skills of only one skill level.

Nevertheless, the current results support the research literature. In regards to the active behavioral domain, the ranking was consistent across all ratings. These findings support the notions of Ostergren (2011) who identified that interns' valued supervisors' openness and approachability; and the finding of Sykes (as cited in Keintz, 2014) who stated that interns liked supervisors who allowed independence.

The second ranking for supervisors was the evaluative domain. These findings are supported by Barnett and Molzon (2014), Bernard and Goodyear (1998), and Johnson et al. (2014) in their defintion for supervision. They stated that supervisors are accountable for intern's performance and growth during supervision. Furthermore, these authors specified that supervisors have the ethical obligation to monitor whether supervisees are providing quality care to their patients. The evaluative domain is also supported by ASHA's (2008c) competency and skills and by ASHA's (2008b) technical report. ASHA (2008c) competencies and skills conferred that it is necessary for supervisors to adhere to ethical, regulatory, and legal requirements; schedule meetings with interns; and assess their growth through evaluation tools. Additionally, ASHA's technical report (2008b) stated that through evaluation, supervisors facilitate interns to employ critical thinking and problem solving skills. The importance of the evaluative domain is also shared by physical therapists. Physical therapy supervisors are required to

schedule and document conferences with the physical therapist assistants (American Physical Therapy Association, 2012).

The third ranking for supervisors was the cooperative domain. These findings support the notions of Bernard and Goodyear (1998), Duncan et al. (2014), and Hudspeth (2015), who documented that supervision is offered by a senior member of a profession who must have advanced knowledge compared to the supervisee. Having advanced knowledge allows supervisors to share information with interns and collaborate with them in developing clinical skills throughout the supervisory process. This domain also supports the views of ASHA (2008a), which stated that supervisors must be experts in their area of practice, have thorough knowledge in their field, and have strong clinical competence. The cooperative domain is also consistent with the following competencies and skills delineated by ASHA (2008c): improving interns' clinical assessment competence, enhance interns' clinical intervention competence, and promoting interns' effective documentation. The importance of the cooperative domain is also shared in the nursing profession and in occupational therapy. Browning and Pront (2015), and Cutcliffe and Sloan (2014), stated that supervision for the nursing student is designed to serve as a peer-educative function. Von Zweck (n.d.) described that effective supervision in occupational therapy should be an interactive process of educating, managing, and assisting support personnel. This reinforces the overall importance of collaboration in clinical supervision not only in speech-language pathology, but in allied health professions as well.

The fourth ranking for supervisors was the affective domain. Surprisingly, supervisors did not consider these factors as important as interns considered them to be.

This domain is supported by ASHA (2008c) who confirmed that supervisors develop and demonstrate effective interpersonal communication skills to create strong relationships with interns. Relationships serve as the bases for a successful supervisory experience. Relationships were discussed by Bernard and Goodyear (1998) who mentioned that supervision allows for relationships to develop over time. Additionally, Geller and Foley (2009) shared that the quality of relationships enhance or impede progress. Furthermore, McCarthy et al. (2012) discussed that the mentoring relationship has an impact on the overall clinical experience for interns. As relationships are highly valued by interns, supervisors must be able to adapt to diversity and be aware of their own biases (ASHA, 2008c).

The last ranking for supervisors was the passive domain. Supervisors who rated novice clinicians in Mandel (2015) study ranked this domain in second place. This supports the notion that supervisors use a direct model of supervision for novice interns. Anderson's (1988) continuum model of supervision stated that supervisors who employ a direct and active role tell interns what to do, model, criticize, and evaluate their performance. Supervisors who rated intermediate interns in Mandel (2015) study ranked this domain in fourth place; supporting the idea that as interns acquire more skills and knowledge, they are more independent in their clinical rotations. Thus, it can be inferred that supervisors rated Tihen's (1983) modified scale taking into account interns at the intermediate or advanced level. Ranking the passive domain as the least important domain supports this view.

