Facilitating Clinical Training: Issues for Supervisees and Their Supervisors

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Clinicians enter their first practicum with a variety of expectations. Generally, they are excited about beginning patient treatment and putting their knowledge into practice. They are often anxious; not knowing if they are going to succeed at the career they have chosen. As a result of being parented, going to school, and having lived life, they bring to the process a variety of ideas about being supervised (Cogan, 1978).

Without academic exposure to supervision, they often enter their first supervisory conference with an expectation that supervisors will tell them what to do and then will also be the judge of their performance. Thus, they often enter the process with the idea that they will assume a passive stance, with the supervisor being the primary decision-maker.

Clinicians rapidly discover that a supervisor’s style that is predominately “telling” is not satisfying. In particular, they begin to feel that they are not viewed as an active, contributing member of the clinical team. According to Dowling (1992b):

Supervisees want, particularly as they gain in experience, to be actively involved in the conference and do not want to assume a passive stance in which they are simply told what to do. They do expect and appreciate feedback. They also desire the opportunity to contribute their thoughts and have their ideas incorporated, respected, and responded to in a thoughtful manner. In sum, they ask to be valued as a person and as an emerging professional with potential. (p. 138)

Supervisees want to become competent and have the ability to function independently as an outcome of clinical training. They also want to feel good about their professional self and the work they do.

The supervisees’ experiences in their first and subsequent practicums are related, of course, to their clinical abilities. They are also shaped by the competencies their supervisors exhibit and the preparation for supervision that these trainers have had (American Speech-Language-Hearing Association, 1985; Dowling, 1992b). Training in supervision for the supervisee optimizes the effect of the training process (McCrea, 1985). Thus, the value of preparing both the supervisor and the supervisee for participation in the supervisory process is the focal point for the material that follows.

ABSTRACT: The educational process in speech-language pathology and audiology is intended to produce a competent supervisee who is capable of independent practice. Academic and clinical training are designed to achieve this goal. This article focuses on the latter aspect of this process—clinical training. Goals for clinical education are proposed and a supervisory model is discussed for fostering clinician independence. The effects on supervisees when they experience optimal and non-optimal supervision are explored through an example. The cause of non-optimal supervision—the lack of supervisor training—is examined. This is followed by a charge to clinicians to (a) seek out quality supervision and (b) be assertive in insisting that instruction in supervision be an integral component of their training program. The final aspect consists of suggestions for clinicians for optimizing supervision when they find themselves in circumstances that are less than ideal.

PURPOSE

The purpose of the following material is to address issues that are related to students’ growth, the effects of supervisory experiences on their development, and the role they may take in enhancing their own education. In particular, goals for clinical education are proposed and a supervisory model is discussed for fostering clinician independence.
The effects on supervisees when they experience optimal and non-optimal supervision are explored through an example. The cause of non-optimal supervision—the lack of supervisor training—is examined. This is followed by a charge to clinicians to (a) seek out quality supervision and (b) be assertive in insisting that preparation in supervision be an integral component of their training program. The final aspect consists of suggestions for clinicians for optimizing supervision when they find themselves in circumstances that are less than ideal.

**Goals for Clinical Training**

Numerous authors such as Anderson (1988), Dowling (1992a), and Farmer and Farmer (1989) have stated that the goal of supervision is to produce a competent supervisee who is capable of independent practice. That is, in novel situations, these clinicians will have the insight, skills, and tools needed to function successfully. The buds of clinical independence may emerge early in training but, in general, are acquired over time, with the emergence being heavily linked to the type and quality of supervision clinicians receive.

As stated above, the ultimate goal for clinicians is clinical competence and independence. Two sub-objectives underlie the emergence of this desired end product. These are (a) the acquisition of the tools, data collection and clinical observation, that form the infrastructure for clinical independence and (b) the increasingly active participation of clinicians in the supervisory process. A change of stance from passive to fully active is fundamental to the development of clinical independence.

