CLINICAL SUPERVISOR CHARACTERISTICS VALUED BY PRACTISING SPEECH LANGUAGE THERAPISTS

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Abstract

Clinical Supervision is an important practice in speech language therapy and related health disciplines. Research in student clinician populations has found that supervisees value interpersonal, personal and teaching characteristics in a clinical supervisor. Research has also shown that perceptions of supervisor characteristics change as student clinicians gain clinical skills. However, there is a significant lack of research examining practising clinicians' perceptions of clinical supervisor characteristics.

The current study aimed to 1) survey practising Speech Language Therapists (SLTs) and examine the knowledge, skills and attitudes valued in a clinical supervisor, and 2) determine if the characteristics valued by more experienced SLTs (> 5 years) differed from those valued by less experienced SLTs ($\leq$ 5 years). A cross-sectional survey design methodology was employed. A five-part survey was developed, and distributed nationally by email. Participants were 72 SLTs practising in New Zealand.

Results indicated that practising SLTs valued interpersonal knowledge and skills, and personal values and attitudes most highly in a clinical supervisor. In addition, it was found that characteristics relating to professional knowledge and identity were least valued. Overall, almost no difference was found between characteristics valued by less and more experienced clinicians. Findings suggest that practicing clinicians' basic human-relationship needs must be met for safe and effective CS to occur. Findings also suggest that regardless of experience level all clinicians are learners. This means clinicians across all different levels of work experience require support from clinical supervisors, to learn reflectively from experiences in the workplace.

Introduction

Clinical Supervision

Clinical Supervision (CS) is a formalised process of learning in which individual clinicians are professionally supported to assume responsibility and accountability for their own practice, through development of knowledge and competence (National Health Service Management Executive, 1993). It is sometimes referred to as professional supervision (Royal College of Speech and Language Therapists, 1996, p. 248). The American Speech-Language-Hearing Association (ASHA) (1985) suggests that CS is "an integral part of the initial training of speech pathologists and audiologists, as well as their continued professional development at all levels and in all work settings" (p. 57). It is commonly undertaken in the allied health and para-medical disciplines (Cooper, 2006; Spence, Wilson, Kavanagh, Strong, & Worrall, 2001; Haynes, Corey, & Moulton, 2003). Clinical supervision usually has two participants: a supervisor and a supervisee, and generally occurs one-to-one; however, it may also occur in groups (Berg & Hallberg, 1999; Hyrkäs & Paunonen-Ilmonen, 2001). The Royal College of Speech-Language Therapists (RCSLT) suggest a supervisor must be qualified and experienced to provide supervision (1996, p. 248). In addition, they suggest that supervisors should have access to training, particularly if they also have a managerial role. However, specific qualifications or types of experience are not fully outlined.

The Importance of Clinical Supervision

Clinical supervision is important for a practising speech-language therapist (SLT) for three primary reasons: (1) adherence to ethical standards; (2) support of clinician

well-being and workplace experience; and (3) development and maintenance of clinical skills and best practice (Bégat, Ellefsen, & Severinsson, 2005; Bégat & Severinsson, 2006; Berg & Hallberg, 1999; Bowles & Young, 1999; Hyrkäs, Appelqvist-Schmidlechner, & Haataja, 2006; Milne, 2007; National Health Service Management Executive, 1993; Spence et al., 2001; Teasedale, Brocklehurst, & Thom, 2001). These areas correspond to the three functions in Proctor's interactive model of supervision: normative, restorative, and formative (Hines-Martin & Robinson, 2006; Sloan & Watson, 2002; Bowles & Young, 1999).

Firstly, CS protects the safety and welfare of clients (National Health Service Management Executive, 1993), through "quality control" or "gate-keeping" of practice (Milne, 2007, p.440). This relates to the normative function of CS, whereby the clinician's accountability to professional standards and ethical guidelines is promoted, through development of knowledge and ongoing monitoring (Hines-Martin & Robinson, 2006; Sloan & Watson, 2002; Bowles & Young, 1999). Ethical codes from professional bodies highlight the need for CS in the workplace; therefore, individual clinicians have an ethical and professional responsibility to seek out and participate in a CS arrangement. In New Zealand, the ethical standards of the New Zealand Speech Therapists' Association (NZSTA) are adopted from the RCSLT guidelines (Simmons Carlsson, Coups, Mueller, Neads, & Thorneley, 2007). The RCSLT currently recommend that practising SLTs receive both management-directed and non-managerial supervision (RCSLT, 1996).

Secondly, research from the field of nursing has examined how CS provides support to clinicians. This corresponds to the restorative function of CS, which focuses on supervisory support for the clinician, focussing on re-establishing the

clinician's overall well-being (Hines-Martin & Robinson, 2006; Sloan & Watson, 2002; Bowles & Young, 1999). It has been found that effective CS supports a clinician's sense of well-being, improving both physical and mental health (Bégat et al., 2005). Bégat et al., (2005) reported that registered hospital nurses who received CS reported fewer physical symptoms of headache or fatigue, less anxiety, and fewer feelings of lacking control than registered nurses who did not receive CS. Research findings also indicate that regular CS diminishes work-related strain, improves psycho-social work experiences and increases job satisfaction (Bégat & Severinsson, 2006; Berg & Hallberg, 1999; Hadfield, 2000; Hyrkäs et al., 2006; Teasedale et al., 2001). For example, Berg and Hallberg (1999) examined the effects of a one-year programme of group supervision on 22 psychiatric nurses' sense of coherence, creativity, work-related strain, and job satisfaction. Using a pre-test post-test quantitative design and a comprehensive assessment battery, Berg and Hallberg (1999) reported that CS increased nurses' trust, creativity and idea time, and reduced workplace conflicts. From a more positive perspective, CS also provides an environment for effective or exceptional practice to be affirmed, ensuring a clinician maintains belief in their skills, particularly in difficult clinical situations (Hadfield, 2000).

Thirdly, in relation to Proctor's formative function, CS helps develop and maintain clinical competence and best practice (Milne, 2007; Spence et al., 2001). CS can be used as a forum for a clinician to analyse, plan and rehearse skills, thus building confidence prior to carrying out actions in the field (Hadfield, 2000). In addition, regular CS has been found to increase the benefits of professional development courses or programmes, for clinicians and clients. (Bradshaw, Butterworth, & Mairs, 2007; Heaven, Clegg, & Maguire, 2006; Spence et al., 2001).

Heaven et al. (2006) found that CS facilitated the transfer of newly attained communication skills to a clinical setting. In a randomised controlled trial of 61 clinical nurse specialists, 29 participants were randomly assigned to take part in a three-day communication skill workshop followed by 12 hours of CS. Clinical supervision occurred over a four-week period and included case discussion and direct observation and feedback from a supervisor. The control group of 32 individuals attended the communication skill workshop but received no supervision. Although findings indicated both groups learned new clinical skills, it was found that those receiving CS were more likely to transfer these skills into practice.

In summary, research has identified that CS helps practising clinicians in three key interrelated areas. In regard to clinical practice, research findings show the positive effect of combining CS with professional development programmes. However, additional research has also suggested other benefits, which relate to the development of best practice.

Associated Benefits of Clinical Supervision

In addition to the three primary functions of CS discussed previously, research also suggests that CS benefits best practice by providing practising clinicians with an environment for the development of reflective practice, and encouragement for the development of life-long learning skills (Hadfield, 2000, Kilcullen, 2007, Spence et al., 2001). Hadfield (2000) investigated perceptions of users of CS in an exploratory descriptive study. Data was gained through semi-structured interviews from 12 paediatric nurses. Findings suggested that CS had an overall positive effect on clinical practice and that it was useful in relation to professional development as well as clinical practice and interpersonal issues. In addition, in an excerpt from a

participant interview, Hadfield (2000) described the practice of reflection and resultant learning within CS. It was revealed that CS helped the experienced clinician identify a re-training opportunity when faced with a clinical skill deficit. This in turn allowed the participant to share knowledge and skill with less experienced nurses.

The work environment provides clinicians with constant ongoing real life situations, which may challenge previously learned clinical skills. Even so, not all clinicians think reflectively, and some try to shape clinical situations to fit their current clinical knowledge and skills (Schön, 1991). Kilcullen (2007) suggests that CS provides practising clinicians time away from clients to stop and reflect on, and analyse their clinical practice. Furthermore, Sines and McNally (2007) suggested clinicians value CS as "protected time" (p. 307). In this respect, it appears that CS supports ongoing learning, by providing a space for reflection, discussion, and planning.

Clinician Preferences in the Process of Clinical Supervision

Research in the health disciplines has shown the importance of CS to practising clinicians. However, there is a significant lack of research examining clinicians' preferences for the specifics and processes of clinical supervision (Smith, Pickering, Crago, and Naremore, 1990). To date, studies examining CS in speech language therapy have primarily concentrated upon the supervision of student or novice clinicians (Dowling, 1983, 1987; Oratio, Sugarman, & Prass, 1981; Shapiro & Anderson, 1988; Wagner & Hess, 1997; Williams, 1995). Research from related disciplines, using predominantly survey design, has found that supervisees generally prefer supervision with a non-manager (Cooper, 2006; Edwards, Cooper, Burnard, et al., 2005), regard the supervisor's ability to uphold confidentiality as highly important

(Cooper, 2006; Cutliffe & Hyrkäs, 2006), and perceive CS to be more effective when they are able to choose their own supervisor (Edwards et al., 2005). In addition, supervisees have been found to prefer supervision sessions that are at least an hour in length, occur at least monthly, and are held outside the workplace (Edwards et al., 2005; Grant, Kilminster, Jolly, & Cottrell, 2003; Hyrkäs et al., 2006). In general, research indicates significant agreement in attitudes across disciplines relating to infrastructure and administration of CS (Cooper, 2006; Cutliffe & Hyrkäs, 2006). Clearly, the clinical supervisor plays an important role in the process of CS. In this respect, further examination of the role and characteristics of a clinical supervisor for practicing clinicians, is required. In particular, there is a disassociation between the importance placed on the processes of clinical supervision for practicing SLTs and the current state of research knowledge into the process (Fey, 1998).

The Role and Characteristics of a Clinical Supervisor

There are limited studies examining the role of a clinical supervisor for practising clinicians. A clinical supervisor's role is to provide CS that encompasses all three functions of Proctors interactive model: normative, restorative, and formative. From the perspective of supervisors themselves, research suggests the clinical supervisor's overall role is both professional and personal (Arvidsson and Fridlund, 2005; McAllister (2001, in McAllister & Lincoln, 2004)). From the field of nursing, Arvidsson and Fridlund (2005) analysed critical incidents reported by 25 clinical supervisors of practising clinicians, to examine supervisor competence. Findings showed that from the nurse supervisor's point of view, their four professional roles were "to facilitate reflection", " to create a secure learning environment", "to use structure as required" (eg appropriate methods, materials and boundary setting), and

"to create an awareness of fundamental nursing values" (p.234). From a personal stance it was found that supervisors expressed self-doubt, and demonstrated security in their role as a supervisor, highlighting the need for supervisors to practice reflectively and participate in CS (p. 237).

Similarly, using a phenomenological and narrative enquiry approach, McAllister (2001, in McAllister & Lincoln, 2004) highlighted the wholistic nature of CS for student clinicians. McAllister (2001) found six dimensions describing the experience of being a clinical educator in speech language therapy. Analysis of data from observations and in-depth interviews with five clinical educators, uncovered themes of: "a sense of self", "a sense of relationship with others", "a sense of being a clinical educator", "a sense of agency as a clinical educator", "seeking dynamic self-congruence", and finally "growth and development" (p 9). Overall, the studies of Arvidsson and Fridlund (2005), and McAllister (2001) showed that supervisors see themselves as a person, a facilitator and an educator, and illustrate the wholistic nature of a supervisor's role.

