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Perceptions of Mentoring SLPs and Clinical Fellows During the Clinical Fellowship

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Abstract

The clinical fellowship (CF) is completed by speech-language pathologists (SLPs) after graduating with a master's degree. The clinical fellow is supervised by a mentoring SLP who meets the qualifications set forth by the American Speech-Language-Hearing Association (ASHA). The current study focused on differences and similarities in expectations during the CF by the mentoring SLP and clinical fellow. Participants were asked about knowledge and skills for which clinical fellows are evaluated at the end of the CF in the areas of assessment and treatment. Clinical fellows wanted more help with assessment and less assistance with treatment. Mentoring SLPs felt assistance was needed for assessment and treatment. A model is proposed at the end to aid in implementing the recommendations based on the results.

Before becoming a fully certified speech-language pathologists (SLP) with the Certificate of Clinical Competence (CCC), a graduate must complete a clinical fellowship (CF). The Council for Clinical Certification in Audiology and Speech-Language Pathology (CFCC) defines the standards

for clinical certification (Council for Clinical Certification in Audiology and Speech-Language Pathology of the American Speech-Language-Hearing Association, 2014). The CF is defined by the American Speech-Language-Hearing Association (ASHA) as a "transition period between being a student in a communication science and disorders (CSD) program and being an independent provider of speech-language pathology clinical services" (ASHA, 2016, p. 1). The CF involves a minimum of 1,260 hours of work, in which a recent graduate holds a clinical position as an SLP, working toward gaining his or her CCC. The CF can be completed as a full-time position or a part-time position under the supervision of an ASHA certified SLP (ASHA, 2016). The CF is the last opportunity a SLP has to receive frequent and direct supervision from a seasoned clinician before working independently and achieving full certification. In fact, the goal of mentoring clinical fellows in speech language pathology is to "facilitate transition from supervised student to mentored professional to certified independent practitioner" (ASHA, 2013, p. 8). Potential beneficial practices for mentoring SLPs can be drawn from literature on supervising graduate students, which suggests including regular supervisory conferences (Gillam, Roussos, & Anderson, 1990; Page, Stritzke, & McLean, 2008; Shapiro, 1995), providing specific feedback (Chang, Chou, & Hauer, 2008; Shapiro & Anderson, 1989), and goal setting by the supervisor and graduate student (Gillam et al., 1990; Shapiro & Anderson, 1989). Supervisory conferences, specific feedback, and goal setting are all components of the CF recommended by ASHA (2008a, 2008b). The current study explored the experiences and perceptions of both the mentoring SLP and clinical fellow with a specific focus on differences in expectations between the two in the areas of assessment and treatment. We propose a model as a first step toward creating a successful CF by providing guidelines to create an open dialogue between the mentoring SLP and clinical fellow.

While much of the supervision literature in the field of speech-language pathology has focused on graduate students, some studies have examined experiences in the workplace during the CF (Britt & Gleaves, 2011; Cutcliff & Hyrkas, 2006). There are documents available that provide guidance for mentoring SLPs working with clinical fellows during the CF and recommendations for products, different types of delivery of information, venues for delivering information, qualified individuals to develop training materials, and recommendations for core curriculum (ASHA 2008a, 2008b, 2013). Yet, there is very little evidence of best practices for mentoring SLPs. Dobbs, McKervey, Roti, Stewart, and Baker (2006) conducted a survey where they asked clinical fellows for the most important skills a mentoring SLP should have after the clinical fellows completed their CF in a medical setting. In the area of assessment, clinical fellows reported integrating knowledge to make appropriate diagnoses as the most important skill they wanted in a mentoring SLP. For treatment, the most important skills clinical fellows wanted in a mentoring SLP were availability and on-site supervision. Ostergren (2011) reported the results of a survey with first-year SLPs in California, 93% of whom were concurrently completing their CF through ASHA—the majority of the clinical fellows were satisfied with their overall CF experiences. For mentoring SLPs, Wright (2011) created a rubric to assist mentoring SLPs with self-assessment of their performance to determine how well prepared they were to be a mentoring SLP. However, each of these studies focused on only one party involved in the CF process. Dobbs et al. (2006) and Ostergren (2011) focused on the clinical fellow, while Wright (2011) focused on the mentoring SLP. Ostergren (2011) suggested future studies should evaluate the perspectives of both mentoring SLPs and clinical fellows. The current study focused on the experiences and perceptions of both the mentoring SLP and clinical fellow, recognizing the importance of both parties during the CF (Smith & Anderson, 1982a, 1982b).