**Clinician Objective 1-Tool 1.** In regard to data collection, supervisees are often exposed to this process as a means to measure client performance. Rarely are they taught it on a more complex level as a tool for clinical problem-solving. In practice, data collection and analysis prove to be essential tools underlying the achievement of clinical self-sufficiency.

Data may take a variety of forms, ranging from a simple tally to sequential methodologies. A tally is just a count of how many times an event occurred. It could be the number of times a client made a correct response or exhibited a specific off-task behavior such as hitting. The data may also be clinician-focused. Tally-type data may be gathered in regard to the number of times a clinician reinforced or used a three-word utterance as a model. Informal sequential data may also be collected where counts are made of more than one event, with the sequence recorded. For example, a clinician may want to know which behaviors precede client off-task behavior, or if presenting certain types of models enhances client performance.

An extensive example of a sequential analysis of clinician-client talk and the related analysis appear in Appendix A. More complex sequential data may also be gathered through the use of a formal observation system such as the Boone-Prescott category system (Boone & Prescott, 1972). The key point is that whenever something is or is not working clinically, through data collection and analysis, it is possible to determine the reasons for success or failure. A more complete discussion of data collection as a tool may be found in Casey, Smith and Ulrich (1988) and in Dowling and Wall (1992).

**Clinician Objective 1-Tool 2.** To succeed, trainees also need to acquire the second tool, accurate clinical observation of both the client and clinician. This includes the definition of the nature of a response and then looking to see if it occurs. Often, initial observation skills are taught in a pre-practicum course. Training might include a discussion of the types of charting that might be used to collect client data in a therapy session. This is then followed by practice watching therapy with guidance to ensure that observations are accurate and consistent. The appropriate interpretation of observations is a higher level skill that is usually refined during the supervisory process.

In general, clinicians are trained to observe client behavior but are rarely taught to extend this observation to their own behaviors. A clinician's reinforcement pattern or even a nonverbal behavior such as eye contact may be considered. The purpose for viewing the clinician is twofold. First, it is intended to assess the impact of clinician behavior on treatment outcomes. For example, a clinician may be convinced that her client accurately self-evaluates his articulation productions. She has data that show that the client thought that eight of his utterances were correct and four were incorrect during the last session. In looking at a videotape of that session, the clinician discovers that when the client's responses are correct, the clinician nods her head slightly before the client self-evaluates. When he has an error, the clinician hesitates and then asks him if it is correct. The clinician sees that the only time she specifically asks "Was that correct?" is when the response is in error. This information makes the clinician reconsider her view that her client is effectively self-evaluating. This finding leads then, to the second purpose for viewing the clinician, which is to assist supervisees in modifying their own behaviors. The information gained from this observation of self allows clinicians to change their personal behaviors in ways that improve therapy and foster ongoing professional development. In sum, accurate observation of both client and self contribute to clinical success.

**Clinician Objective 2.** The second goal stated for clinicians as they move toward clinical independence is active participation in the supervisory process. In essence, they are learning to be their own supervisor. At the outset, most are likely to be passive participants. To begin the process of moving toward independence, supervisees benefit from involvement in observation, data collection, problem-solving, and the beginnings of collaboration in the conference. A supervisory model that may be used to guide supervisees toward this active participation follows.

The Anderson (1988) continuum of supervision model appears in Figure 1. It is an excellent vehicle for adapting supervision to supervisee needs. The first stage, evaluation-feedback, is a direct style of supervision in which supervisors actively guive supervisee performance by engaging in a significant amount of telling. At this stage, supervisees are generally new to clinical work and feel a strong need for how-to directions from the supervisor. As a result, they are relatively passive participants in the conference. They, as
well as the supervisor, bring observations and concerns to the conference, but it is the supervisor who problem-solves and suggests what will be done in the next therapy session. This style of supervision is appropriate in the initial stages for a beginning clinician. It is also appropriate for experienced clinicians in crisis situations and when a clinician is working with a client with a disorder that has not been seen previously. However, a movement into the transitional stage of supervision should begin as soon as possible.