To date, only the studies of Arvidsson and Fridlund (2005), and McAllister (2001) have examined the roles of a clinical supervisor. These are limited by small sample sizes and findings from the perspective of supervisors only. On this basis, there is a critical need for further research into the role of a clinical supervisor from the supervisee perspective. To fully examine the role of a clinical supervisor, it is necessary to determine the characteristics that are important for the role. However, in order to examine clinical supervisor characteristics, it is also necessary to identify an appropriate system to classify them.

Classifying supervisor characteristics. Various classification systems have been developed to describe characteristics and behaviours of supervisors, from the perspective of both supervisees and supervisors (Arvidsson & Fridlund, 2005; Cochran, Paukert, Scales, & Neumayer, 2004; J. Fowler, 1995; McAllister (2001, in McAllister & Lincoln, 2004); Paukert & Richards, 2000; Tang, Chou, & Chiang, 2005). For example, Cochran et al. (2004) and Paukert and Richards (2000) utilised categories identified in Ullian et al. (1994), to classify survey responses. These included "person", "teacher", "physician", and "supervisor". In addition, Tang et al. (2005) reviewed previous research (particularly that of Brown (1981) to develop headings of professional competence, personal relationship, personality characteristics and teaching ability to define survey questions. Furthermore, qualitative research has also uncovered dimensions which help classify characteristics of clinical supervisors (Arvidsson & Fridlund, 2005; McAllister (2001, in McAllister & Lincoln, 2004). Table 1 outlines these categories and dimensions.

Table 1

Categories and Dimensions Classifying Supervisor Characteristics

Categories / Dimensions	**Authors**
professional personal	Arvidsson & Fridlund (2005)
a sense of self a sense of relationship with others a sense of being a clinical educator a sense of agency as a clinical educator seeking dynamic self-congruence growth and development	McAllister (2001, in McAllister & Lincoln, 2004)
person teacher physician supervisor	Ullian et al. (1994) Paukert & Richards (2000) Cochran et al. (2004)
knowledge base teaching/supervisory skills relationship skills	Fowler (1995)
professional competence personal relationship personality characteristics teaching ability	Tang, Chou and Chiang (2005)

However, in addition to these labels and dimensions that classify clinical supervisor characteristics, it is possible that the existing classification system of knowledge, attitude and skill (KAS) also has direct relevance. The KAS classification of competence is currently used across a range of professions (The Carnegie Foundation, 2006; Jackson, 2007; Kamhi, 1995). The systems' cognitive (knowledge), affective (attitude) and psychomotor (skill) domains were originally developed within higher educational facilities; beginning with Blooms Taxonomy in the cognitive domain in 1956 (Bloom, 1956). Current research from the discipline of

psychology, suggests KAS classification can be used within CS, in relation to supervisor competence or supervisee development (Gonsalves, Oades, & Freestone, 2002; and Falender & Schafranske, 2007). The use of the KAS classification system to identify supervisor characteristics is logical, because of its applicability to the practice of CS and widespread use across the professions. Furthermore, it is likely that the identification of supervisor characteristics under these terms will help develop a profile of an effective and competent supervisor.

Characteristics of an effective supervisor. There is relatively little research regarding characteristics of an effective supervisor. However, reviews of research in student populations from related disciplines have identified characteristics of good, ideal or effective clinical supervisors (Barnett, Erickson-Cornish, Goodyear, & Lichtenberg, 2007; Carifio & Hess, 1987; Haynes et al, 2003; Kilminster & Jolly, 2000; Kilminster, Cottrell, Grant, & Jolly, 2007; Ladyschewsky, 1995; McAllister & Lincoln, 2004). Based on reviews and commentaries by authors such as Barnett (2007), Kilminster & Jolly (2000), and Kilminster et al. (2007) there appears to be general agreement that an effective supervisor has excellent interpersonal skills and positive personal characteristics, and the ability to make the supervisee feels safe and supported. Indeed, in their seminal article, reviewing 16 studies pertaining to ideal supervisory behaviours and attributes, Carifio and Hess (1987) suggest similar characteristics. Carifio and Hess (1987) and McAllister and Lincoln (2004) also suggest effective supervisors require self awareness and self congruence, a keen awareness of the supervisee's development and needs within the supervision process, and the ability to provide appropriate support accordingly. Finally, an effective supervisor is a skilled teacher, facilitator and role-model (Kilminster & Jolly, 2000;

Kilminster et al., 2007; Ladewschewsky, 1995; McLeod, 1997); he or she guides clinical work by offering direct feedback, helping the supervisee link theory and practice, and developing joint problem solving.

To date, there has been minimal research relating to effective supervisors of practising clinicians. Indeed, there are no such studies in the field of speech language therapy. However, to facilitate optimum supervisory relationships for individual clinicians, it is important to determine whether effective or ideal characteristics are also those that are valued by supervisees.

Supervisor characteristics valued by supervisees. There are a limited number of studies specifically examining supervisees' perceptions of supervisor characteristics. Studies across paramedical and allied health professions, from mostly student or novice populations have shown that supervisees value characteristics of a clinical supervisor across a number of key areas. These include interpersonal competence, professional knowledge, clinical skills, teaching ability, and administration (Cochran et al., 2004; Oratio et al., 1981; Tang et al., 2005). In addition, supervisees value supervisors with affirming personal values / attitudes, and an ability to make the supervisee feel safe (Shanfield, Hetherly & Matthews, 2001).

Research indicates supervisees place a great deal of importance on clinical supervisors' interpersonal skills and personal values / attitudes (Cochran et al., 2004; Oratio et al., 1981; Shanfield et al., 2001; Tang et al., 2005; Nahas, Nour, & Al-Nobani, 1999). Shanfield et al. (2001) qualitatively and quantitatively evaluated psychiatry resident's perspectives about former supervisors. Thirty former residents were asked to view video footage of supervision sessions undertaken several years prior. It was found that males rated supervisor effectiveness higher than females and

that former residents focussed on the supervisory relationship; specifically supervisors that were “non-judgemental”, “accepting” and “calm”. Findings also showed that former residents appreciated supervisors who helped residents “understand their own responses to their patients” (p. 25). Even in retrospect, interpersonal skills and personal characteristics were highly valued by supervisees. However, research findings suggest supervisees value a range of other characteristics in their clinical supervisor.

In addition to interpersonal and personal characteristics Tang et al. (2005) identified the perceived importance of a clinical supervisor’s professional competence and teaching ability. Using a survey design study, Tang et al. (2005) investigated perceptions of clinical teacher effectiveness of student nurses. Effective teachers were perceived to demonstrate high levels of professional competence, interpersonal skills, positive personal characteristics and teaching ability. However, ineffective teachers were perceived as less proficient across these areas. Specifically, differences between effective teachers and ineffective clinical teachers related to personal characteristics and interpersonal relationship abilities. It was concluded that teachers’ attitudes toward students had more impact than their professional abilities. However, the importance of characteristics relating to clinical skills and professional competence cannot be disregarded (J. Fowler, 1995). Moreover, medical education studies have reported that supervisees perceived them to be very important (Elzubeir and Rizk, 2001; Nahas et al., 1999; and Paukert & Richards, 2000).

In relation to teaching characteristics, Cochran et al. (2004) identified similar findings to Tang et al. (2005), and Elzubeir and Rizk (2001). In particular, Cochran et al. (2004) found that characteristics relating to teaching ability were valued equally to personal or interpersonal characteristics. Using a survey design, Cochran et al. (2004)

investigated 84 third-year medical students' definitions of the qualities of their best clinical teachers. Findings showed that students used descriptions of "teacher and "person" roles significantly more often than that of 'physician' or 'supervisor'. Specifically, it was reported that participants appreciated characteristics such as 'supportive', 'fun' and 'committed to teaching'. It is unsurprising that student clinicians value their supervisors ability to educate and inspire learning, however it is not yet known if this also applies to practising clinicians.

Finally, administrative or organisational characteristics are necessary for practical reasons, such as CS venue arrangements and time management within CS sessions. However, there are limited data showing their value. A single study, from the field of speech language therapy, identified administrative characteristics to be highly valued (Oratio et al., 1981). In a factor analysis study, based on evaluations of 164 student clinicians, Oratio et al. (1981) identified behaviours perceived to be critical to the process of supervision and supervisory effectiveness. Using regression analysis it was found that two major dimensions contributed to perceived supervisor effectiveness: interpersonal and administrative.

Overall, research has shown that supervisees value interpersonal, personal and teaching characteristics. However, findings also suggest that professional, clinical and organisational characteristics are perceived to be important. It appears that the characteristics valued by supervisees correspond to those that describe an effective supervisor. These research findings are limited by samples from student clinician populations only. Currently, there is almost no research examining clinical supervisor characteristics valued by practising clinicians.

Supervisor characteristics valued by practising clinicians. To date, only one study has specifically examined the characteristics that practising clinicians value in their clinical supervisor. Sloan (1999) evaluated community mental health nurses' perspectives of good characteristics of a clinical supervisor. Qualitative analysis of data obtained from eight participants using a questionnaire and focus discussion groups found that supervisees placed importance on "personal qualities and interpersonal competence, over and above any specific qualification" (p. 719). Participants ranked the supervisors ability to make them feel comfortable enough to discuss their own failings, and providing a supportive relationship characterised by trust, empathy and mutual regard as most important. It was reported that supervisees also perceived clinical skills and knowledge to be important and they viewed a supervisor as an inspiring role-model. Also identified as important was the supervisor's perceptiveness about the supervisee, clients and team as a whole. Interestingly, participants noted a difference between supervisors having the ability to form supportive relationships and supervisors actually providing a supportive relationship with the supervisee. This suggests once again that supervisees value competent supervisors who integrate knowledge, attitude and skill into positive and effective actions. Additionally, participants viewed managers as supervisors, storage of supervision documents by managers, and not being able to choose their supervisor as limiting the process of CS. Given the small number of participants and convenience sampling employed, generalisations to other settings or populations cannot be made.

To date only one study, from the field of nursing (Sloan, 1999), has examined clinical supervisor characteristics valued by practising clinicians. The results of this study suggest that practising clinicians perceive personal characteristics and

interpersonal qualities to be important in a clinical supervisor. However, limited generalisations can be made from a single study. Research is required to explain why certain characteristics are perceived as more important to the process of CS. Furthermore, to understand why supervisees value certain supervisor characteristics, it is necessary to examine a supervisee's role within CS. Moreover, as CS has been found to provide an environment that contributes to ongoing learning (Hadfield, 2000, Kilcullen, 2007, Spence et al., 2001) it is also necessary to examine the clinican's role as a learner.

Clinicians as Learners

Developmental models of skill development describe step-like growth as student clinicians develop competence. Benner (1982) applied the Dreyfus Model of Skill Acquisition to nurses' clinical learning. In this model, learners are described as novice, advanced beginner, competent, proficient or expert based on skill acquisition and development (Benner, 1982, p. 402). Research findings show that clinical supervisor play an integral role with a student clinician, in the early stages of the learning continuum (Laitinen-Väänänen, Talvitie and Luukka, 2007; McAllister, Higgs, & Smith, 2008). Developmental models of CS indicate early supervision requires more structure and support, and progresses to a level where the supervisee leads the process and less structure is required (Holloway, 1994; Stoltenberg, 2005). These models tend to apply more readily to the development of student clinicians. Indeed, applying Anderson's Continuum Model of Supervision (Anderson, 1988) practising clinicians can be assumed to be functioning at a self-supervision stage of the continuum model, requiring consultative-type supervision only. However, based

on theoretical models of adult learning, it appears that practising clinicians can also be viewed as learners, within workplace environments.

