Articles Section

SUPERVISION IN SPEECH-LANGUAGE PATHOLOGY AND AUDIOLOGY IN CANADIAN EMPLOYMENT SETTINGS. II

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This paper is based on a panel presentation with panel members representing various employment settings in Canada. The purpose of the discussion is to share ideas and experience and summarize the current state of the practice of supervision in Canada. The sections include 1) responsibilities of the supervisor, 2) the responsibilities of the supervisee and 3) techniques to facilitate the supervisory process.

Issues discussed under 1) evaluation, teaching versus monitoring, facilitation, client welfare versus staff development, 2) role, accountability and goals and expectations, and 3) techniques, observations systems, conferences, objective evaluation techniques and supervisor/clinician relationships.

After each section there is a summary of the comments of the panel members. The panel is followed by a discussant representing the profession of clinical psychology. Audience comments are summarized.

Cette étude est basée sur une présentation de membres experts représentant divers établissements au Canada. Le but de la discussion est de partager ses idées et son expérience et de résumer l'état actuel de la pratique de la surveillance au Canada. Les diverses sections comprennent: 1) les responsabilités du surveillant, 2) les responsabilités de la personne surveillée et 3) les techniques visant à faciliter le processus de surveillance.

Les questions soulevées concernent: l'évaluation, l'enseignement versus le contrôle, la facilitation, le bien-être du client versus le développement du personnel, 2) le rôle, la responsabilité, les objectifs et les espérances, et 3) les techniques, les systèmes d'observation, les conférences, les techniques d'évaluation des objectifs et les relations surveillant/clinicien.

A la fin de chaque section, un résumé est présenté sur les commentaires des membres experts. Le débat est suivi d'une discussion à laquelle participent des représentants de la profession de la psychologie clinique. Les commentaires de l'assistance sont également brièvement exposés.

This paper is based on a penel presentation given at the 1980 convention of the Canadian Speech and Hearing Association. Virginia Martin served as moderator for panelists Elaine Heaton, Susan Mattingly and Sandra McCaig. Eric Ellis served as panel discussant.
*Susan Mattingly was employed as Director of Audiology, Montreal Children's Hospital at the time of the panel presentation.

The initial portion of this panel discussion was published in Volume VII, Number 8 1983 of Human Communication Canada. In that section, the panel moderator reviewed the concept of supervision and the available literature. She pointed out that the literature is very sparse and deals primarily with the supervision of students in training.

The first panelist then made some remarks on the responsibilities of the supervisor in an employment setting. She suggested that some of these responsibilities included evaluation (both formal and informal), facilitation, and a careful balance of efforts to ensure simultaneous protection of the client's welfare as well as the professional development of the supervisee's skills.

The second panelist discussed the responsibilities of the supervisee. She suggested that the supervisee has three major areas of concern regarding his status - his role, his accountability and his goals and expectations. He must be able to analyze his clinical knowledge, insight and personality. He must also develop his own supervisory skills in terms of self-supervision and as a future "Master clinician".

The following portion of this paper will deal with techniques to facilitate supervision in employment settings, together with a psychologist's perspective on issues affecting supervision in speech pathology and audiology.

TECHNIQUES TO FACILITATE SUPERVISION IN EMPLOYMENT SETTINGS

Sandra McCaig

Many of us supervising in employment settings have acquired this position on the basis of clinical experience, circumstance, or administrative expertise, having had no specific training in supervision. In addition, many of us carry heavy case loads or administrative responsibilities, which do not allow time for the development of supervisory skills relative to each individual's employment setting. A lack of training is not a deterrent to undertaking supervisory responsibilities and the task is frequently seen as a simple process for an experienced clinician: Be a foundation of knowledge, answer all questions and provide solutions; avoid criticism and provide positive feedback and be accepting of other's values. This approach may endear a supervisor to a clinician but it does not encourage clinicians to become independent, innovative, or skilled in using problem solving techniques.