In the transitional phase, supervisees begin to take an increasingly active role in the conference. They become involved in data collection and in the observation of the clinical process. Supervisees assume incremental responsibility for the agenda of the conference, problem-solving, and strategy development. A conference near the end of the transitional stage will reflect this shift in responsibility. The clinician will dominate talk time, problem-solving, and strategy development. This will be paralleled by a decrease in the same behaviors by the supervisor as the supervisory relationship moves toward extensive collaboration.

When appropriate, a shift into the final stage of the supervisory model—self-supervision—will occur. Here, supervisees will be actively involved in self- and client-analysis, will independently problem-solve, and will generate strategies and examine outcomes. Supervisees will also determine if and when conferences are needed. In response, the supervisor will assume a consultative role, serving predominately as a resource and/or sounding board.

Two major concepts are the foundation of Anderson’s (1988) continuum of supervision. First, the model is fluid in that supervision changes depending on the needs of the supervisee. Thus, for a given supervisee, the supervisor’s style fluctuates from direct to collaborative to consultative as the supervisee moves through the three stages of supervision: evaluation-feedback, transitional, and finally self-supervision. Second, the underlying tenet of this model is to continually guide a supervisee along the continuum toward self-supervision and clinical autonomy. In sum, this model provides the structure for supervision that is responsive to a supervisee’s level of development. However, it is important to note that implementation of this model requires substantial skill on the part of the supervisor in order to accurately diagnose the clinician and to respond with the appropriate type of supervision.

In optimal circumstances, supervisees will receive supervision at their level of need. When they need active support, their supervisors will be direct. As they grow, they will be given opportunities to become increasingly involved in data collection, problem-solving, and strategy development through collaboration with their supervisor. And then, when they are able, they will be encouraged to engage in self-supervision. Ideally, all clinicians will have this experience. Unfortunately, in actual practice, ideal supervision frequently does not occur.

Supervisee Outcomes With and Without Optimal Supervision

The experiences of two clinicians, Pam and Debra, will be used to illustrate the potential outcomes of supervision: that which is at the level of supervisee need and that which is not. The clinicians are both beginning their first practicum. Both have excelled in the classroom and have demonstrated strong clinical potential. They are each assigned a 4-year-old client who exhibits a moderate articulation and language disorder.

Pam. During her first conference with her supervisor, Pam appreciates the specific suggestions from her supervisor. As a result, she feels comfortable on the first day of therapy. However, Pam soon finds her conferences with her supervisor falling into a pattern. The meetings begin in an impromptu fashion to a question like “Well, how did things go this week?” Pam might then share some concerns with the supervisor and/or the supervisor may raise issues. Pam then reports relevant observations regarding what has occurred in therapy. Her supervisor then reflects on the meaning of what has happened and then tells Pam how to move forward or solve the problem.

Although Pam really likes her supervisor and is doing well clinically, she begins to feel frustrated because she is not being allowed to take responsibility for her client. She does what the supervisor suggests, but doesn’t feel that she is able to try things or figure out issues on her own. Pam is often aware of aspects of treatment that go well and of others that do not. But, she remains anxious because she hasn’t been able to puzzle out why events happen the way they do or how to alter them.
By the end of the term, Pam feels confident she could treat other clients who exhibited a disorder similar to her current case. But, she senses that she will be starting over, at the beginning, with clients exhibiting other types of disorders. She does appreciate that her supervisor guided her to success with this client. At the same time, she is disappointed that she hasn’t grown as a professional to the degree she expected.

Debra. Debra, too, is pleased with the outcomes of her initial conferences with her supervisor. The supervisor gives her suggestions that help her get her feet on the ground that first few weeks. She likes that her supervisor has a planned agenda for the conference and always asks Debra what she wants to talk about during the meeting. Her supervisor then begins to bring data regarding Debra’s session to the conferences. Debra is pleased when the supervisor asks her what she thinks the therapy-related data mean. She also likes being encouraged to contemplate what she might do in her next therapy session as a result of the data-based information regarding her therapy. She appreciates that her supervisor has assisted her in setting goals for her own professional growth for the term. Although she thinks using data in the conference to problem-solve is helpful, Debra becomes somewhat annoyed when her supervisor suggests that she begin to take responsibility for the data collection. It is extra work for Debra and the other clinicians aren’t having to do it.