Clinical Skills in Assessment and Treatment

The mentoring SLP must rate performance in four areas using the Clinical Fellowship Skills Inventory (CFSI): assessment, treatment, management, and interaction skills (ASHA, n.d.). Of these four areas, assessment and treatment comprise the bulk of clinical service activities performed by SLPs involving direct client contact. These two areas are also the main focus of content in graduate programs. Eighty percent of the clinical fellow's time during the CF "must be

spent in direct clinical contact (assessment/diagnosis/evaluation, screening, treatment, report writing, family/client consultation, and/or counseling)" (ASHA, 2016, p. 1). The remaining two areas on the CFSI are management and interpersonal skills. Given the emphasis on gaining experience in assessment and treatment, we focused on differences in expectations between mentoring SLPs and clinical fellows for these two key areas, while also asking questions pertaining to report writing, consultation, and counseling in the context of assessment and treatment.

Assessment and Treatment

As individuals begin their CF, they have already had many supervisory experiences while providing assessment and treatment. Indeed, most of the supervision literature in the field of speech-language pathology has focused on graduate students (Austin, 2013; Brouwer & Messersmith, 2013; Cassidy, 2013; Epstein, 2008; Fredrickson & Moore, 2014; Hart & Kleinhans, 2014; Oswalt, 2013; Shapiro, 1995; Walden & Gordon-Pershey, 2013). However, the mentoring experience during the CF is different from graduate school since the clinical fellow is more independent, receiving less frequent guidance from the mentoring SLP than graduate students receive from their supervisors. The CF is the final step to working independently as an SLP and can be quite formative in the clinical fellow's development. Therefore, the current study aimed to bridge this gap in the literature by examining perceptions of both mentoring SLPs and clinical fellows in relation to assessment and treatment during the CF. We asked questions to gain insight on the mentoring SLPs' and clinical fellows' perspectives regarding how much support mentoring SLPs felt they needed to provide and how much support clinical fellows felt they needed.

Anderson's (1988) Continuum of Supervision can be used as a guide for the mentoring SLP and clinical fellow to discuss the amount of supervision and mentoring the mentoring SLP expects to give and the amount the clinical fellow expects to receive (McCrea & Brassseur, 2003). The three stages of supervision, according to Anderson (1988) include: evaluation-feedback stage, transitional stage, and self-supervision stage. During the evaluation-feedback stage, a more direct active style of supervision is used, while during the transitional stage, a collaborative style of supervision is more appropriate. Finally, in the self-supervision stage, a consultative style of supervision is more effective. If there are differences in where the mentoring SLP and clinical fellow believe they are on the continuum, the mentoring SLP and clinical fellow can discuss why these differences are present and have an open communication to minimize misunderstandings.

McCrea and Brasseur (2003) suggest focusing on specific components when studying the CF process; we decided to focus on mentoring SLPs and clinical fellows who participated in the CF process in a school-based setting. Therefore, we aimed to answer the following questions:

1. Do mentoring SLPs and clinical fellows in school-based settings agree on the level of support required for the clinical fellow in the area of assessment?
2. Do mentoring SLPs and clinical fellows in school-based settings agree on the level of support required for the clinical fellow in the area of intervention?

Agreement on levels of support is important for a successful CF for both the mentoring SLP and clinical fellow because this allows the mentoring SLP to provide the necessary support for the clinical fellow and for the clinical fellow to believe that he/she is working independently enough.

Method

Participants

In order to reach as many individuals as possible across the state of Texas, we conducted the survey via the Internet which also provided low-cost access to all state association members and allowed for rapid data collection (Czaja & Blair, 2005). We were aware of the potential

disadvantages of using online access, but decided this would provide the most effective and efficient means of acquiring current data. Further, we believed the potential for a low response rate was offset by the fact that this study was intended as a preliminary project which would serve as the basis for a more in-depth study at a later date.

We identified 102 potential SLPs working in school settings from the state association website. These individuals were initially contacted through an e-mail which explained the purpose of the survey, indicated that it would take approximately 15–20 minutes to complete, and included a link for easy access. Approximately two weeks later, a follow-up e-mail was sent to the same list of potential participants reminding them to complete the survey. We received at least partial responses from all prospects. The invitation letter specifically asked for only those SLPs who had either supervised a clinical fellow (classified as mentoring SLP) or completed their CF (classified as clinical fellow) in the last three years. Only individuals who met one of these criteria (N = 63) were retained in the final dataset. We recruited participants who had already completed the CF as perceptions have been documented to change during that experience (Dobbs et al., 2006) and whose CF experience was recent (within three years). We also wanted the experience to be recent enough so that the participants could accurately report information about their experience during the CF. This generated a final response rate of just over 60%. Although this represents a relatively small sample, we believe it is important to report findings (Dugard, File, & Todman, 2012) to begin filling the gap in research on mentoring experiences during the CF, from the perspective of both the mentoring SLP and clinical fellow. We would encourage readers to use caution in making generalizations from our findings. Instead, we hope others will be encouraged to conduct similar research in other geographic locations and with larger numbers of participants to present more robust information on the CF.