Requirements for supervision vary according to employment setting and province. For example, in Manitoba all clinicians are required to complete one year of supervised practice, in order to obtain a fully registered licence from the Manitoba Speech and Hearing Association. The purpose of supervision as outlined in the guideline is, "to monitor and improve the ability of newly licensed members in their first employment in the province which will enable them to function as independent professional speech pathologists or audiologists". Also, clinicians working in school settings are required to complete two years of supervised experience, as a requirement for a school clinician's certificate from the Department of Education. Supervision is expected to entail one day per month of activities, including on-site observations of the supervisee in diagnostic, therapeutic and consultative activities, use of audio, video and written correspondence,

a review of diagnostic reports and therapy plans and consultation with personnel in the employment setting. Also many employment agencies have additional requirements for supervision in order to obtain tenure within the employment setting.

The literature provides several techniques for enhancing supervision and this paper will present an overview of techniques available Each supervisor must experiment, evaluate and apply those most appropriate to his/her employment setting.

TECHNIQUES

1. Observation Systems

If the purpose of supervision is to monitor and improve clinical effectiveness and evaluating clinicians in the field is a top priority, the use of an observation system can provide objective data for discussing client/clinician relationships and monitoring changes in clinical behavior. Two monitoring systems are available. The system developed by Boone and Prescott (1971) is a category system in which events in therapy are assigned to one of ten categories. Data is recorded each time a change occurs in the interaction in therapy. A five minute segment of therapy provides a representative sample of a thirty minute therapeutic session and allows one to look at both the content and sequence of therapy. The behaviours observed include the clinician's use of explanation, modeling, and reinforcement; correctness of client's responses and client's awareness of correctness of response; as well as inappropriate social responses by both client and clinicians.

The "Analysis of Behavior of Clinicians System" (ABC) is a twelve category system developed by Schubert et al, (1973) which indicates the amount of clinician time spent in instructing, demonstrating, and modifying lessons. It also indicates the clinician's use of reward and authority, client success and irrelevant therapeutic behaviors. At every three second interval the event in therapy is assigned to a category. This observation scale yields far more information regarding the amount of time spent on specific activities and allows one to look at the ratio and sequence of events in therapy.

Implicit in the supervisor's use of an observations system is the supervisor's observations of therapy, either through video tape or on-site observation. On-site observations allow one to observe the client and clinician in context and provide for immediate feedback. Supervisors can also gain a more realistic picture of clinician's schedules, communication skills, and organizational skills. On-site observations are often difficult to schedule in rural areas or in settings which do not regularly employ supervisors. In such cases, video tape recordings can provide valuable objective data to assist in "long distance" supervision.

2. Conferences

On-site observations do not provide time for discussion of techniques, concerns, research, or new materials. In addition to on-site observations, individual and/or group conferences are recommended.

(a) Individual conferences provide time to review individual caseloads and concerns, study cases intensively and monitor recording procedures. They can provide opportunities to develop skills of self growth and self awareness. However, they can also create a perceived authoritarian relationship and create an opportunity for increased dependency upon a supervisor.

(b) Group conferences provide an opportunity for clinicians to share ideas, materials, tests, develop new insights, and support each other. Peer modeling is a more positive approach than a supervisor/clinician relationship, as a group can provide a supportive environment in which the trust level is higher and communication easier. By assuming responsibility for their own learning, group members discuss issues which are relevant. The group should be small enough to allow everyone an opportunity to contribute to the learning process. The role of the supervisor should be to keep the focus on learning, act as a resource person and control competitiveness.

During the initial year of employment, it is important to have regular access to a supervisor for individual consultation. Once a clinician has become established, regular individual contact is not as important and peer groups can play a valuable role for individual support and ongoing professional development. Peer group reviews may also be useful in senior staff evaluations.

3. Objective Evaluation Techniques

How should one use the information gleaned from observations and conferences? Two forms for evaluation are referred to in the literature.

(a) Wisconsin Procedure for Appraisal of Clinical Competence (W-PACC): this evaluation technique developed by Shriberg et al (1975) assesses clinical effectiveness in given skills and assesses to what extent clinical effectiveness is dependent upon the need of supervisor input.

(b) Pennsylvania State University: this form, developed by Klevans and Volz (1974), is based on the theory that objective feedback is an essential aspect of clinical supervision. The feedback provided is both positive and negative, and focusses on skills which help clinicians become more effective. The form can be used several times during the year to outline long term goals and progress.