Toward the end of the term, Debra finds that she enjoys collecting data and that she often has two or three solutions for a problem before she even meets with her supervisor to discuss the issue. She also discovers that she really likes suggesting agenda items for the conference with her supervisor. She feels that they really talk about her concerns and that she is an active participant in supervision.

At the end of the term, Debra reflects on her experience. She is very satisfied with her clinical and supervisory experience. She is confident that she will be able to decide what to do with her next client, even if her client presents with a totally different problem. Of utmost importance is her feeling that she has really grown as a clinician this term.

Analysis

In the scenarios above, Pam has experienced direct, unchanging supervision. She wasn’t allowed to become an active participant in the conference. The outcomes are apparent. Pam has succeeded in clinic but has not begun to take the steps toward clinical independence. She has been a passive participant in the conference and has not collected data, problem-solved, or generated strategies. As a result, she feels comfortable working with a client with a disorder with which she has had experience, but has no new tools to assist her with a different clinical experience. Supervision was not responsive to her level of need.

In contrast, Debra’s supervision began as direct but, as she was ready, her supervisor guided her into the transitional stage of supervision by encouraging her to actively participate in the conference. She has learned the importance of data collection and its use as the basis for clinical problem-solving. Debra was also taught the merit of setting personal professional growth goals and the value of taking increasing responsibility for the content of the conference. The supervision she experienced was responsive to her level of need and has allowed her to begin the progression toward clinical independence.

The discrepancies in the supervisory experiences noted here reflect a commonly found problem. Many supervisees find themselves in circumstances in which they experience direct, unchanging supervision when it is in their best interest to have supervision that is responsive to their needs. Many clinicians report that even when they are near the end of their training and are in externship sites, they are being told what to do and are not being encouraged to be active participants in the supervisory process. They report that it is a rare circumstance in which clinician professional goals are set or data is collected for the purpose of problem-solving. The question then, is: “Why does this happen?” The answer lies in the fact that the majority of supervisors have evolved into supervisory positions and have not had specific training in the supervisory process. They have not been trained to diagnose clinicians, nor do they have a working knowledge of effective supervisory models. As a result, they have not practiced implementing collaborative supervision nor studied the effects of using different supervisory styles on supervisee professional growth. A brief look at the literature on supervision and supervisory training may be helpful in showing why supervisory training is so important.

Supervisory Training and Its Effects

Much of the early literature in supervision clearly documents that persons without specific supervisory training tend to provide direct supervision in most instances. This is true whether it is a beginning or mature clinician (Roberts & Smith, 1982). This occurs even when supervisors think that they generally use a style other than direct (Blumberg & Amidon, 1965).

Supervision also does not change with time in a given supervisor-clinician relationship (Culatta & Seltzer, 1977). Supervision tends to be direct or telling, with clinician passive participation independent of the clock hour experience level of the clinician. It also remains static over the length of the relationship.

Attempts to modify supervisor behavior show variable findings. Specific interventions without broad training meet with mixed success. Hagler, Casey, and DesRochers (1989) reported that they provided feedback to supervisors regarding their interpersonal effectiveness in the conference. The supervisors were given (a) computerized feedback regarding their levels of performance and (b) suggestions for improvement. However, the feedback had no effect on supervisor talk behavior in the conference.

In another study, Hagler (1986) discovered that specific prompts to talk less through a “bug-in-the-ear” did decrease supervisory talk time. The provision of data regarding talk time and contingent social praise for reducing talk time, however, has no impact.
Brasseur (1989), Strike-Roussos (1988), and Dowling (1993) have done broader-based training studies that demonstrate that supervisor talk behavior may be altered in the conference. Strike-Roussos (1988) reported designing a specific training program to teach two behaviors: (1) the use of open-ended questions and (2) the inclusion of talk regarding the supervisory process in the conference. These behaviors do increase in frequency of occurrence following instruction.