Practising clinicians as learners. It can be assumed that clinicians in the workforce are not only competent, but that many are proficient or expert clinicians. Some have the capacity to perform the role of clinical supervisor themselves (Bennett, 2003). In addition to their clinical skills, practising clinicians have a range of professional, personal and life experiences (Knowles, 1978). Relevant theoretical models of adult learning provide a framework for examining CS for skilled adult learners (Jarvis, 1987, 2005; Kolb, 1984; Quinn, 2000; and McMillan, Bell, Benson, et al., 2007). Jarvis (2005) describes learning as:

> "the combination of processes whereby the whole person – body (genetic, physical and biological) and mind (knowledge, skills, attitudes, values, emotions, beliefs and senses) – is in a social situation and constructs an experience which is then transformed cognitively or practically (or through any combination) and integrated into the individual's own biography" (p. 7)

Using Jarvis' definition, effective CS takes place when a clinician is guided through a process of transformation and integration of learning experiences, constructed in the clinical or workplace setting. An effective clinical supervisor facilitates reflective learning (Jarvis, 1987): encouraging contemplation, development of reflective skills, and involvement in experiential learning (Jarvis, (1987, in Jarvis, 2005); Quinn, 2000). Experiential Learning (Kolb ,1984) draws on Piaget's theory of cognitive development, but it relates to the learning of adults. It describes a cycle whereby concrete experience, reflective observation, abstract conceptualisation, and active experimentation take place (Kolb, 1984,). Significantly, different people are

more skilled in different areas of the cycle. CS and the clinical supervisor play a role in supporting the clinician through the learning cycle, which can be likened to practical hypothesis testing.

Practising clinicians have ongoing opportunity for reflective learning, in the workplace, based on clinical experiences, and supported by a clinical supervisor. Developmental models of competence and CS (Anderson, 1988; Benner, 1982; Holloway, 1994; Stoltenberg, 2005) suggest clinicians with less experience have different CS needs. In addition, research findings have found that supervisees value particular supervisor characteristics. It is therefore necessary to examine how levels of supervisee experience influence perceptions of clinical supervisor characteristics.

Differences in valued supervisor characteristics as experience is gained. In the field of speech language therapy, Anderson's Continuum Model of Supervision (Anderson, 1988) is widely used and accepted in relation to the development of student clinicians, and assumes that supervisees expectations and needs will change over time (Dowling, 2000; McCrea & Brasseur, 2003; Wagner & Hess, 1999; Williams, 1995). Studies of student or novice clinicians from medical education and nursing have found that as clinical experience is gained, supervisees' perceptions of their clinical teachers change (Elzubeir & Rizk, 2001, J. Fowler, 1995; Nahas et al., 1999; Paukert & Richards, 2000, Ullian et al., 1994). In addition, the supervisee's own role within CS changes, according to their learning needs.

Changes in perceptions of supervisees were reported by Elzubeir and Rizk (2001). In a survey-design study, of 120 student doctors and graduates, Elzubeir and Rizk (2001) identified perceptions of supervisor characteristics across different levels of clinical learners. It was found that graduates (interns and residents) rated certain

teaching characteristics more highly than students who had less clinical experience. These characteristics included the ability to teach to different levels, demonstration of positive interactions with team members, placing patients' needs first, and being able to perform a range of clinical procedures. Differences in perceptions due to experience levels were also noted by Nahas et al. (1999). They found that fourth year students rated personal qualities as most important; whereas less experienced students perceived professional competence to be most important. Findings from the descriptive survey-design study, of 452 student nurse participants across three year-levels, differed to most other studies investigating supervisor characteristics. It was suggested that "cultural beliefs and values about education" (p. 639) explained why professional competence was valued to such a degree. However, J. Fowler (1995) also found that novice supervisees with less experience regarded a supervisor's clinical competence and professional knowledge to be of more importance than other factors.

Further research shows changing supervisee perceptions relating to developing clinical competence (Paukert and Richards, 2000; and Ullian et al., 1994). Paukert and Richards (2000) investigated perceptions of fourth year medical students, and compared findings with those of Ullian et al. (1994) who investigated perceptions of medical residents. Across both studies, it was found that whilst student clinicians place high value on teaching characteristics, those gaining practical experience valued knowledgeable clinical teachers who offered opportunities for learning, and who were available when help was required (Paukert & Richards, 2000, p. 845). In addition, it appeared that those about to work in the field independently, valued clinical teacher characteristics that showed they were being treated as a colleague (Paukert & Richards, 2000, p. 845).

Based on data from student or novice clinician populations, it appears supervisees' value different clinical supervisor characteristics as clinical experience is gained and learning needs change. However, there is limited research investigating (1) changes in practising clinicians' learning needs as they gain clinical experience and (2) how this influences the process of CS. Indeed, there have been no studies examining differences in practising clinicians' perceptions of clinical supervisor characteristics based on levels of work experience. Such research is required to help structure more effective supervision environments for practising clinicians.

Aims of the study

Findings from studies in allied health and related medical disciplines have identified characteristics of a competent or effective supervisor. Characteristics related to interpersonal knowledge and skills and personal values and attitude are highly valued, as are those relating to professional, clinical and teaching competence. However, there is limited data examining practising clinicians' perceptions of clinical supervisors, and no studies in the field of speech language therapy. If CS is intended to help develop and maintain the clinical practice of clinicians, it is important to understand the characteristics practising SLTs value in a clinical supervisor.

Developmental approaches to clinical supervision have shown that the learning and CS needs of student clinicians change across time. In addition, research indicates student perceptions of clinical supervisor characteristics change as clinical skills develop. However, there is no data examining how clinical experience influences practising clinicians' perceptions of clinical supervisor characteristics.

As a result, the current study aims to: (1) Examine the knowledge, attitude and skills of a clinical supervisor that are perceived to be of value by SLTs practising in New Zealand and (2) Use cross-sectional data to determine if the attitudes of more experienced clinicians and less experienced SLTs differ in regard to characteristics perceived to be of value in a clinical supervisor. Based on limited data relating to practicing clinicians, it is hypothesised that a clinical supervisor's interpersonal knowledge and skills and personal values / attitude characteristics are valued by supervisees as much or more than clinical competence, and professional knowledge and identity. It is also hypothesised that less experienced clinicians value different characteristics to more experienced clinicians.

Method

Participants

A self-administered survey was designed and completed by 80 SLTs currently practising in New Zealand. Of these, 72 were able to be included in the final analysis of results. Eight surveys were excluded from data analysis for the following reasons: two had insufficient data; three had visual analogue lines that did not measure 100mm; and three had formatting errors. Surveys used in analysis of results were from 4 males (6%) and 68 females (94%); of whom 30 had $\leq$ 5 years and 42 had > 5 years work experience. Full demographic data can be found in the results section (p. 25). Participants were initially recruited from a University of Canterbury clinical contacts list. Six to eight weeks later, mail-outs were sent to SLTs via the national Private Practitioners (NZSTA, 2007) and Special Schools registers (Ministry of Education, 2007). Those who received the first mail-out were asked to forward the survey to practising SLTs in their contact, to increase sample size. Therefore, the response rate to the survey is not known. This study received ethical approval from the University of Canterbury Human Ethics Committee (see Appendix A for letter).

Survey Instrument

A self-administered survey instrument was designed (see Appendix B). The survey instrument was developed following the guidelines of Polgar and Thomas (1995), Pring (2005), and F.J. Fowler (2002). Steps followed included defining information sought, drafting the survey, piloting the survey, making changes as required and finally administering the survey. Firstly, previous research findings were reviewed and key concepts were noted. Ninety statements about supervisor

characteristics were drafted and discussed with thesis supervisors and a fellow student undertaking a similar topic in the student population. Secondly, questionnaire-design studies from health and related fields were reviewed (Cooper, 2006; Cutliffe & Hyrkäs, 2006, Drysdale & Martin, 2003; Edwards et al., 2005; Hyrkäs et al., 2006, Zipoli & Kennedy, 2005), including those that had used visual analogue scale (Blyth, Anderson, & Stott, 2006; and Rozen & Rozen, 2006). Thirdly, questions were put into survey format and again discussed and critiqued. Once all three researchers had reached agreement, ambiguous questions were excluded and the survey was rewritten for succinctness and clarity.

Fourthly, the survey was piloted with six students from the University of Canterbury, Masters in Speech and Language Therapy (MSLT) programme, who had varying levels of computer and English language literacy. The participants took between 15 and 45 minutes to complete the survey. Feedback indicated that the following changes were required: the use of an age range rather than specific number for demographic characteristics, insertion of the marker on the visual analogue scale, and rectifying identified problems with the formatting of the survey. Revision of the format included the use of a moveable vertical line to cross the visual analogue scale. Finally, to decrease potential order bias, two surveys were formatted (A and B) with different random order of statements.

The survey had five sections. The first section sought demographic data questions including age, gender, ethnicity, qualification, years of practice experience, any years spent out of the work force, and sector of work. The second section related to the participant's current CS situation and included questions relating to participation, type, frequency, duration, method used, whom CS was undertaken with (clinical supervisor), and where it took place. The third section comprised of fifty

statements probing different knowledge (cognitive), attitudinal (affective), or skill (psycho-motor) characteristics, based on seven different concept headings. These concept headings were professional knowledge and identity, clinical competence, education, teaching and learning, interpersonal knowledge and skill, personal values / attitude, safety, and organisation.

All 50 statements began with the carrier phrase – "It is important to me that a clinical supervisor…." to ensure participants responded with an answer indicating their personal perception. Instructions asked participants to indicate on a visual analogue scale how they perceived the importance of each supervisor characteristic, though not necessarily in relation to their current clinical supervisor. A 100 millimetre visual analogue scale was used for response to the 50 statements, as it is a reliable, valid measure to obtain ordinal data about perceptions. (Blyth et al., 2006; Couper, Tourangeau, Conrad, & Singer, 2006; Patrician, 2004; and Rozen & Rozen, 2006). Participants were given the option of completing the survey by computer, therefore steps were taken to ensure that the length of scale (100mm) would not change (a fixed image was used). Text stating *strongly agree* and *strongly disagree* was positioned underneath, equal distance from either end of the scale. A fourth section was a rank order exercise based on four headings previously used by Brown (1981) and Tang et al. (2005). A final qualitative section (for open-ended comment) was incorporated into the quantitative design, to allow for participants who were more likely to respond to a closed question type survey, if given opportunity to answer open format questions (as discussed in Forti, Martin, Jones & Herman, (1996, p. 433).

Survey Distribution and Return

The survey was distributed by email with an information sheet (see Appendix C). Approximately equal numbers of Survey A and B were distributed. Participants were invited to participate in the survey by completing it on their computer or returning by mail. Due dates (approximately three weeks later) were given for each mail-out, to enable data collection and analysis to occur within an allocated timeframe. Of 80 surveys, 52 were returned by email and 28 by post.

Data and Statistical Analysis

After coding to protect confidentiality, visual analogue data was measured and all survey data were manually entered into a computer spreadsheet. Descriptive statistics were calculated for demographic and CS situation data. Data from the ≤ 5 and > 5 years groups were compared to determine if significant differences existed across the groups for the 50 statements. As the data did not conform to the assumption of normal distribution, Mann-Whitney Rank Sum tests were employed to test for significant difference. Given the large number of comparisons undertaken, Boneferri adjustment of p-values was completed. On this basis, data were considered statistically significant at $p < 0.001$. In addition, data from section four of the survey were excluded from analysis, as many responses were not ranked from 1- 4 as per instructions.

Results

Seventy-two surveys were included in data analysis. The sample was divided into two work experience levels: ≤ 5 years and > 5 years. Thirty participants had five or less years work experience (42% of total sample), and forty-two had greater than five years work experience (58% of total sample).

Demographic Data

Figure 1 summarises the ages of all participants across the two experience levels. Sixty-eight participants were female (94%) and four were male (6%). The two primary age-ranges in the study were 20-29 years (39 %), and 30-39 years (35%).