Differences in Perceptions

Interns and supervisors differed in their ranking for the affective, evaluative, and cooperative domains.

The greatest difference in perceptions took place on the affective domain. Interns placed this domain as the second most important behavior, while supervisors ranked it on fourth place. As the affective domain is the basis for working alliances, supervisors, may use self-reflection as a means to enhancing their relationship with interns. This is consistent with ASHA's (2008b) expanded definition of supervision in speech-language pathology, which mentioned that the analysis and evaluation of one's behavior enriches the clinical experience for both parties. The importance of self-reflection is also shared in the nursing profession. Butterworth and Faugier (2013) described that nursing supervisors reflect on their own experiences in order to better understand the needs of their mentees. Furthermore, this supports the notions of Salimi and Dehghani (2013) regarding supervision; they mentioned that through reflection, supervisors' recall their own clinical experiences as mentees to deepen their understanding of what can be improved during clinical practicum.

The ranking for the evaluative domain differed between both groups as well. Interns ranked the evaluative domain on third place, while supervisors ranked it on second place. This may suggest that supervisors highly valued intern's growth. This notion is consistent with ASHA (2008c), who stated that it is necessary for supervisors to adhere to ethical, regulatory, and legal requirements; schedule meetings with interns; and assess their growth through evaluation tools. In addition, these results are consistent with Anderson's (1988) notion of supervision. Anderson (1988) pointed out that the main

goal of supervision is the professional growth and development of both supervisors and interns. Supervision is such an important undertaking, that interns may not realize what it entails. It is a challenging task to take an intern by the hand and teach him or her multiple clinical skills throughout a semester. Because supervisors are able to see the whole picture of their responsibilities, as well as the responsibilities of their interns, it is reasonable that they place a higher value on evaluation as a means to promote growth and success.

Finally, interns and supervisors differed in their ranking for the cooperative domain. Interns rated it on fourth place, while supervisors ranked it on third place. Supervisors' ranking suggest that they value working with interns. Supervisors are willing to help interns develop competent clinical skills. Acquiring or enhancing competent clinical skills is something many interns look for, mostly novice interns. Interns who rated Tihen (1983) scale were at the intermediate or advanced level. Thus, at this stage they looked for less direct instruction from supervisors in some aspects of the supervisory process. Nevertheless, interns' ranking are consistent with the notions of Taylor et al. (2012) who indicated that interms want assistance in clinical management, data collection, report writing, developing clinical skills, and writing client goals.

Limitations

First, the current study employed a small sample size with different number of participants per group. The number of intern participants did not equal the number of supervisor participants. An overall larger sample size is recommended to increase the validity of the study.

Second, this study surveyed graduate students (known as interns) enrolled in one Master's of Science in Speech-Language Pathology. Similarly, the study surveyed supervisors in only two counties in South Florida with a broad Hispanic population. Students enrolled in a variety of university programs and supervisors across various counties and demographics should be surveyed to generalize these results to the larger population.

Finally, although the Tihen scale (Tihen, 1983) is a well-known and used assessment scale, it is lengthy, making it tedious for participants to complete. Furthermore, results from the exploratory factor analysis revealed the need to possibly revise the way items are worded or formatted. This is because the number of factors to be investigated were revealed in actuality to be 11 behavioral domains instead of five. These 11 domains may require identification. Furthermore, a bigger sample size is warranted to duplicate the results and confirm the number of factors in the data.

Future Studies

It is suggested that future studies on this topic refine Tihen's scale, use a different scale, or focus on qualitative data via interview process. A different scale or a revised version of the Tihen scale (Tihen, 1983) is recommended to assess only the five behaviors investigated on this study (passive, evaluative, active, cooperative, and affective). Alternatively, an interview process, either by phone or in person, may allow for further questioning regarding the level of importance of the supervisory domains for both interns and supervisors.