On a more global level, Brasseur (1989) described a 9-academic-hour training program instituted over three semesters for off-campus practicum supervisors. Brasseur reported that the training regimen allowed participants to add behaviors that were not previously in their repertoires. Their conference styles became more collaborative and their interpersonal skills improved.

Dowling (1993) reported that a formal academic course in clinical supervision with a grade-contingent goal-setting component assisted supervisors-in-training to shift their conference talk behavior away from a direct style. As a result of training, they reduced the amount of supervisor talk time, collected data, and used it in the conference for problem-solving. Dowling (1992a) reported that coursework in supervision also changed philosophical orientations regarding supervision. With training, supervisors were more likely to have a plan for observing a clinician, a goal to collect data during the observation, and an attitude regarding observing that shifts away from a direct model of supervision to one that is more facilitative.

The American Speech-Language-Hearing Association (ASHA) adopted a position statement regarding clinical supervision in 1985 (ASHA, 1985). The 13 tasks of supervision and the underlying competencies needed by supervisors for implementation were stated as the basis of effective clinical supervision. The tasks appear in Appendix B. The skills and competencies relating to the tasks may be obtained through formal coursework and practicums in supervision or through a wide variety of continuing education opportunities. It is clear, though, that training is needed to achieve the specified supervisory skills. In particular, knowledge regarding supervisory models and their appropriate implementation are critical.

To foster supervisee development, the supervision literature underscores the need for supervisory training. The supervisory skill of providing optimal supervision rarely emerges spontaneously. ASHA (1985) supports the view that to provide quality supervision, supervisors need the skills and competencies underlying the implementation of the 13 tasks of supervision.

Supervisees clearly benefit from supervision at their level of need. And yet, supervisees often find themselves participating in supervision that is not optimal. This problem is compounded by the supervisees' lack of information regarding the supervisory process and their appropriate role. If these circumstances are to change, supervisees need to take a stand and become active advocates for components in their training programs that enhance professional growth. They may do this by carefully selecting where they train and by becoming involved in the development of the curriculum in the program they do select.

**CHARGE TO CLINICIANS**

Prospective graduate students are wise to solicit information regarding a training program's commitment to supervisory training. This might take the form of a letter of inquiry to the program chair. Examples of some appropriate questions would be:

- Have the supervisors in the program had formal training in supervision?
- Are training opportunities in supervision provided to externship supervisors?
- Are members of the supervisory staff involved in research on the supervisory process and its effects on clinical training?
- Is there a supervision course in the curriculum?

Answers to these questions will allow the potential student to assess the value attached to quality supervision in a given program.

It is in the prospective graduate student's best interest to select a graduate program that has supervisors with specific preparation in supervision and a program that offers coursework and ideally practicum opportunities in the supervisory process. If, after they have selected a program, they find themselves in a less than optimal environment, students need to take responsibility for their professional development. Students need to actively urge their graduate programs to provide education in supervision. This instruction would be for in-house supervisors, supervisors in externship sites, and supervisors-in-training, as well as for clinicians moving into the clinical process.

Supervisees at both the undergraduate and beginning graduate level benefit from training in supervision (McCrea, 1985). It assists them in having a realistic expectation regarding supervision and their role in that process. Indeed, they learn that their role is not that of a passive participant. They also develop skill in collecting data and applying it to clinical problems. They will understand the need to look at diagnosis and treatment critically with an eye to puzzling out the whys and appropriate solutions. They will understand the importance of not only considering client performance, but their own as well. If they have these skills and an understanding of the path leading to clinical independence, they will be more likely to participate actively in supervisory conferences when they begin clinical practice. The resulting collaboration between the clinician and supervisor will aid them in moving through the continuum of supervision toward clinical independence.