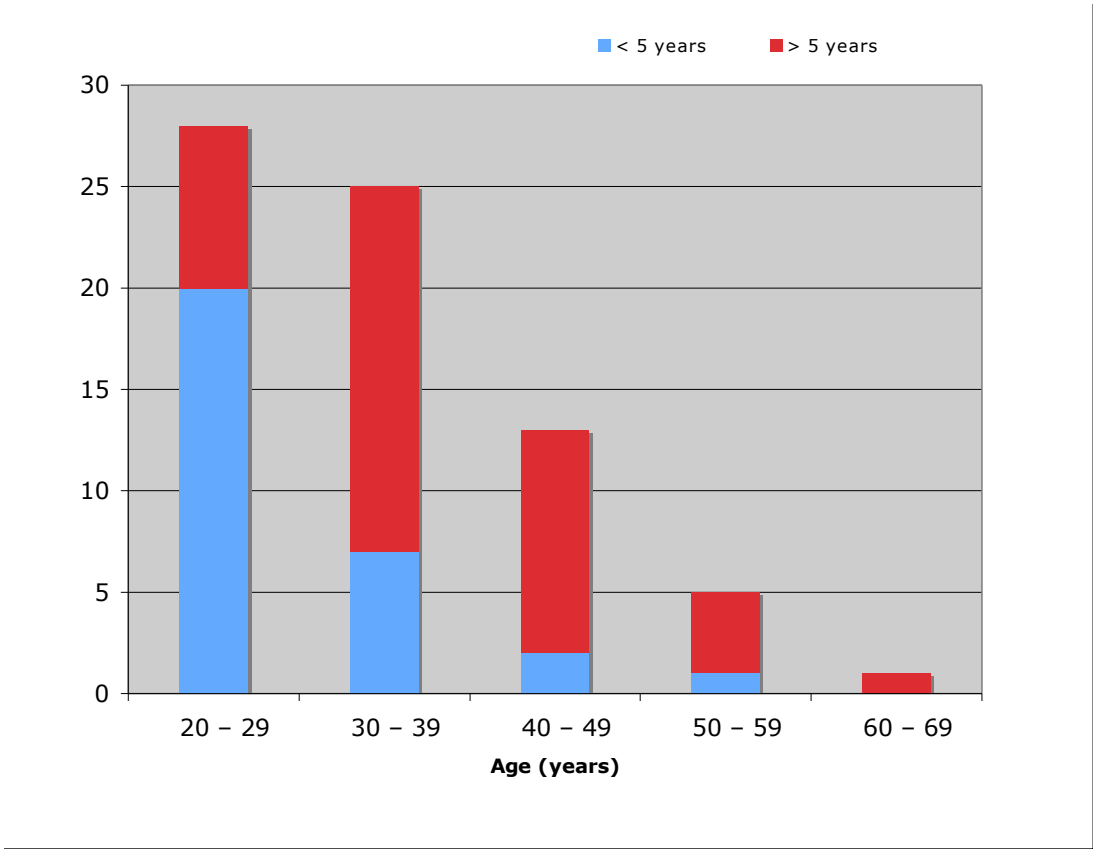

Figure 1. Age of participants

Over half of the participants stated their ethnicity as New Zealand European (65.3%). New Zealand Maori was also represented (2.8%). Other ethnicity (31.9%)

was made up of: British (19.4%), European, including American (6.9%) and Australian (1.4%), Indian (1.4%), South African (1.4%), and not indicated (1.4%).

Figure 2a contains demographic data related to work sector of the participants. The primary work sector of the respondents was education (46%), followed by health (29%), private / self-employed (7%), rehabilitation (3%), non-governmental organisation (NGO) / charity / trust (6%), special school (6%), other (4%). When examined by the two work experience levels, the ≤ 5 years group were equally represented in education and health, whereas half of the > 5 years group worked in the education sector (see Figure 2b).

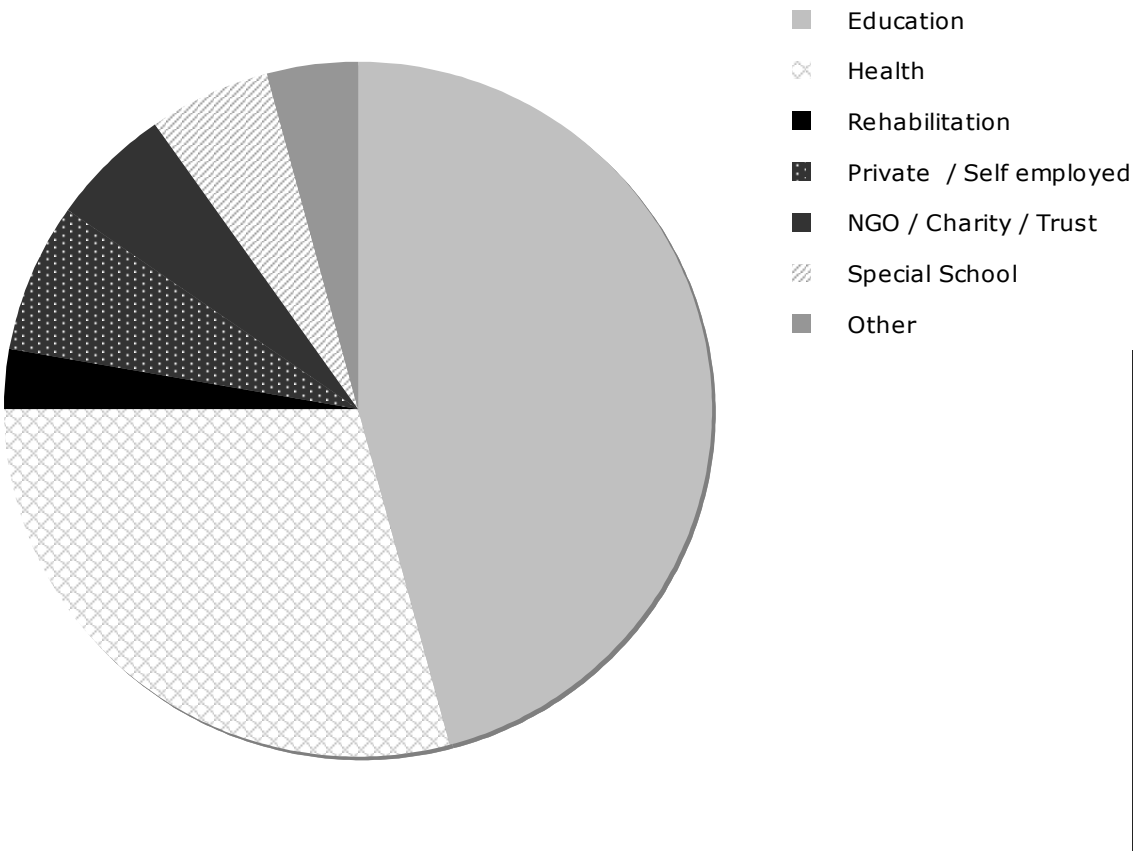

Figure 2a. Work Sector of Participants

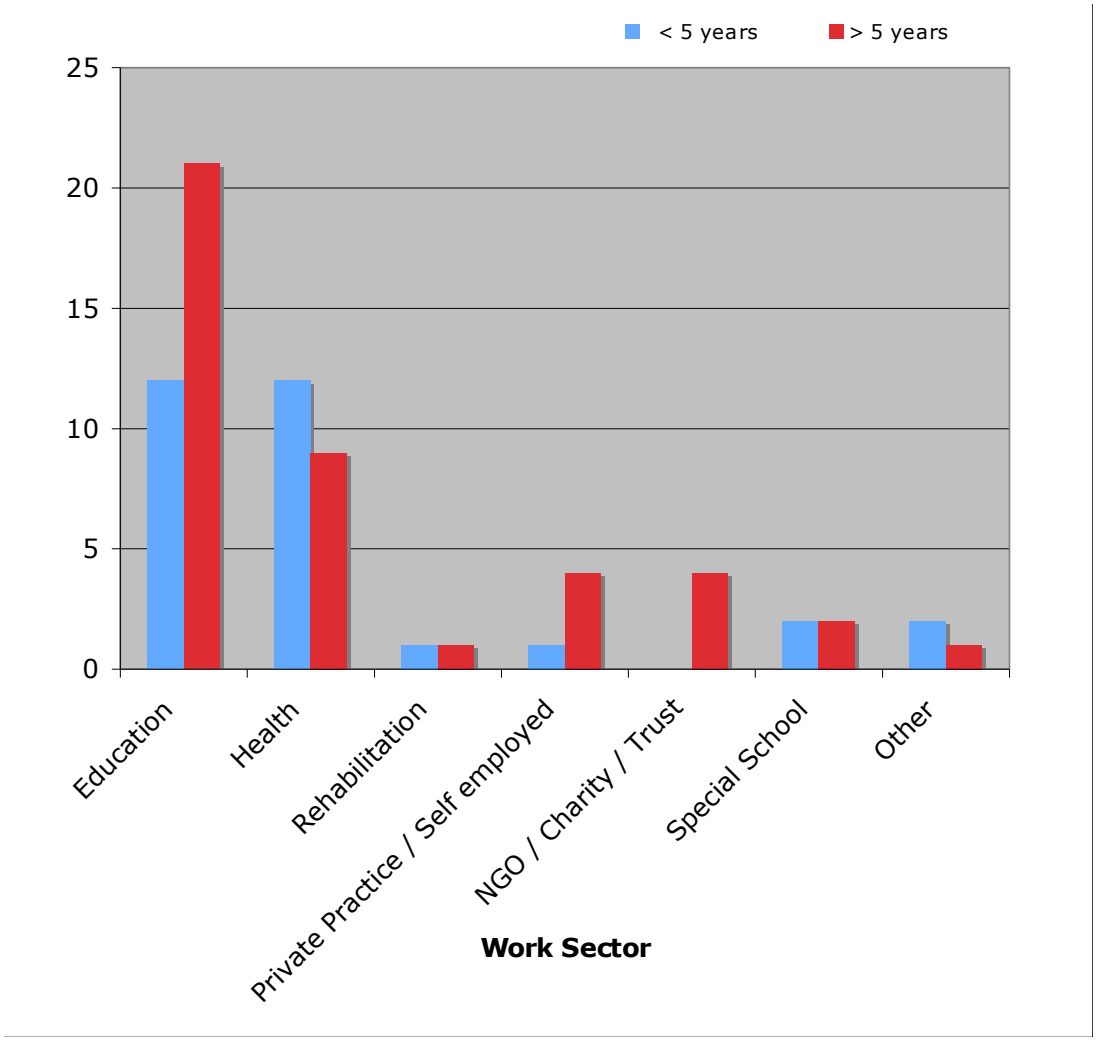

Figure 2b. Representation of Experience Levels across Work Sectors.

Table 2 summarises data regarding year and place of SLT qualification. Regarding date of training, 41 participants gained their highest SLT qualification after 1997 (57%). Forty-three participants were New Zealand trained (60%) while 19 trained in the UK (26%). Other places of training included South Africa (4%), Australia (3%), US (3%), Canada (1%).

Table 2

Year and Place of Qualification

	Total	≤ 5 years experience	> 5 years experience
Year of primary SLT qualification	6 (8%)	-	6 (8%)
Pre – 1986	22 (31%)	1 (1%)	21 (29%)
1986 – 1997	41 (57%)	29 (40%)	12 (17%)
1997 onwards	3 (4%)	-	3 (4%)
Not identified			
Place of Highest qualification	43 (60%)	24 (33%)	19 (26%)
New Zealand	19 (26%)	5 (15%)	14 (19%)
United Kingdom	8 (11%)	1 (1%)	7 (10%)
Other	2 (3%)	-	2 (3%)
Not identified			

Clinical Supervision Situation

Table 3 summarises current type and location of CS of participants. Of the 72 participants, 64 (89%) currently participated in CS. This group comprised of 27 from ≤ 5 years (38% of the total sample) and 37 from > 5 years (51% of the total sample) work experience levels. Five participants with ≤ 5 years experience and five with > 5 years experience participated in group CS only. Of note was that all group CS was undertaken with other SLTs as supervision group members.