Summary of Findings

Results of the current investigation revealed discrepancies between interns and supervisors expectations during the clinical practicum experience. Specifically, on average, interns' considered that supervisors perceived all behavioral domains significantly less important than what supervisors did. The ranking of behavioral domains for what interns considered their supervisors thought important (from most to least important) were: (1) active, (2) affective, (3) evaluative, (4) cooperative, and (5) passive. The order of behavioral domains for supervisors from most to least important were (1) active, (2) evaluative, (3) cooperative, (4) affective, and (5) passive. Interns and supervisors differed in their ranking for the affective, evaluative, and cooperative domains. These differences in perceptions may affect the intern-supervisor working alliance, and in turn, the overall clinical practicum experience. Thus, it is imperative that supervisors prepare for the supervisory experience, encourage open, clear, and honest communications, and set clear expectations to enhance the clinical experience for both parties. It is presumed that eliminating misunderstandings in expectations, and barriers to communication, promotes optimal learning and partnership during clinical rotations.

REFERENCES

Adler, S., Rosenfeld, L. B., & Proctor, R. F. (2001). *Interplay: The process of interpersonal communication*. New York: Harcourt.

American Physical Therapy Association (2012). *Direction and supervision of the physical therapist assistant*. Retrieved from http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Practice/DirectionSupervisionPTA.pdf

American Speech-Language Hearing Association (2008a) *Clinical supervision in speech language pathology* (Position statement). Retrieved from http://www.asha.org/policy/PS2008-00295.htm

American Speech-Language Hearing Association (2008b). *Clinical supervision in speech-language pathology* (Technical report). Retrieved from http://www.asha.org/policy/TR2008-00296/

American Speech-Language Hearing Association (2008c) *Knowledge and skills needed by Speech-language pathologists providing clinical supervision*. Retrieved from http://www.asha.org/policy/KS2008-00294.htm

Anderson, J. L. (1988). *The supervisory process in speech language pathology and audiology*. Austin, TX: Pro-Ed.

Barnett, J. E., & Molzon, C. H. (2014). Clinical supervision of psychotherapy: Essential ethics issues for supervisors and supervisees. *Journal of clinical Psychology*, *70*(11), 1051-1061.

Begat, I., Ellefsen, B., & Severinsson, E. (2005). Nurses' satisfaction with their work environment and the outcomes of clinical nursing supervision on nurses' experiences of well-being–a Norwegian study. *Journal of Nursing Management*, *13*(3), 221-230.

Bernard, J., & Goodyear, R. (1998). *Fundamentals of Clinical Supervision* (2nd Ed.). Needham Heights, MA: Allyn & Bacon.

Browning, M., & Pront, L. (2015). Supporting nursing student supervision: An assessment of an innovative approach to supervisor support. *Nurse Education Today*, *35*(6), 740-745.

Butterworth, T., & Faugier, J. (2013). *Clinical supervision and mentorship in nursing*. New York, NY: Springer.

Cassidy, C. (2013). The relationship between perceived supervisory roles, working alliances, and students' self-efficacy in speech-language pathology practicum experiences. *SIG 11 Perspectives on Administration and Supervision, 23*, 92-109.

Cutcliffe, J. R., & Sloan, G. (2014). Towards a consensus of a competency framework for clinical supervision in nursing: Knowledge, attitudes, and skills. *The Clinical Supervisor*, *33*(2), 182-203.

Dawson, M. (2013). *Allied Health Professionals' perceptions of clinical supervision* (Doctoral dissertation). La Trobe University, Melbourne, Victoria, Australia.

Dobbs, A., McKervey, H., Roti, E., Stewart, R., & Baker, B. M. (2006). Supervisees' expectations of supervisor characteristics: Preclinical fellowship year versus postclinical fellowship year. *Contemporary Issues in Communication Disorders, 33*, 113-119.