4. Supervisor/Clinician Relationship

It is essential that supervisors develop communication skills which will enhance interpersonal relationships. Supervisors can provide facilitative conditions for learning and resource material in this area is readily available (Kaplan & Dreyer, 1973; Carracciolo, Rigrodsky and Morrison 1978). The development of listening skills, problem solving techniques, goal setting, and evaluative techniques will assist a supervisor in creating situations whereby supervisees are encouraged to experiment with various methods of solving problems and thus become independent of supervisors.

Two systems are presently available for analyzing the supervisor/clinician relationship:

(a) Underwood Category System (Underwood, 1974): This system charts supervisor/clinician interaction during the supervisory session. Nine supervisory behaviors are monitored including: supportive; use of praise and criticism; use of clinician's ideas; problem identification; request for, and provision of, factual information; and requests for, and provision of, opinions/suggestions. Six clinician behaviors are monitored including problem identification; requests for, and provision of, factual information; requests for, and provision of, opinions and suggestions; and positive and negative social behavior.

(b) Content and Sequence Analysis of the Supervisory Session (Culatta & Seltzer, 1976): this is a modified version of the Boone-Prescott system which analyzes interactions occurring during the supervisory session. It provides a 12 category rating system and measures the total speaking time of each participant over a five minute period.

In two separate studies using the Content and Sequence Analysis procedure, Culatta and Seltzer (1976) reported that the majority of all strategy statements were made by supervisors, and the majority of observation and information statements were made by trainees. They concluded that trainees were providing the raw data of their observations to supervisors who then developed overall therapy strategies.

In a further study by Culatta & Seltzer (1977) supervisors were asked to determine target behaviors for change in supervisory sessions. They chose the question/information strategy series. The study reported that knowledge of how a supervisory session should be conducted did not exert enough motivation to bring about behavioral change. Culatta & Seltzer concluded that the self evaluation process alone may not be sufficient to motivate behavioral change, and that lack of change in supervisory styles may be due to the fact that supervisors were accountable only to themselves.

From a review of the literature it would appear that a total supervisory approach should include; the use of observation systems, individual and group conferences, objective evaluation scales, the development of communication skills which facilitate learning and an accountability system for supervisors as well as supervisees.

However, with the frustration of arranging conferences, driving to on-sites, reviewing video tapes, compiling materials and resources, it is often difficult to: listen, avoid providing answers and strategies, provide evaluative objective feedback, admit limitations and be sensitive to the feelings of others. But in spite of these difficulties, these are goals supervisors should continue to strive toward.

PANEL COMMENTS: Ms. McCaig's Presentation

In response to this presentation Panelist 1 introduced the topic of group supervision directed by a supervising clinician. Panelist 3 pointed out the increased effort required on the part of the supervisor and the need for extra training and group facilitating techniques to effectively operate in this modality. The moderator questioned the prevalent view that this modality is more efficient in terms of time. Panelist 1 noted that while this technique can be very successful in terms of quality of supervision experience, it appears to have a

cyclical course which limits its effectiveness to six to nine months with each group. Panelist 2 suggested that the cycles were related to seasonal patterns of staff burn-out.

Panelist 3 emphasized the role differentiation between administrators of programs and supervisors. These require differing competencies and training. One of the difficulties is that the administrative aspects, such as budgeting are often a large part of the role in a program. Often a professional is hired for skills in one aspect and must also do the other.

A PERSPECTIVE ON ISSUES AFFECTING SUPERVISION IN SPEECH AND HEARING

Eric Ellis

The papers presented in this series on issues in the supervision of speech and hearing clinicians have covered a wide range of supervision related topics. The papers are linked however, in that they share the vision of supervision as a relatively new and undeveloped activitiy within this profession that presents a sometimes surprising and often times bewildering challenge to those senior clinicians and administrators who are beginning to confront these issues. The issues regarding the role of supervision and the context of the structure and development of a profession have a much longer history in the professions of psychiatry and psychology. While it would be presumptuous to suggest that these professions have confronted and resolved all of the issues involved in supervision, a discussion of supervision in the context of these professions might help put some of the issues of supervision in the speech and hearing profession into clearer perspective.