Table 3

Type and Location of Clinical Supervision

	Overall Total	≤ 5 years experience	> 5 years experience
Type of Supervision			
1 to 1	51 (80%)	22 (82%)	29 (78%)
Group	5 (8%)	0 (0 %)	5 (14%)
1 to 1 and Group	8 (13%)	5 (19%)	3 (8%)
Location of CS			
In workplace	47 (73%)	22 (82%)	25 (68%)
Outside of workplace	13 (20%)	3 (11%)	10 (27%)
Both in and outside of workplace	4 (6%)	2 (7%)	2 (5%)

Note: percentages calculated for each sample group: n = 64, n = 27, and n = 37 respectively.

Figure 3 summarises who participants were supervised, by across experience levels. Participants whose CS type was one to one, most frequently indicated their supervisor was a SLT (59.4%). However participants also indicated their clinical supervisors were managers (23%), lead practitioners / professional advisors / supervisors (13%%), or from other professional groups eg social work or occupational therapy (6%). One participant did not identify whom they received supervision from.

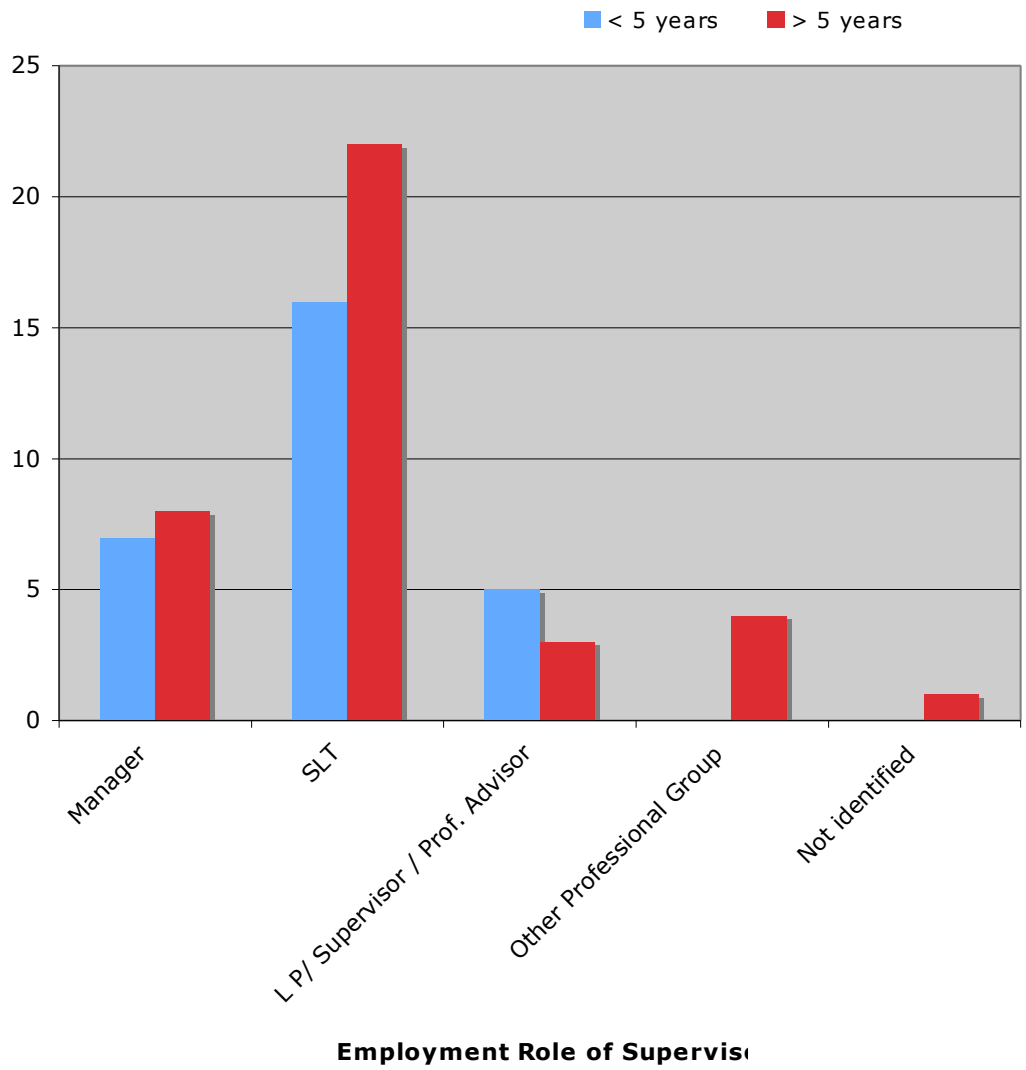

Figure 3: Comparison between experience levels of the job type of clinical supervisors of participants.

Figure 4 shows the usual duration of participants' CS sessions. The majority of participants specified the duration of their supervision sessions were approximately an hour long (61%). Twenty-one participants (33%) indicated their CS session was between one and two hours in length.

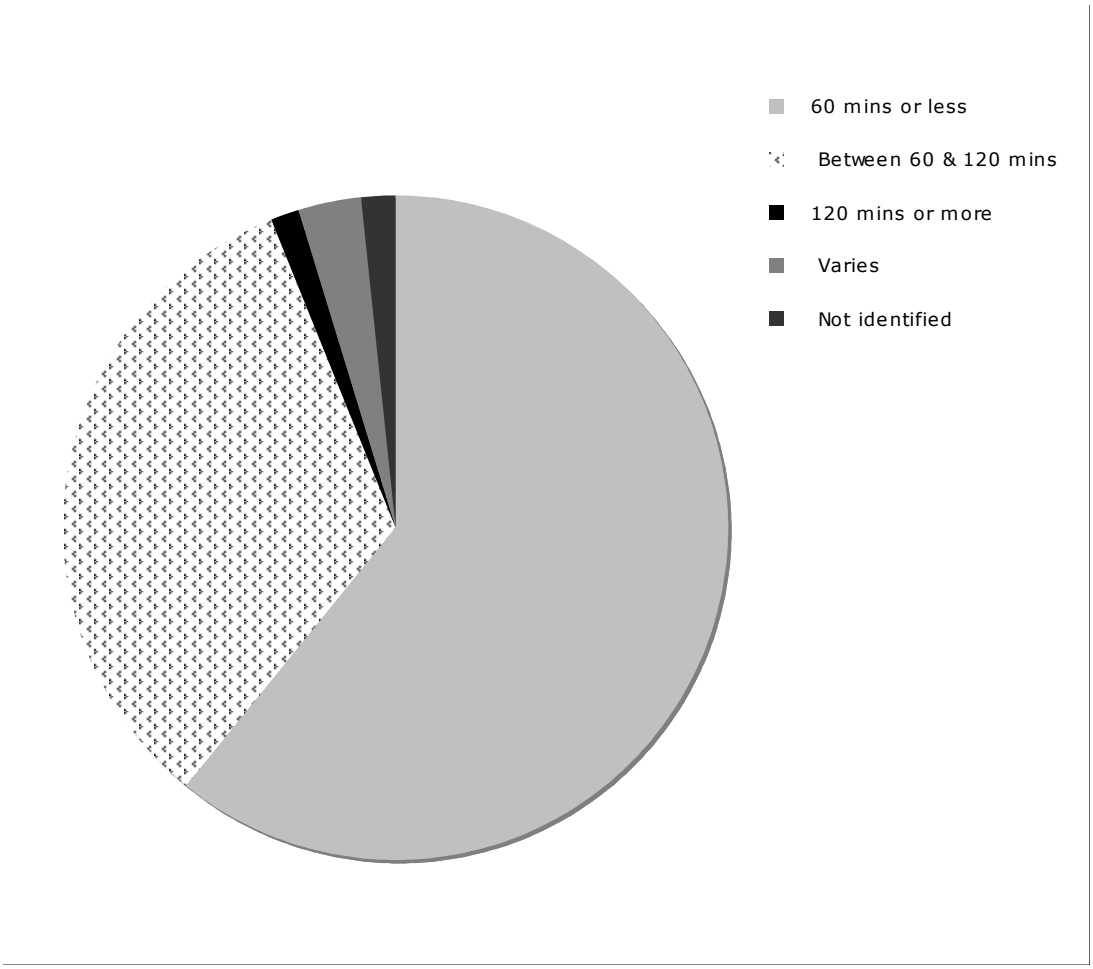

Figure 4: Duration of Participants' CS sessions

Participants indicated various frequencies of CS sessions. The majority of participants had CS sessions at monthly intervals (48%), followed by fortnightly (20.3%). Other CS session frequencies indicated were between four and twelve weeks (17%), between two and four weeks (7.8%), weekly (4.7%), and as required (1.6%).

Table 4 outlines CS methods used by participants. Face to face supervision was the primary method of interaction. Participants also reported using technology to varying degrees to carry out CS.

Table 4

Supervision Methods used by Participants

	Overall Total	≤ 5 years experience	> 5 years experience
Methods			
Face to face	63 (98%)	26 (96%)	37 (100%)
Phone	9 (14%)	4 (15%)	5 (14%)
Videoconference	5 (8%)	2 (7%)	3 (8%)
Internet	3 (5%)	2 (7.4)	1 (2.7)
Teleconference	2 (3%)	0 (0.0)	2 (5.4)
Email	1 (1.6)	1 (3.7)	0 (0.0)

Note: percentages in parentheses are calculated from each sample total, n = 72, n = 30 and n = 42 respectively.

Clinical Supervisor Characteristics

Rank order. Based on overall means, perceived importance of supervisor characteristics was determined by ranking statements from most to least important. Appendix D contains the full list of the fifty statements in rank order from most to least important. Table 5 shows the 10 most important characteristics perceived by participants. Five of the top 10 characteristics fit in the interpersonal knowledge and skills category. Table 6 ranks the 10 least important characteristics perceived by participants, from least important. Five of the 10 least important characteristics fit in the professional knowledge and identity category.

Table 5

Ten Supervisor Characteristics perceived as Most Important

Statement		Category	Mean	*SD*
1	listens carefully to me	I	93.6	*(7.9)*
2	keeps everything we discuss confidential	S	92.0	*(11.8)*
3	asks questions and makes comments that make me think	I / ETL	91.6	*(11.1)*
4	allows me to ask questions	I	91.3	*(12.9)*
5	is honest	P	90.4	*(16.1)*
6	is positive about meeting with me	ETL	90.4	*(13.0)*
7	is supportive	P	90.0	*(15.4)*
8	is an effective communicator	I	89.3	*(13.9)*
9	helps me see my mistakes as learning opportunities	ETL	89.1	*(11.6)*
10	is genuine in interactions	I	88.7	*(17.6)*

Note: SD = standard deviation, I = Interpersonal Knowledge and Skills, S = Safety, ETL = Education, Teaching & Learning, P = Personal Values / Attitude

Table 6

Ten Supervisor Characteristics perceived as Least Important

Statement		Category	Mean	*SD*
50	belongs to the national professional body	Prof	40.2	*(31.5)*
49	provides written feedback	O	40.4	*(28.7)*
48	has a qualification in clinical supervision	Prof	44.1	*(26.9)*
47	works for the same organisation I do	Prof	45.0	*(29.1)*
46	shows understanding of the principles of the Treaty of Waitangi	S	50.4	*(28.4)*
45	has specialist knowledge in human behaviour	I	52.9	*(25.0)*
44	undertakes regular PD in CS	Prof	59.0	*(25.2)*
43	helps me make PD goals	ETL	61.0	*(28.3)*
42	is currently working as a SLT	Prof	62.6	*(29.0)*
41	demonstrates new ways of working with clients	ETL	66.1	*(23.8)*

Note: SD = standard deviation, I = Interpersonal Knowledge and Skills, S = Safety, ETL = Education, Teaching & Learning, O = Organisational, Prof = Professional Knowledge & Identity

Differences between experience levels. Table 7 summarises statistical results related to the two experience levels. Statistical analysis of results indicated a significant difference for ‘suggests techniques I can use in my practice’ ($U = 285$, $p < 0.001$). There were no significant differences ($p > 0.001$) between responses from $\leq$ 5 years and > 5 years experience levels for 45 of the 50 statements. However, trends towards significance were observed for ‘has a qualification in CS’ ($U = 822.5$, $p = 0.028$), ‘provides verbal feedback about my work’ ($U = 445.0$, $p = 0.035$), ‘is caring’ ($U = 428.0$, $p = 0.021$), and ‘is available at the times they specify’ ($U = 817.0$, $p = .033$).