Duncan, K., Brown-Rice, K., & Bardhoshi, G. (2014). Perceptions of the importance and utilization of clinical supervision among certified rural school counselors. *The Professional Counselor*, *4*(5), 444.

Ferguson, A. (2009). Appraisal in student-supervisor conferencing: A linguistic analysis. *International Journal of Language Communication Disorders*, 45(2), 215-229.

Fitzgerald, M. (2009). Reflections on Student Perceptions of Supervisory Needs in Clinical Education. *Perspectives on Administration and Supervision*, 19(3), 96-105.

Fowler, J. (1996). The organization of clinical supervision within the nursing profession: A review of the literature. *Journal of Advanced Nursing*, *23*(3), 471-478.

Geller, E. (2014). Broadening the "Ports of Entry" for Speech-Language Pathologists: A Reflective Model of Supervision. *Perspectives on Administration & Supervision*, 24(2), 51-61.

Geller, E., & Foley, G. (2009). Broadening the "Ports of Entry" for Speech-Language Pathologists: A Relational and Reflective Model for Clinical Supervision. *American Journal of Speech-Language Pathology*, 18, 22-41.

Hall, M., McFarlane, L., & Mulholland, S. (2012). Positive clinical placements: Perspectives of students and clinical educators in rehabilitation medicine. *International Journal of Therapy and Rehabilitation*, *19*(10), 549-556.

Haynes, R., Corey, G., & Moulton, P. (2013). Clinical supervision in the helping professions: A practical guide. *Reflective Practice: Formation and Supervision in Ministry, 1*.

Ho, D., & Whitehill, T. (2009). Clinical supervision of speech-language pathology students: Comparison of two models of feedback. *Journal of Speech-Language Pathology*, *11*(3), 244-255.

Hudspeth, E. F. (2015). An introduction to clinical supervision in play therapy: Research, practice, and application. *International Journal of Play Therapy*, 24(2), 55.

Johnson, W. B., Skinner, C. J., & Kaslow, N. J. (2014). Relational mentoring in clinical supervision: The transformational supervisor. *Journal of Clinical Psychology*, 70(11), 1073-1081.

Keintz, C. (2014). Professional supervision in speech-language pathology. *e 2014 Ohio Speech-Language-Hearing Association Annual Convention.* Ohio: Ohio Speech-Language-Hearing Association.

Lulai, R., & DeRuiter, M., Schober-Peterson, D. (2012). Supervision: The new clinical supervisor: Tools for the medical setting. *SIG 11 Perspectives on Administration and Supervision, 22*(3), 85-90.

Mandel, S. (2015). Exploring the differences in expectations between supervisors and supervisees during the initial clinical experience. *SIG 11 Perspectives on Administration and Supervision*, *25*(1), 4-30.

McCarthy, M. P., Kimble, C., & Turner, G. (2012). University: Student peer mentoring in the clinical training of speech-language pathologists. *SIG 11 Perspectives on Administration and Supervision*, *22*, 12-27.

McCrea, E. (2014, April 1). Clinical Supervision: Back to the Future. *The ASHA Leader*, 6-8.

McCrea, E., & Brasseur, J. (2003). *The supervisory process in speech-language pathology and audiology*. Boston, MA: Pearson Education.

Mead, J., Young, A., Sakowitz, L., Tienstra, J., Perez, M., McComas, K., Zelenke III, J. (2014). *Making A Comparison: The Differences Between Students Expectations of the Supervisory Process.* Poster Presentation Presented at the Florida Association of Speech-Language Pathologists and Audiologists, Marco Island, Florida.

Mead, J., Marshall, K., Prentice, A., Marin, A., Cruz, B., Zelenke III, J. (2015). *Supervisory Expectations: Are There Perceived Differences Between Interns and*

Supervisors? Poster Presentation Presented at the Florida Association of Speech-Language Pathologists and Audiologists, Marco Island, Florida.

O'Connor, L. (2008, April 15). A Look at Supervision in the 21st Century. *The ASHA Leader*, 14-18.