Supervision in psychiatry and psychology is a major vehicle by which the application and knowledge and skill in the professional development of clinicians is fostered. In these professions, the body of knowledge and the basic technical skills are taught in seminars and workshops. The major issue in training and the development of professionals in these specialties is not knowledge and technical skill but the application of these to the clinical interactions between a clinician and the patient/client. Just as the clinician works to help the patient/client recognize his strengths and weaknesses and augment and modify these, so must the clinician know something of his personal strengths and weaknesses when it comes to the application of knowledge and technical skill to the clinical endeavour. In this context, this supervision becomes a major vehicle by which professional development is fostered in the developing professional. While the terminal objective of supervision in training is the development of a professional capable of functioning independently with a knowledge of his/her strengths and weaknesses, the longer term objective is the fostering of the value of self-motivated, continuing education for professional and personal development, and the recognition of the value of the professionally mature equivalent of supervision: collaboration and consultation. Thus in training in psychiatry and psychology, supervision is a mode of training, the objective of which is the production of a competent, independently functioning clinician who recognizes the value of continuing education and consultation in the life-long quest for personal and professional development.

Training in both psychiatry and psychology includes supervised practical experience in employment settings provided in settings which are clearly recognized as providing training for this purpose. In psychology after a minimum of 600 hours of supervised practical training within the degree granting program, students complete another year in full time training (minimum 1600 hours) usually in a setting separate from the degree program for further intensive training. This additional year of full time training is mandated by the profession as a prerequisite for the terminal degree and a graduate is considered a fully trained, generalist capable of independent functioning. Such training is provided in programs accredited for that purpose, involves a minimum of four hours a week of supervision, and comes with a stipend.

Once graduated and in the employment setting, the clinician is not seen as being deficient in professional functioning or requiring further supervision. Once graduated, it is the responsibility of the clinician to seek upgrading of his skills or to seek the development of new skills. It is the responsibility of the employer to respect the need for professional development of his employees and provide opportunities in the employment setting for professional development because this helps to maintain the highest quality of clinical service. On occasion, an employee-senior clinician will enter into a consultative relationship with an employee in which the employee retains his identity as an independent professional. Where a graduated clinician feels in need of further supervision, he will most likely seek this in a setting removed from his principal place of employment, thus retaining his identity as an independent professional. Of course, the right of an employee and employer to oversee the productivity and other administrative indices of an employees functioning is recognized, although this sometimes comes in conflict with a professional's well-ingrained sense of independent functioning. It must be remembered, however, that the most prevalent, professionally approved training standard of the psychologist is the doctorate and of the psychiatrist, the medical degree plus four years of specialty training. Those functioning in the field with lesser qualifications are not considered either fully trained or capable of independent functioning.

An examination of the papers in this series on supervision of speech and hearing clinicians reveals that supervision in the speech and hearing profession has a less specific definition and seems to encompass at least two distinct activities. The potential conflict between these two activities in the context of the terminal objectives of training and the expectations for professional development may contribute to an undermining of the professional development objectives of supervision in the speech and hearing profession.

As it is described in these papers, training in a University setting encompasses both casework and supervised clinical experiences. Upon graduation, however, a further prolonged period of supervised work in the employment setting must occur before a speech and hearing clinician is considered fully qualified. It also appears that supervision continues after the professional designation is obtained and begins to shade into other activities of an administrative nature that have few implications for personal and professional development. Thus supervision in the field of speech and hearing has come to mean both the relationship between experienced clinician and student by which the application of knowledge and technical skill is fostered, and also the relationship between the employer and the employee regarding the

monitoring of employee functioning and productivity for administrative and institutional purposes. It also appears that in some or many employment situations, both activities called supervision are delivered by the same person, that both become a component of the employer-employee relationship and that supervision is a responsibility of the employer to be accepted as part of the employment contract by the employee.

While the shorter period of mandated professionally accepted training may account for the reason why speech and hearing clinicians are graduated from training in a state considered professionally deficient by both employers and the profession as a whole, the employment of persons considered professionally immature must create a number of difficulties for both the clinician and the employer. This state passes onto the employment setting from the educational setting, part of the responsibility for training, and expensive and time consuming activity that interferes, in service settings that are not also clearly seen as training institutions, with the effective and efficient delivery of service. It passes onto employers the responsibility for professional development and the need to provide two types of supervision which are not infrequently mutually exclusive. For the student, such a state likely interferes with the development of a secure professional identity and robs the students of a need to see his professional and personal development as an individual, personal responsibility. Receiving supervision-cum-training from an employer whose administrative supervision decides not only professional acceptance but also merit increases and promotion interferes with the development of the professionally neutral environment that ensures the optimum benefit from training supervision. The developing clinician who must impress the supervisor with strength and productivity to receive merit increases and be promoted, is not truly free to admit professional deficiencies or confront safely, personal barriers to learning. The challenge to a supervisor to provide an optimal environment for the professional development of the trainee is immense, particularly where the supervisor works in a different area from the clinician. Despite the receipt of the professional designation, it must be unclear for all concerned at what point the clinician becomes a truly autonomous professional when the employer continues to provide supervision and the employee remains dependent on the employer for professional development. When these factors become part of the fabric of the development of the profession as a whole, it may come to effect the development of the identity of the profession as a truly autonomous, responsible, vigorous profession with something valuable to offer its clients and with a valuable, autonomous, assertive and respected place to assume among its health, rehabilitation, and educational colleagues.