**Clinician Strategies in Non-Optimal Supervision Circumstances**

Even in the best of circumstances, clinicians may find themselves in a supervisory relationship that is direct in style and unchanging. When this happens, they may choose to engage in behaviors that are likely to alter the supervisor's behavior. The suggestions that follow are only a sampling of tactics a supervisee might employ to modify
supervisor behavior in ways that enhance supervisee growth. For example, instead of coming to the conference unprepared, the supervisee may come to the meeting with a list of agenda items. Because the supervisor using a direct style of interaction is unlikely to have a planned agenda for the conference, the supervisee’s entries are likely to be discussed. If supervisors have learned to collect data, they benefit from bringing the information they have gathered to the conference. Raising issues in regard to the specific data is likely to trigger active problem-solving, which is hopefully joint in nature. Collecting data and initiating discussion will also convey a message to the supervisor that the supervisee wants to and is capable of being actively involved.

Another example is that a supervisee might use the Crago (1987) format for preparing for the conference. This includes picking out three segments of therapy: one that was successful, one that was not successful, and a third that surprised the clinician. The supervisee then picks one to present during the conference, with a specific issue selected as the focal point for the discussion. This is likely to alter the direction of the conference from the general “What would you like to talk about today?” to a discussion of issues that are relevant to the supervisee’s level of need. Each of the above are samples of strategies that are likely to nudge the supervisor away from telling and into a more shared supervisory relationship. Thus, when optimal circumstances do not exist, clinicians may choose to intervene in ways that will cause supervisors to behave in ways that will enhance clinician professional development.

CONCLUSION

Clinician professional development is the responsibility of all involved: training programs, supervisors, and supervisees. The goal of supervisee clinician competence and independence is best achieved in settings that have made a commitment to supervision. Clinicians are then prepared for the process so that they know what to expect and have the tools to participate as fully as they are able. The supervisors, both in-house and in externship settings, are knowledgeable about supervisory models, diagnosing clinicians, and adapting supervision to the level of supervisee need. The likely result is optimal clinician growth with ongoing movement toward clinical competency and independence. When these circumstances do not exist, supervisees must become active advocates for quality supervision.

REFERENCES


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APPENDIX A. EXAMPLE OF SEQUENTIAL DATA COLLECTION FOR USE IN CLINICAL PROBLEM-SOLVING

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Clinician talk total = 51  Client talk total = 18
Clinician to client talk ratio = 2.83 to 1

The above example relates to the ratio of clinician and client talk during one treatment activity. Three categories of clinician talk were recorded: model, reinforcement, and “other” statements. Correct, incorrect, and other responses were also collected for the client but, interestingly enough, “other” responses did not occur for the client. The clinician modelled 12 times, reinforced in seven instances, and made additional comments 32 times, for a total of 51 clinician utterances. In contrast, the client had nine correct responses and seven incorrect, a total of 16 responses. As part of the analysis, the ratio of clinician to client talk was calculated and was found to be 2.8:1. It was determined that the clinician was talking too much. It was noted that if the clinician were able to eliminate the “other” comments alone, the level of supervisee to client talk would drop to 1:1. The latter would appear to be more appropriate in a therapeutic relationship. As a result of these data, the clinician developed a goal to reduce her talk time in treatment.


APPENDIX B. THE THIRTEEN TASKS OF SUPERVISION (ASHA, 1985)

“The tasks are:
1. Establishing and maintaining an effective working relationship with the supervisee;
2. Assisting the supervisee in developing clinical goals and objectives;
3. Assisting the supervisee in developing and refining assessment skills;
4. Assisting the supervisee in developing and refining management skills;
5. Demonstrating for and participating with the supervisee in the clinical process;
6. Assisting the supervisee in observing and analyzing assessment and treatment sessions;
7. Assisting the supervisee in development and maintenance of clinical and supervisory records;
8. Interaction with the supervisee in planning, executing, and analyzing supervisory conferences;
9. Assisting the supervisee in evaluation of clinical performance;
10. Assisting the supervisee in developing skills of verbal reporting, writing, and editing;
11. Sharing information regarding ethical, legal, regulatory, and reimbursement aspects of the profession;
12. Modeling and facilitating professional conduct; and
13. Demonstrating research skills in the clinical or supervisory process.”