Ostergren, J. (2011). The first year of professional service in speech-language pathology: supervisory role, working relationships, and satisfaction with supervision. *Contemporary Issues in Communication Science and Disorders, 38*, 61-75.

Pickering, M. (1984). Interpersonal communication in speech-language pathology supervisory conferences. *Journal of Speech and Hearing Disorders*, *49*, 189-195.

Salimi, T., & Dehghani, H. (2013). Clinical supervision in nursing education: Definitions and models. *Iranian Journal of Medical Education*, *13*(3), 179-187.

Special Interest Group 11, Administration and Supervision (Special Interest Group 11, Administration and Supervision, n.d.)

Tihen, L. D. (1983). Expectations of Student Speech/Language Clinicians During Their Clinical Practicum. ProQuest Dissertations and Theses.

Taylor, K., White, E., Kaplan, R., & O'Rourke, C. M. (2012). University: The supervisory process in speech-language pathology: Graduate students' perspective. *Perspectives on Administration & Supervision, 22*(2), 47-54.

Von Zweck, C. (n.d). *The art of supervision for occupational therapists*. Retrieved from http://www.caot.ca/otnow/nov%2007/supervision.pdf

Young, S., & A. Steelman, L. (2012). The role of feedback in supervisor and workgroup identification. *Personnel Review*, *43*(2), 228-245.

APPENDIX A

Tihen's STUDENT EXPECTATIONS OF THEIR CLINICAL SUPERVISOR(S) Scale

Please circle the number that in your opinion best represents the importance you place on the following supervisory behaviors in the (left column), labeled "Students" and the importance you believe your supervisor has on the same behavior in the right column, labeled "SOR". The numbers correspond to the following categories:

1-Very Unimportant 4- Neutral 7-Very Important
2-Medium Unimportant 5-Low Important
3-Low Unimportant 6-Medium Important

Student		SOR
1 2 3 4 5 6 7	1. The supervisor should provide me with suggestions during the supervisory conference.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	2. The supervisor should demonstrate behavior modification techniques to control inappropriate behavior by my clients.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	3. The supervisor should function as a teacher during my clinical practicum.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	4. The supervisor should relate academic information to therapy situations.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	5. The supervisor should evaluate my performance during the clinical practicum.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	6. The supervisor should provide the opportunity for me to express my opinions during supervisory conferences.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	7. The supervisor should provide the opportunity for me to evaluate my performance during the clinical practicum.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	8. The supervisor and I should work together in determining the therapy goals and objectives for my client.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	9. The supervisor should be patient with me.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	10. The supervisor should provide the opportunity for me to identify my clinical weaknesses.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	11. The supervisor should provide the opportunity for me to identify my clinical strengths.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	12. The supervisor should function as an evaluator during my clinical practicum.	1 2 3 4 5 6 7

1 2 3 4 5 6 7	13. The supervisor should provide the opportunity for me to regulate my own professional conduct.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	14. The supervisor should encourage me to discuss my personal feelings about the clinical practicum.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	15. The supervisor and I should work together in identifying my clinical strengths.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	16. The supervisor and I should work together in identifying my clinical weaknesses.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	17. The supervisor should provide the opportunity for me to develop therapy lesson plans.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	18. The supervisor should evaluate my lesson plans.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	19. The supervisor should evaluate me primarily for the purpose of making appropriate modifications in my clinical performance.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	20. The supervisor should keep me informed of my progress throughout the clinical practicum.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	21. The supervisor and I should work together in the writing of my clients' clinical reports.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	22. The supervisor should provide me with the clinical techniques/strategies to be used with my client.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	23. The supervisor should be a warm, accepting person.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	24. The supervisor should provide me with well-defined, objective criteria that will be used to determine my success in the clinical practicum.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	25. The supervisor should provide me with the opportunity to determine the therapy goals and objectives for my client.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	26. The supervisor and I should work together in developing therapy lesson plans.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	27. The supervisor's comments and suggestions should be directed to my clinical behavior.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	28. The supervisor should diagnose the client's problems/needs.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	29. The supervisor should regulate my professional conduct.	1 2 3 4 5 6 7