PANEL COMMENTS:

In the discussion following the presentations the panel members expressed considerable concern regarding where formal evaluation protocols are recorded and who is given access to this information. This issue takes on particular importance when it appears that in many employment settings a person who officially makes decisions regarding promotion or merit increases is not a speech or hearing clinician and may not be aware of the professional issues involved. Panelist 2 reported that in the setting where she is the senior clinician, actual evaluations are confidential and are destroyed upon termination of employment. She forwards to non-clinician administrators information

that does not relate to technical issues of professional functioning itself. Panelist 2 and 3 both spoken to the value of having supervisee formally evaluate supervisors.

Panelist 3 again brought up the challenge the profession faces because of the lack of consensus regarding the justification for supervision, or who requires supervision. In addition there are no recognized standards of qualifications for training and evaluating supervisors. In this context she wondered whether the profession was merely having supervision for the sake of having supervision.

There were several comments on the use of the term "supervision" for the administrative aspects of the role. It was suggested a "facilitator" or "coordinator" label might be more appropriate.

The necessity to differentiate among the various levels of experience when deciding on supervision was emphasized. The requirements for supervision, and the role of the supervisor should vary depending on whether the supervisee is a student, a new clinician, a new employee, or an experienced employee.

To end the discussion the moderator referred to the thought expressed by Joan Fleming in "Teaching the Basic Skills of Psychotherapy" (1967) that a supervisor should exercise the student's mind rather than demonstrate his own.

The comments and thoughts in this article are representative of the panelists' beliefs at the time of the conference. Since that time individual ideas have been modified, new techniques have been attempted and new philosophies proposed. "Supervision" is still a largely undefined activity, and the competencies and qualifications required of "supervisors" are still under discussion. However, it is hoped that there can be some continuing communication and discussion about the issues involved among all speech-language pathologists and audiologists employed in Canada.

References

Boone, D., and Prescott, T. "Speech and Hearing Therapy Scoring Manual" Denver, University of Denver Press, 1971.

Caracciolo, G.L., Rigrodsky, S., and Morrison, E., Perceived interpersonal conditions and professional growth of master's level speech and language pathology students during the supervisory process. ASHA, 20, 467-477, 1978.

Culatta, R. and Seltzer, H., Content and sequence analysis of the supervisory session. ASHA, 18, 8-12, 1976.

Culatta, R. and Seltzer, H., Content and sequence analysis of the supervisory session: A report of clinical use. ASHA, 19, 523-526, 1977.

Fleming, Joan, "Teaching the basic skills of psychotherapy". Arch. Gen. Psychiat., 16, 416-426, 1967.

Kaplan, N. and Dreyer, D., An investigation of the influence of self awareness training on variables put to student speech pathologist-client relationships. Paper presented at the Annual Convention of ASHA, Detroit 1973.

Klevans, D.R. and Volz, H.B. Development of a clinical evaluation procedure. ASHA, 16, 489-491, 1974

Schubert, G., Miner, A. and Till, J.A. "The Analysis of Behaviour of Clinicians (ABC System." Grand Forks, N.D., University of North Dakota Press 1973.

Shriberg, L.D., Filley, F.S., Hayes, D.M., Kwiatkowski, J., Schatz, J.A., Simmons, K.M. and Smith, M.E. The Wisconsin procedure for appraisal of clinical competence (W-PACC). ASHA, 17, 158-165, 1975.

Underwood, Judy K. Clinical supervision. Journal of the Colorado Speech and Hearing Association, 8, 6-9, 1974.