Table 7

Statistical Analysis results for Clinical Supervisor Characteristics

Supervisor Characteristics	≤5 yrs Mean (*SD*)	>5 yrs Mean (*SD*)	*U*	*p*
Professional Knowledge and Identity				
Is a trained SLT	82.3 *(21.8)*	70.8 *(31.8)*	497.0	.129
Belongs to the national professional body	38.8 *(34.3)*	41.2 *(29.7)*	644.5	.736
Has a qualification in CS	36.8 *(27.8)*	49.3 *(25.2)*	822.5	.028*
Undertakes regular PD in CS	59.0 *(25.5)*	59.0 *(25.3)*	647.0	.850
Works for the same organisation I do	48.5 *(28.7)*	42.5 *(29.5)*	561.5	.437
Is currently working as an SLT	66.3 *(23.1)*	59.9 *(32.7)*	563.5	.553
Clinical Competence				
Models evidence-based practice	83.8 *(15.2)*	74.2 *(20.9)*	464.5	.059
Has considerable clinical expertise	79.0 *(16.1)*	74.2 *(24.7)*	606.5	.793
Demonstrates up-to-date theory in CP	82.1 *(18.3)*	74.9 *(22.6)*	484.5	.097
Education, Teaching and Learning				
Understands & applies theoretical models of teaching and learning	64.2 *(24.6)*	71.3 *(26.0)*	765.5	.123
Models life long learning	77.8 *(20.0)*	77.0 *(22.9)*	643.5	.882
Helps me identify gaps in my practice	81.0 *(20.4)*	78.3 *(21.2)*	578.0	.556
Suggests techniques I can use in my practice	86.8 *(15.7)*	67.6 *(23.1)*	285.0	**<.001**
Demonstrates new ways of working with clients	69.6 *(23.6)*	63.5 *(23.8)*	538.5	.298
Helps me see my mistakes as learning opportunities	89.6 *(10.5)*	88.8 *(12.5)*	614.5	.864
Helps me make PD goals	66.7 *(23.6)*	56.9 *(30.8)*	518.0	.203
Provides verbal feedback about my work	80.4 *(24.4)*	68.6 *(28.7)*	445.0	.035*****
Celebrates my successes with me	77.4 *(20.9)*	77.1 *(20.4)*	583.5	.770
Is positive about meeting with me	92.1 *(11.0)*	89.2 *(14.2)*	487.0	.102
Is motivated about providing CS	89.6 *(11.6)*	84.7 *(19.3)*	525.5	.233
Interpersonal Knowledge and Skill				
Has specialist knowledge in human behaviour	48.7 *(26.8)*	56.0 *(23.4)*	*725.0*	.202
Is an effective communicator	88.6 *(16.7)*	89.8 *(11.7)*	570.5	.498
Communicates clearly and succinctly	86.1 *(13.5)*	83.8 *(18.4)*	606.0	.788
Gets on well with a range of people	70.4 *(27.2)*	65.0 *(24.5)*	522.5	.221
Uses appropriate technique to support me to facilitate change	82.4 *(19.7)*	87.5 *(16.8)*	761.5	.134
Asks questions and makes comments that make me think	90.8 *(12.9)*	92.2 *(9.7)*	625.0	.959
Listens carefully to me	93.8 *(6.9)*	93.4 *(8.7)*	583.5	.596
Allows me to ask questions	94.2 *(7.9)*	89.1 *(15.2)*	472.0	.071
Shares ideas calmly	76.4 *(26.0)*	79.1 *(20.7)*	604.0	.958
Is aware of own personal strengths and weaknesses	74.7 *(17.2)*	78.5 *(20.7)*	743.5	.197
Is in tune with own thoughts and feelings	68.4 *(19.2)*	71.9 *(24.2)*	717.5	.320

Table 7 (continued).

Supervisor Characteristics	≤5 yrs Mean (*SD*)	>5 yrs Mean (*SD*)	*U*	*p*
Personal Values / Attitude				
Is genuine in interactions	90.3 *(17.6)*	87.5 *(17.7)*	507.0	.159
Is honest	88.2 *(22.6)*	92.0 *(9.0)*	608.0	.805
Shows a sense of humour when appropriate	84.9 *(18.1)*	78.4 *(19.9)*	490.5	.111
Is caring	83.2 *(18.0)*	71.2 *(24.0)*	428.0	.021*
Is open	91.0 *(10.4)*	86.2 *(13.2)*	460.0	.081
Is supportive	92.4 *(12.3)*	88.4 *(17.2)*	519.5	.293
Safety				
Accepts what I say without judgement	83.7 *(19.9)*	84.7 *(14.3)*	549.0	.591
Is overt about what they are trying to achieve in session	73.7 *(21.7)*	76.8 *(18.0)*	663.0	.710
Helps me solve ethical issues	88.1 *(11.7)*	84.6 *(15.0)*	521.0	.275
Accepts my individual differences	86.3 *(14.3)*	83.8 *(19.9)*	594.5	.689
Values my personal opinion	88.5 *(14.5)*	81.9 *(20.3)*	496.0	.126
Keeps everything we discuss confidential	88.4 *(15.1)*	94.5 *(8.0)*	761.5	.131
Shows understanding of principles of the Treaty of Waitangi	48.6 *(28.2)*	51.7 *(28.8)*	651.0	.815
Organisation				
Is available at the times they specify	70.0 *(23.9)*	80.4 *(20.2)*	817.0	.033*
Allows me to set an agenda for the supervision session	70.1 *(22.0)*	77.4 *(21.8)*	712.5	.161
Manages time effectively within the supervision session	63.8 *(24.9)*	75.0 *(19.7)*	805.5	.046
Is organised	66.0 *(28.4)*	77.6 *(22.9)*	775.0	.099
Is flexible in their approach	83.7 *(15.0)*	80.6 *(15.3)*	530.5	.258
Provides written feedback at the end of the session	37.0 *(25.1)*	42.9 *(31.2)*	691.5	.486

Note: Standard deviation (SD) in parentheses after mean, SLT = speech language therapist, CS = Clinical Supervision, PD = professional development, CP = Clinical Practice, * = trend, **bold** = statistically significant difference.

Discussion

This study examined the practices and perceptions of supervisor characteristics in the process of CS from 72 practising clinicians in New Zealand. Of these, 89% currently participated in clinical supervision. This figure is substantial in comparison to previous CS studies (Drysdale and Martin, 2003; Edwards et al., 2005; Kelly, Long, & McKenna, 2001).The study found that the current group of SLTs perceived interpersonal knowledge and skills and personal values / attitude characteristics to be important in a clinical supervisor. Findings also demonstrated that clinical competence characteristics were perceived to be somewhat important, and professional identity and knowledge and organisational characteristics less important. This confirmed previous study findings that supervisees value a clinical supervisor's interpersonal knowledge and skills, and personal values / attitude as much, or more, than clinical competence and professional identity and knowledge (Cochran et al., 2004; Oratio et al., 1981; Shanfield et al., 2001; Tang et al., 2005).

In general, there was little difference in perceptions regarding importance of supervisor characteristics between SLTs with $\leq$ 5 years experience and those with >5 years experience. This suggests that regardless of experience levels, all practising clinicians have similar supervisory needs. Only one significant difference was noted with participants with <5 years experience rating "suggests techniques I can use in my practice" as significantly more important than participants with >5 years experience. This finding suggests that SLTs with less experience require some direct guidance in clinical techniques, because they are still learning clinical skills.

Supervisor Characteristics Perceived as Important

Findings of the current study showed that practising SLTs value interpersonal knowledge and skills and personal values / attitude characteristics more than clinical competence and professional or organizational characteristics in a clinical supervisor. The findings confirmed that a clinical supervisor's interpersonal knowledge and skills and personal characteristics are valued by practising clinicians as much or more than clinical competence, and professional knowledge and identity. As this study is the first of its kind in SLT, direct comparison to previous research findings cannot be made. However, the current findings can be compared with an earlier related study in the field of SLT and studies from other health disciplines (Oratio et al., 1981; Shanfield, 2001; Sloan, 1999; and Tang et al., 2005). Oratio et al. (1981) found that student SLT clinicians perceived interpersonal supervisory factors of respect and empathy to be most important for effective supervision. Similarly, Tang et al. (2005) found that the greatest differences between effective and ineffective teachers related to interpersonal relationship and personality characteristics. When identifying characteristics of a good supervisor, Sloan (1999) reported that practising community health nurses valued a supervisor's ability to develop supportive relationships (encouraging trust, empathy and mutual regard) and to provide an environment where the supervisee felt comfortable enough to discuss limitations.

Findings from the current study confirm previous results for one primary reason. From a humanistic perspective (Rogers, 1951), individuals' basic needs are the same. A clinical supervisor with interpersonal knowledge and skills, and affirming personal characteristics, makes a supervisee feel safe and supported. In their ethics commentary, Barnett et al. (2007) says that a supervisee feeling unable to discuss mistakes, and sharing perceived successes instead, may result in supervision, with less

opportunities for "growth and learning" (p. 269). Edwards et al. (2005) also suggested that if a safe, comfortable environment is offered, more effective supervision occurs.

Further findings from the current study relate to the importance of safety in the CS environment. It was found that SLTs perceived a supervisor's ability to maintain confidentiality as highly important. Furthermore, current findings indicated that one fifth of SLTs who participated in CS, did so outside of the work environment. Moreover, findings in this study showed SLTs did not perceive it important that a clinical supervisor worked in the same organisation them. These findings are comparable to studies from related health disciplines (Cooper, 2006; Cutliffe & Hyrkäs, 2006; Edwards et al., 2005; Grant et al., 2003). In a multidisciplinary study, Cutliffe & Hyrkäs (2006) found that clinicians ranked confidentiality as the most important characteristic for group supervision. Findings are also comparable to those of Edwards et al. (2005). They suggested supervisees were more able to discuss confidential or sensitive issues when they had high levels of support, trust and rapport with their supervisor, particularly when CS took place away from the workplace. It could be interpreted that not all SLTs practising in New Zealand experience CS where confidentiality is assured, as some appear to be taking measures to arrange CS outside of the workplace.

Results of the current study indicated that participants also valued education, teaching and learning, clinical competence, and organisational characteristics to some degree. These current findings can be compared with numerous previous studies (Cochran et al., 2004; Elzubeir and Rizk, 2001; Nahas et al., 1999; Oratio et al., 1981; Paukert & Richards, 2000; and Tang et al., 2005). For example, Elzubeir and Rizk (2000) found that in general students, interns and residents valued teaching characteristics. In particular, it was stated that more experienced students valued a

supervisor's ability to teach to different levels, place patients needs first, and demonstrate clinical competence. Findings of the current study can also be compared to those of Cochran et al. (2004). In a survey design study of 84 medical students Cochran et al. (2004), found that characteristics relating to teaching ability were valued equally to personal or interpersonal characteristics. Therefore, positive results regarding interpersonal and personal characteristics should not be interpreted to mean that other characteristics are not important.