1 2 3 4 5 6 7	30. The supervisor should provide the opportunity for us to contribute information during supervisory conferences.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	31. The supervisor should tell me which diagnostic instruments are to be used with my client.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	32. The supervisor should make positive value judgments about my clinical competence (praise).	1 2 3 4 5 6 7
1 2 3 4 5 6 7	33. The supervisor should provide me behavior modification techniques to control inappropriate behavior by the client.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	34. The supervisor should evaluate my clinical reports.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	35. The supervisor should have a sense of humor.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	36. The supervisor should provide the opportunity for me to write my clients' clinical reports.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	37. The supervisor should provide the opportunity for me to make suggestions during the supervisory conference.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	38. The supervisor and I should work together in regulating my own professional conduct.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	39. The supervisor should talk more than me during supervisory conferences.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	40. The supervisor should demonstrate diagnostic techniques/procedures with my client.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	41. The supervisor and I should work together in determining the clinical techniques/strategies to be used with my client.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	42. The supervisor should provide the opportunity for me to develop behavior modification procedures to control inappropriate behavior by my clients.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	43. The supervisor should provide me with therapy goals and objectives for my client.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	44. The supervisor should provide the opportunity for me to ask questions during the supervisory conference.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	45. The supervisor and I should work together in determining which diagnostic instruments are appropriate for use with my	1 2 3 4 5 6 7

	clients.	
1 2 3 4 5 6 7	46. The supervisor should identify my clinical strengths.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	47. The supervisor should provide the opportunity for me to determine the clinical techniques/strategies to be used with my client.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	48. The supervisor should be an understanding person.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	49. The supervisor should be considerate of me.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	50. The supervisor should identify my clinical weaknesses.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	51. The supervisor should respect my individuality.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	52. The supervisor should provide supervision that is free of anxiety.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	53. The supervisor should provide the opportunity for me to diagnose the clients' problems/needs.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	54. The supervisor should maintain confidentiality about my performance during the clinical practicum.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	55. The supervisor and I should work together in the application of my academic work to therapy situations.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	56. The supervisor and I should work together in evaluating my performance during the clinical practicum.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	57. The supervisor and I should provide demonstration therapy with my client.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	58. The supervisor and I should work together in developing behavior modification procedures to control inappropriate behavior by my clients.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	59. The supervisor should provide me with therapy lesson plans.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	60. The supervisor should provide the opportunity for me to select the appropriate diagnostic instruments to use with my clients.	1 2 3 4 5 6 7
1 2 3 4 5 6 7	61. The supervisor should provide the opportunity for me to relate my academic work to therapy situations.	1 2 3 4 5 6 7

1 2 3 4 5 6 7	62. The supervisor should provide me with information during supervisory conferences.	1 2 3 4 5 6 7

APPENDIX B

Tihen's STUDENT EXPECTATIONS OF THEIR CLINICAL SUPERVISOR(S) Scale

(Modified to be completed by Supervisors)

Please circle the number that in your opinion best represents the importance you place on the following supervisory behaviors.

1-Very Unimportant
2-Medium Unimportant
3-Low Unimportant
4- Neutral
5-Low Important
6-Medium Important
7-Very Important

1. The supervisor should provide suggestions during the supervisory conference.	1 2 3 4 5 6 7
2. The supervisor should demonstrate behavior modification techniques to control inappropriate behavior by the patients/clients.	1 2 3 4 5 6 7
3. The supervisor should function as a teacher during the clinical practicum.	1 2 3 4 5 6 7
4. The supervisor should relate academic information to therapy situations.	1 2 3 4 5 6 7
5. The supervisor should evaluate student performance during the clinical practicum.	1 2 3 4 5 6 7
6. The supervisor should provide the opportunity for the intern to express his/her opinions during supervisory conferences.	1 2 3 4 5 6 7
7. The supervisor should provide the opportunity for the intern to evaluate his/her performance during the clinical practicum.	1 2 3 4 5 6 7
8. The supervisor and the intern should work together in determining the therapy goals and objectives for the clients/patients.	1 2 3 4 5 6 7
9. The supervisor should be patient with the intern.	1 2 3 4 5 6 7
10. The supervisor should provide the opportunity for the intern to identify his/her clinical weaknesses.	1 2 3 4 5 6 7
11. The supervisor should provide the opportunity for the intern to identify his/her clinical strengths.	1 2 3 4 5 6 7
12. The supervisor should function as an evaluator during the clinical practicum.	1 2 3 4 5 6 7
13. The supervisor should provide the opportunity for the intern to regulate his/her own professional conduct.	1 2 3 4 5 6 7
14. The supervisor should encourage the intern to discuss his/her personal feelings about the clinical practicum.	1 2 3 4 5 6 7

15. The supervisor and the intern should work together in identifying the intern's clinical strengths.	1 2 3 4 5 6 7
16. The supervisor and the intern should work together in identifying the intern's clinical weaknesses.	1 2 3 4 5 6 7
17. The supervisor should provide the opportunity for the intern to develop therapy lesson plans.	1 2 3 4 5 6 7
18. The supervisor should evaluate the intern's lesson plans.	1 2 3 4 5 6 7
19. The supervisor should evaluate the intern primarily for the purpose of making appropriate modifications in his/her clinical performance.	1 2 3 4 5 6 7
20. The supervisor should keep the intern informed of his/her progress throughout the clinical practicum.	1 2 3 4 5 6 7
21. The supervisor and the intern should work together writing the patients'/clients' clinical reports.	1 2 3 4 5 6 7
22. The supervisor should provide the intern with the clinical techniques/strategies to be used with the patients/clients.	1 2 3 4 5 6 7
23. The supervisor should be a warm, accepting person.	1 2 3 4 5 6 7
24. The supervisor should provide the intern with well-defined, objective criteria that will be used to determine the intern's success in the clinical practicum.	1 2 3 4 5 6 7
25. The supervisor should provide the intern with the opportunity to determine the therapy goals and objectives for the clients.	1 2 3 4 5 6 7
26. The supervisor and intern should work together in developing therapy lesson plans.	1 2 3 4 5 6 7
27. The supervisor's comments and suggestions should be directed to the intern's clinical behavior.	1 2 3 4 5 6 7
28. The supervisor should diagnose the patients/client's problems/needs.	1 2 3 4 5 6 7
29. The supervisor should regulate the intern's professional conduct.	1 2 3 4 5 6 7
30. The supervisor should provide the opportunity for both intern and supervisor to contribute information during supervisory conferences.	1 2 3 4 5 6 7
31. The supervisor should tell the intern which diagnostic instruments are to be used with the patients/clients.	1 2 3 4 5 6 7
32. The supervisor should make positive value judgments about the intern's clinical competence (praise).	1 2 3 4 5 6 7
33. The supervisor should provide the intern behavior modification techniques to control inappropriate behavior by the patient/client.	1 2 3 4 5 6 7
34. The supervisor should evaluate the intern's clinical reports.	1 2 3 4 5 6 7
35. The supervisor should have a sense of humor.	1 2 3 4 5 6 7