Interestingly, current findings showed that professional knowledge and identity characteristics were least valued by practising SLTs. This area encompassed characteristics identifying the clinical supervisor as an SLT, and as an active member of the profession. For example, characteristics such as current employment as an SLT, working for the same organization as the participant, belonging to the national organisation for SLTs, and evidence of their knowledge as a clinical supervisor (i.e., qualifications and professional development) were not as highly valued as characteristics based on personal values and attitudes, and interpersonal, teaching and clinical competence. Based on these findings, it appears practising clinicians do not require a clinical supervisor to be of the same discipline as them, to be practising in their field, or to have specific qualifications in CS. However, results did indicate supervisees prefer a clinical supervisor to have knowledge and experience of a SLTs role (see rank number 32 in Appendix D). These current findings can be directly compared with findings from the only other available study investigating perceptions of supervisor characteristics, of practising clinicians (Sloan, 1999). In a qualitative study of 8 practising nurses, Sloan (1999) found that supervisees placed importance on "personal qualities and interpersonal competence, over and above any specific qualification" (p. 719). It could be interpreted that practising clinicians need CS that

is less related to professional practice issues and more focussed on individual wellbeing, and supporting experiences in the workplace. As such, practising clinicians' restorative needs must be taken care of before clinical issues are addressed.

Different Perceptions across Experience Levels

In general, findings from the current study showed no significant difference in perceptions of important clinical supervisor characteristics between the two experience levels. Therefore, less experienced clinicians generally value similar characteristics to more experienced clinicians. This study was the first to evaluate the differences in practising SLTs perceptions of supervisor characteristics across work experience levels. Therefore, no research data from health or related disciplines is available, to directly compare with current findings. However, studies in medical education of student and novice clinician populations have shown differences in perceptions across experience levels (Elzubeir & Rizk, 2001, Nahas et al., 1999; Paukert & Richards, 2000, Ullian et al., 1994). However, it is possible that the current findings showed almost no significant differences because of the choice of experience levels. Analysis across different work experience levels, or alternatively participants' age, ethnicity, place of training, current workplace, rural versus urban location, or current CS situation, may have produced different results. Another possible explanation for the current findings can be drawn from theoretical models of CS and adult learning. Applying Anderson's continuum model of CS (Anderson, 1988; Dowling, 2000) those who have graduated are likely to be competent, and are at a consultative level of CS. However, based on Kolb's experiential learning model (Kolb, 1981) clinical experiences provide all practising clinicians with continual opportunity for learning, and CS supports this process. Furthermore, the role of a

clinical supervisor can be described using Jarvis's concept of reflective learning, where the supervisor acts as a guide. One interpretation as to why clinicians value similar characteristics regardless of experience level, could be that all clinicians are learners.

Some minor differences were found in perceptions between experience levels. In particular, less experience clinicians valued "suggests techniques I can use in my practice", more than those with greater experience. This is unsurprising, given that those with less experience are likely to be competent, but not yet proficient or expert, and are still building their clinical skill repertoire. In comparison to current findings, Laitinen-Väänänen et al., (2007) found that supervisors were more likely to teach or instruct on practical skills, than promote critical thinking or reflective practice. Using qualitative discourse analysis of physiotherapy treatment sessions, Laitinen-Väänänen et al. (2007) evaluated interactions between 12 supervisors and 12 physiotherapy students as patients were treated. Also, in comparison to current findings, Kilminster and Jolly (2000) identify that a characteristic helpful to CS, is a supervisor's ability to give direct guidance on clinical work. One way of advancing clinical skills early in a clinician's career is to trial techniques suggested by more experienced clinicians. However, this can inhibit the reflective learning process (Laitinen-Väänänen et al., 2007). It is possible less experienced clinicians based their perceptions of clinical supervisors on expectations built from clinical education experiences. On the other hand, findings could suggest experienced clinicians are less open to direct suggestions about clinical practice. Schön (1991) states that reflective practice "involves personal risk, because the questioning of practice requires practitioners to be open to examination of beliefs, values and feelings about which there is great sensitivity". Therefore, it could be interpreted that a clinical supervisor of practising clinicians

may require specific training to develop knowledge, attitude and skills, to be able to use appropriate specific methods appropriate to an individual clinician's needs.

Conclusion

It was hypothesized that a clinical supervisor's interpersonal knowledge and skills and personal values / attitude characteristics are valued by practising clinicians as much or more than clinical experience and theoretical knowledge. The results of the current study support this hypothesis, showing overall that interpersonal characteristics and positive personal values and attitudes were perceived as most important. In addition, results indicated that practicing clinicians also value clinical competence, education, teaching and learning, safety and organizational characteristics. Professional identity and knowledge characteristics were perceived as the least important. It was also hypothesized that less experienced clinicians value different characteristics to more experienced clinicians. Results from this study disprove the second hypothesis, showing that overall there was little difference between the perceptions of clinicians who had more or less than five years work experience.

These findings suggest that practicing clinicians' basic human-relationship needs must be met for a supervisee to feel safe and supported and for effective CS to occur. However, it must be remembered that clinicians value a range of characteristics, rather than a group of characteristics in isolation. Findings also suggest that regardless of experience level, all clinicians are learners. Based on Kolb's experiential learning model, all clinicians have the same opportunity for reflective learning, from personal and professional experiences in the workplace. This is in contrast to the belief that less experienced clinicians require more CS and support due to their level of clinical skill.

A clinical supervisor who integrates a range of highly valued characteristics, would not only provide effective CS, but would also be perceived positively by clinicians. Ramos-Sánchez et al (2002) found that the negative effects of a supervisory experience lacking in "mutuality, trust and confidence", could be ongoing and extensive (p 200). Tang, Chou & Chiang (2005) found teachers' attitudes toward students had more impact than their professional abilities. In relation to the current findings, a clinical supervisor with characteristics valued by practising clinicians could have an effect on clinical practice, individual learning and retention of SLTs in the workplace.

Clinical Implications

Findings from the current study have a number of clinical implications. It is likely that practising clinician's will feel valued and supported, if they receive CS from a clinical supervisor using a humanistic approach. Clinicians would also benefit from clinical supervisors who demonstrate knowledge, attitudes and skills in the areas of clinical competence, and facilitation of reflective learning. In addition, findings suggest it is important that clinicians' needs related to overall wellbeing and workplace experiences are supported. Another clinical implication of the current study is that all practising clinicians should view themselves as learners. This has particular implication for those clinicians who are less open to attempting new clinical practices based on theoretical evidence or examining their practice through reflection. Finally, clinical supervisors of practising clinicians require knowledge, attitude and skills enabling them to use appropriate CS methods, according to individual needs of clinicians. This could mean that highly skilled professionals with expertise in clinical supervision are employed, or alternatively that personnel with appropriate

characteristics receive comprehensive training to become specialist clinical supervisors. This implies that appropriate training opportunities for prospective clinical supervisors, may need to be sourced or developed.

Limitations of the study and Future directions

The current study was the first to examine the perceptions of supervisor characteristics of practising SLTs. However, some design limitations should be considered for future studies in this area. Firstly, distribution of the first mail out by email encouraged "forwarding" to recruit participants. As a result, the researcher was unable to calculate a reliable overall response rate. Future studies should employ survey methods that ensure overall response rate can be calculated. A second limitation of the study was relatively small sample size. Follow-up emails or phone-calls, or survey redistribution could have increased the response rate (Begat, Ellefsen and Severinsson, 2005; Blyth, Anderson, & Stott, 2006). In future, studies with increased participant numbers may comprehensively analyse data regarding perceptions of practising across different work experience levels, age, ethnicity, place of training or work sectors.

Thirdly, sample bias may have occurred in the survey results. Specifically, it is possible SLTs who returned the survey may have had an interest in CS, or alternatively SLTs who did not return survey might have had more resistant attitudes toward CS practice. Sample bias is a common limitation of surveys, and can lead to invalid conclusions (Edwards et al., 2005; Hegde, 2003). Future studies using survey design should employ random sampling methods, or use an alternative research designs to increase validity of conclusions.

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Appendices

Supervisor Characteristics valued by practising Speech Language Therapists

Thank-you for completing this survey. Please copy and paste the following symbol as required: ✓

Background Questions:

1. Are you: Male ☐ Female ☐

2. How old are you: 20 – 29 years ☐ 30 – 39 years ☐ 40 – 49 years ☐

50 – 59 years ☐ 60 - 69 years ☐ 69 + years ☐

3. Your ethnicity(s): NZ European ☐ NZ Maori ☐ Samoan ☐

Cook Island Maori ☐ Tongan ☐ Niuean ☐

Chinese ☐ Indian ☐ Other ☐

Please state: _____

4. Where do you work: Health ☐ Education ☐ Rehabilitation ☐

Private/Self Employed ☐ Special School ☐ Other ☐

Please state: _____

5. Do you work: Full-time ☐ Part-time ☐

State your Full time Equivalent eg 0.6 _____

6. What is your qualification: _____ **Year qualified:** _____

From which Institution: _____

7. How long have you worked in your current job:

0 - 2 years ☐ 3 - 5 years ☐ 6 - 10 years ☐ 11–20 years ☐ 20+ years ☐

8. How many years experience in speech language therapy do you have:

0 - 2 years ☐ 3 - 5 years ☐ 6 - 10 years ☐ 11–20 years ☐ 20+ years ☐

9. Have you spent time away from practising speech language therapy: Yes ☐ No ☐

If so, please indicate approximately how long? Continuous ☐ Intermittent ☐

0 - 2 years ☐ 3 - 5 years ☐ 6 - 10 years ☐ 11–20 years ☐ 20+ years ☐

Please answer the following questions about your current Clinical Supervision (CS) situation.

10. Do you currently receive Clinical Supervision: Yes ☐ No ☐

11a. Is your supervision undertaken in:

One-to-one ☐ Group ☐ Other ☐

Please state: _____

b. If you indicated <u>one-to-one</u> supervision please answer:

Is your supervisor: A manager ☐ A Peer SLT ☐ Other ☐

Please state: _____

c. If you answered <u>group</u> supervision:

Are members of your group: All SLTs ☐ From other disciplines ☐

Please list: _____

_____

12. How often do you receive CS:

Weekly ☐ Fortnightly ☐ Monthly ☐ Other ☐ Please specify: _____

13. How long is the supervision session: _____

14. Is the supervision session undertaken in your workplace: Yes ☐ No ☐

15. Which methods do you use for supervision:

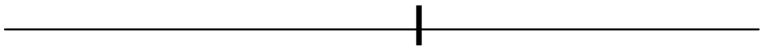
Face to face ☐ Phone ☐ teleconference ☐ Videoconference ☐ Internet ☐

What characteristics do you value in a Clinical Supervisor?

Please answer the following statements by thinking about what you value in a clinical supervisor. This *does not* have to relate to your current clinical supervision situation.

If you plan to return this survey by email, please use the vertical marks on the left hand side of the page to indicate how closely you agree or disagree with the following statements. You will need to move your cursor to the left hand side of the |, then use your space bar to move it to where you want it to be placed.

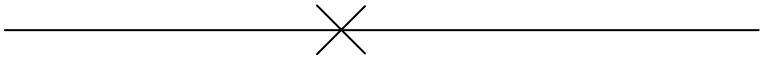
Example



strongly disagree *strongly agree*

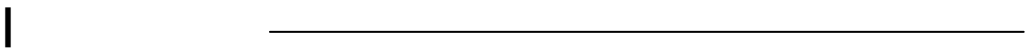
If you have printed this survey to return in hard copy, please mark an X **on** the visual analogue scale to indicate how closely you agree or disagree with the following statements.