36. The supervisor should provide the opportunity for the intern to write the patients'/clients' clinical reports.	1 2 3 4 5 6 7
37. The supervisor should provide the opportunity for the intern to make suggestions during the supervisory conference.	1 2 3 4 5 6 7
38. The supervisor and the intern should work together in regulating the intern's own professional conduct.	1 2 3 4 5 6 7
39. The supervisor should talk more than the intern during supervisory conferences.	1 2 3 4 5 6 7
40. The supervisor should demonstrate diagnostic techniques/procedures with the patients/clients.	1 2 3 4 5 6 7
41. The supervisor and the intern should work together in determining the clinical techniques/strategies to be used with the patients/clients.	1 2 3 4 5 6 7
42. The supervisor should provide the opportunity for the intern to develop behavior modification procedures to control inappropriate behavior by the patients/clients.	1 2 3 4 5 6 7
43. The supervisor should provide the intern with therapy goals and objectives for the patients/clients.	1 2 3 4 5 6 7
44. The supervisor should provide the opportunity for the intern to ask questions during the supervisory conference.	1 2 3 4 5 6 7
45. The supervisor and the intern should work together in determining which diagnostic instruments are appropriate for use with the patients/clients.	1 2 3 4 5 6 7
46. The supervisor should identify the intern's clinical strengths.	1 2 3 4 5 6 7
47. The supervisor should provide the opportunity for the intern to determine the clinical techniques/strategies to be used with the patients/clients.	1 2 3 4 5 6 7
48. The supervisor should be an understanding person.	1 2 3 4 5 6 7
49. The supervisor should be considerate of the intern.	1 2 3 4 5 6 7
50. The supervisor should identify the intern's clinical weaknesses.	1 2 3 4 5 6 7
51. The supervisor should respect the intern's individuality.	1 2 3 4 5 6 7
52. The supervisor should provide supervision that is free of anxiety.	1 2 3 4 5 6 7
53. The supervisor should provide the opportunity for the intern to diagnose the clients' problems/needs.	1 2 3 4 5 6 7
54. The supervisor should maintain confidentiality about the intern's performance during the clinical practicum.	1 2 3 4 5 6 7
55. The supervisor and the intern should work together in the application of academic work to therapy situations.	1 2 3 4 5 6 7
56. The supervisor and the intern should work together in evaluating the intern's performance during the clinical	1 2 3 4 5 6 7

practicum.	
57. The supervisor and the intern should provide demonstration therapy with the patients/client.	1 2 3 4 5 6 7
58. The supervisor and the intern should work together in developing behavior modification procedures to control inappropriate behavior by the patients/clients.	1 2 3 4 5 6 7
59. The supervisor should provide the intern with therapy lesson plans.	1 2 3 4 5 6 7
60. The supervisor should provide the opportunity for the intern to select the appropriate diagnostic instruments to use with the patients/clients.	1 2 3 4 5 6 7
61. The supervisor should provide the opportunity for the intern to relate academic work to therapy situations.	1 2 3 4 5 6 7
62. The supervisor should provide the intern with information during supervisory conferences.	1 2 3 4 5 6 7

APPENDIX C

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Office of Research Integrity
Research Compliance, MARC 270

MEMORANDUM

To: Dr. Jean Mead

CC: File

From: Maria Melendez-Vargas, MIBA, IRB Coordinator

Date: July 23, 2015

Protocol Title: "A Comparison between Student Interns' and Supervisors' Beliefs on Supervisory Behaviors in Speech Language Pathology"

The Florida International University Office of Research Integrity has reviewed your research study for the use of human subjects and deemed it Exempt under 46.101(b) (1) of the Common Rule via the **Exempt Review** process.

IRB Protocol Exemption #: IRB-15-0260 **IRB Exemption Date:** 07/23/15
TOPAZ Reference #: 103841

As a requirement of IRB Exemption you are required to:

1) Submit an Event Form and provide immediate notification of:
   - Any additions or changes in the procedures involving human subjects.
   - Every serious or unusual or unanticipated adverse event as well as problems with the rights or welfare of the human subjects.
2) Submit a Project Completion Report Form when the study is finished or discontinued.

Special Conditions:

For further information, you may visit the IRB website at http://research.fiu.edu/irb.

MMV/em