Example



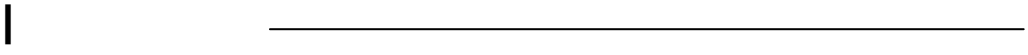
strongly disagree *strongly agree*

1 **It is important to me that a clinical supervisor is currently working as a speech-language therapist.**



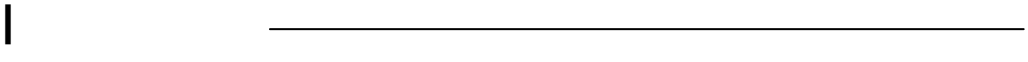
strongly disagree strongly agree

2 **It is important to me that a clinical supervisor allows me to set an agenda for the supervision session.**



strongly disagree strongly agree

3 **It is important to me that a clinical supervisor gets on well with a range of people.**



strongly disagree strongly agree

4 **It is important to me that a clinical supervisor has a qualification in clinical supervision.**

strongly disagree strongly agree

5 **It is important to me that a clinical supervisor works for the same organisation I do.**

strongly disagree strongly agree

6 **It is important to me that a clinical supervisor is positive about meeting with me.**

strongly disagree strongly agree

7 **It is important to me that a clinical supervisor models evidence-based practice.**

strongly disagree strongly agree

8 **It is important to me that a clinical supervisor has considerable clinical expertise.**

strongly disagree strongly agree

9 **It is important to me that a clinical supervisor is a trained Speech Language Therapist.**

strongly disagree strongly agree

10 **It is important to me that a clinical supervisor understands theoretical models of teaching and learning and their application to supervision.**

strongly disagree strongly agree

11 **It is important to me that a clinical supervisor models life-long learning.**

strongly disagree strongly agree

12 **It is important to me that a clinical supervisor communicates clearly and succinctly.**

strongly disagree strongly agree

13 **It is important to me that a clinical supervisor helps me identify gaps in my practice.**

strongly disagree strongly agree

14 **It is important to me that a clinical supervisor belongs to the national professional body (New Zealand Speech-Language Therapists' Association).**

strongly disagree strongly agree

15 **It is important to me that a clinical supervisor suggests techniques I can use in my practice.**

strongly disagree strongly agree

16 **It is important to me that a clinical supervisor helps me see my mistakes as learning opportunities.**

strongly disagree strongly agree

17 **It is important to me that a clinical supervisor provides verbal feedback about my work.**

strongly disagree strongly agree

18 **It is important to me that a clinical supervisor values my personal opinion.**

strongly disagree strongly agree

19 **It is important to me that a clinical supervisor celebrates my successes with me.**

strongly disagree strongly agree

20 **It is important to me that a clinical supervisor undertakes regular professional development in clinical supervision.**

strongly disagree strongly agree

21 **It is important to me that a clinical supervisor is motivated about providing clinical supervision.**

strongly disagree strongly agree

22 **It is important to me that a clinical supervisor is caring.**

strongly disagree strongly agree

23 **It is important to me that a clinical supervisor has specialist knowledge about human behaviour.**

strongly disagree strongly agree

24 **It is important to me that a clinical supervisor is an effective communicator.**

strongly disagree strongly agree

25 **It is important to me that a clinical supervisor is in-tune with his or her own thoughts and feelings.**

strongly disagree strongly agree

26 **It is important to me that a clinical supervisor demonstrates new ways of working with clients.**

strongly disagree strongly agree

27 **It is important to me that a clinical supervisor is open.**

strongly disagree strongly agree

28 **It is important to me that a clinical supervisor asks questions and makes comments that help me think about my clinical issues.**

strongly disagree strongly agree

29 **It is important to me that a clinical supervisor listens carefully to me.**

strongly disagree strongly agree

30 **It is important to me that a clinical supervisor accepts what I say without judgement.**

strongly disagree strongly agree

31 **It is important to me that a clinical supervisor demonstrates up to date theory in clinical practice.**

strongly disagree strongly agree

32 **It is important to me that a clinical supervisor is overt about what they are trying to achieve within the supervision session.**

strongly disagree strongly agree

33 **It is important to me that a clinical supervisor shares ideas calmly.**

strongly disagree strongly agree

34 **It is important to me that a clinical supervisor is aware of his or her personal strengths and weaknesses.**

strongly disagree strongly agree

35 **It is important to me that a clinical supervisor helps me make professional development goals.**

strongly disagree strongly agree

36 **It is important to me that a clinical supervisor is genuine in his or her interactions.**

strongly disagree strongly agree

37 **It is important to me that a clinical supervisor shows a sense of humour when appropriate.**

strongly disagree strongly agree

38 **It is important to me that a clinical supervisor is supportive.**

strongly disagree strongly agree

39 **It is important to me that a clinical supervisor helps me to solve ethical issues.**

strongly disagree strongly agree

40 **It is important to me that a clinical supervisor accepts my individual differences.**

strongly disagree strongly agree

41 **It is important to me that a clinical supervisor allows me to ask questions.**

strongly disagree strongly agree

42 **It is important to me that a clinical supervisor keeps everything we discuss confidential.**

strongly disagree strongly agree

43 **It is important to me that a clinical supervisor shows an understanding of the principles of the Treaty of Waitangi.**

strongly disagree strongly agree

44 **It is important to me that a clinical supervisor is available at the times they specify.**

strongly disagree strongly agree

45 **It is important to me that a clinical supervisor is honest.**

strongly disagree strongly agree

46 **It is important to me that a clinical supervisor uses appropriate techniques to support me to facilitate change.**

strongly disagree strongly agree

47 **It is important to me that a clinical supervisor manages time effectively within a supervision session.**

strongly disagree strongly agree

48 **It is important to me that a clinical supervisor is organised.**

strongly disagree strongly agree

49 **It is important to me that a clinical supervisor is flexible in their approach.**

strongly disagree strongly agree

50 **It is important to me that a clinical supervisor provides written feedback at the end of a supervision session.**

strongly disagree strongly agree

Supervisor Characteristics: General

Please rank the following categories of characteristics,from 1-4 according to the level of importance you perceive each to have (e.g. 1 = most important).

Teaching Ability _____
Professional / Clinical Competence _____
Interpersonal Skills _____
Personality Characteristics _____

Further comments about Clinical Supervision:

Please retain this sheet for your information

By completing the questionnaire it is understood that you have consented to participate in the project, that you consent to publication of the results of the project, and that you consent for the demographic data to be used for any related investigations into clinical supervision for Speech Language Therapists, with the understanding that confidentiality will be preserved.

Please return to the following email address: hcm29@student.canterbury.ac.nz by Monday 29th October 2007.

If you choose to return a printed version of this survey by mail, please address as follows:
Attention: Helen Mataiti, MSLT student
Department of Communication Disorders
University of Canterbury
Private Bag 4800
Christchurch

Appendix C

Information Letter

Information Sheet

Department of Communication Disorders

UNIVERSITY OF CANTERBURY
Te Whare Wānanga o Waitaha
CHRISTCHURCH NEW ZEALAND

Project Name: Supervisor characteristics valued by practising Speech Language Therapists

Investigators: Helen Mataiti, Dr Megan McAuliffe, Gina Tillard

You are invited to participate as a subject in the research project titled "*Supervisor characteristics valued by practising Speech Language Therapists".*

The aim of this project is to examine the characteristics that practising Speech Language Therapists (SLTs) value in a clinical supervisor. The project will also evaluate any differences between supervisor characteristics valued by more experienced and less experienced clinicians.

If you choose to participate in this project, you will be asked to complete the attached survey and return it by email or post. The survey will take approximately thirty minutes to complete.

The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this investigation: the identity of participants will not be made public without their consent. To ensure confidentiality, no specific identifying information is being asked within the survey and upon return of your survey, identifying information such as email addresses or postal addresses on envelopes will be separated from actual surveys. Your returned survey will be allocated a code to ensure further confidentiality. You have the right to withdraw from the project at any time, including withdrawal of any information provided.

Currently, no plans exist for the future use of this data. However, it is possible that the demographic data generated in the present study may be used for further investigations into Clinical Supervision for Speech Language Therapists. Completion and return of the survey will be viewed as your consent for use of the information provided in the survey for the current study and any future studies if required.

The project is being carried out as a requirement for the Masters of Speech and Language Therapy degree by Helen Mataiti, Speech Language Therapist (phone: 03 348 0102 or 021 174 7869), under the supervision of Dr Megan McAuliffe (phone 03 364 2987 extension 7075) and Gina Tillard (phone 03 364 2497). We will be pleased to discuss any concerns you may have about participation in the project.

The project has been reviewed ***and approved*** by the University of Canterbury Human Ethics Committee.

Appendix D

Table of Supervisor Characteristics ranked from most to least important

Appendix D. Characteristics ranked from Most to Least Important based on Means

Clinical Supervisor Characteristics	Category	Mean (*SD*)
1. listens carefully to me	I	93.6 (*7.9*)
2. keeps everything we discuss confidential	S	92.0 (*11.8*)
3. asks questions and makes comments that make me think	I / ETL	91.6 (*11.1*)
4. allows me to ask questions	I	91.3 (*12.9*)
5. is honest	P	90.4 (*16.1*)
6. is positive about meeting with me	ETL	90.4 (*13.0*)
7. is supportive	P	90.0 (*15.4*)
8. is an effective communicator	I	89.3 (*13.9*)
9. helps me see my mistakes as learning opportunities	ETL	89.1 (*11.6*)
10. is genuine in interactions	I	88.7 (*7.6*)
11. is open	P	88.2 (*12.3*)
12. is motivated about providing CS	ETL	86.8 (*16.6*)
13. helps me solve ethical issues	S	86.1 (*13.8*)
14. uses appropriate techniques to support me to facilitate change	I / ETL	85.4 (*18.1*)
15. accepts my individual differences	S	84.8 (*17.7*)
16. communicates clearly and succinctly	I	84.8 (*16.5*)
17. values my personal opinion	S	84.7 (*18.3*)
18. accepts what I say without judgement	S	84.3 (*16.7*)
19. is flexible in their approach	O	81.9 (*15.1*)
20. shows a sense of humour when appropriate	P	81.1 (*19.3*)
21. helps me identify gaps in my practice	ETL	79.4 (*20.7*)
22. models evidence based practice	C	78.2 (*19.2*)
23. shares ideas calmly	I	78.0 (*22.9*)
24. demonstrates up to date theory in clinical practice	C	77.9 (*21.1*)
25. models life long learning	ETL	77.3 (*21.6*)
26. celebrates my successes with me	ETL	77.2 (*20.5*)
27. is aware of own personal strengths and weaknesses	I	76.9 (*19.3*)
28. is caring	P	76.2 (*22.4*)
29. has considerable clinical expertise	C	76.2 (*21.6*)
30. is available at the times they specify	O	76.1 (*22.2*)
31. suggests techniques I can use in my practice	ETL	75.6 (*22.3*)
32. is a trained SLT	Prof	75.6 (*28.4*)
33. is overt about what they are trying to achieve in session	S	75.5 (*19.5*)
34. allows me to set an agenda for the supervision session	O	74.4 (*22.0*)
35. provides verbal feedback about my work	O	73.5 (*27.4*)
36. is organised	O	72.7 (*25.8*)
37. is in tune with own thoughts and feelings	I	70.4 (*22.1*)
38. manages time effectively within the supervision session	O	70.3 (*22.5*)
39. understands & applies theoretical models of teaching / learning	ETL	68.3 (*25.5*)
40. gets on well with a range of people	I	67.3 (*25.6*)
41. demonstrates new ways of working with clients	ETL	66.1 (*23.8*)
42. is currently working as a SLT	Prof	62.6 (*29.0*)
43. helps me make professional development goals	ETL	61.0 (*28.3*)
44. undertakes regular PD in CS	Prof	59.0 (*25.2*)
45. has specialist knowledge in human behaviour	I	52.9 (*25.0*)
46. shows understanding principles Treaty of Waitangi	S	50.4 (*28.4*)
47. works for the same organisation I do	Prof	45.0 (*29.1*)
48. has a qualification in clinical supervision	Prof	44.1 (*26.9*)
49. provides written feedback at the end of the session	O	40.4 (*28.7*)
50. belongs to the national professional body (NZSTA)	Prof	40.2 (*31.5*)

Key to Appendix D

Prof	Professional Knowledge and Identity
C	Clinical Competence
ETL	Education, Teaching and Learning
I	Interpersoanl Knowledge and Skill
P	Personal Values / Attitude
S	Safety
O	Organisation