Demographics

Demographic analysis of the respondents revealed a highly homogenous sample. The participant demographics are comparable to the state data reported by ASHA (2015) and provide a representative sample of the population (see Table 1). Participants were predominantly Caucasian (98%) females (98%) working in urban settings (75%) between the ages of 30–49 (53%). An additional 40% were aged 50 years or older. Of the 8% of respondents who were between the ages of 21–29, 90% were clinical fellows. Slightly more than 70% of the respondents were mentoring SLPs (n = 43) and approximately 30% were clinical fellows (n = 20).

Table 1. Participant Demographics.

Characteristic	**Classifications**	**Number of Participants**
Race	Caucasian	61
	Other	2
Gender	Female	61
	Male	2
Work Setting	Urban	47
	Rural	16
Group	Mentoring SLP	43
	Clinical Fellow	20

(continued)

Mentoring SLP Ages	Under 30	12
	30–49	12
	50 and older	19
Clinical Fellow Ages	Under 30	18
	30–49	2
	50 and older	0

While these numbers constitute a relatively small sample size viewed from a classical parametric perspective, our decision to use a nonparametric, distribution-free analysis enabled us to use these data effectively to gain preliminary insight into a social science research query (Pett, 1997).

Survey Instrument

Using the CFSI from ASHA for mentoring SLPs and clinical fellows as a starting point, we developed a questionnaire to explore perceptions about mentoring during the CF in the areas of assessment and treatment (ASHA, n.d.). McCrea and Brasseur (2003) state that studying all components of a CF at once is difficult, suggesting instead, picking an element of the CF when conducting studies about mentoring. We also wanted the survey to be manageable for respondents and so we limited the scope of the instrument to the areas involving direct client contact. The survey instrument contained 39 questions covering experiences of both mentoring SLPs and clinical fellows, perceptions about the preferred frequency and purpose of contacts between mentoring SLPs and clinical fellows, and demographics. Table 2 provides greater detail on the types and numbers of questions.

Table 2. Illustrative Survey Information.

Topic	**Number of Questions**	**Sample Question**
Demographics and caseload information	9	Classification as supervisor or CF, ethnicity, gender, district location, age, etc.
Supervisory experience and preparation	6	Indicate your years of experience supervising CFs, graduate students, undergraduate students, or volunteers
Supervisory training and knowledge of ASHA's (2008) *Knowledge and Skills for Supervisors*	4	What supervisory training have you participated in? Have you read the *Knowledge and Skills for Supervisors* put out by ASHA in 2008?
Meetings with supervisors and goal setting	4	How often do you meet in person ○ Once every third segment of the DFY ○ Once a month ○ 2–3 times a month ○ Once a week ○ 2 or more times a week

(continued)

Assessment Activities	8	While the CF utilizes standardized assessment tools: ○ CFs should administer the test under direct supervision for the first few times ○ CFs should administer the test independently and meet with the supervisor after each administration ○ CFs should administer the test independently and ask the supervisor specific questions, as needed ○ CFs should administer the test independently
Treatment Activities	8	While conducting therapy: ○ CFs should be observed by the supervisor for the first few sessions for each client ○ CFs should be observed by the supervisor for sessions with specific clients ○ CFs should conduct therapy independently and ask supervisor questions as needed ○ CFs should conduct therapy independently

The structure of the survey instrument provided standardized response options for participants in the form of a Likert-type scale. For each question, response options were presented in the same order, beginning with a highly dependent choice, and then successively moving forward to a highly independent choice. An example of a question on interpreting evaluations and the selection of responses available to participants follows:

When the clinical fellow interprets evaluation results:

__ Clinical fellows should meet with the mentoring SLP to discuss each individual evaluation.

__ Clinical fellows should meet with the mentoring SLP to discuss the first few evaluations.

__ Clinical fellows should meet with the mentoring SLP if an evaluation is particularly difficult.

__ Clinical fellows should attempt to interpret results independently and ask the mentoring SLP questions as needed.

__ Clinical fellows should interpret results independently.

The survey was piloted with six SLPs who worked in public schools (three mentoring SLPs and three clinical fellows). Based on the responses and feedback from the six pilot participants, we shortened the survey and revised the wording of some questions and responses.

During the data coding process, these response options were coded one through five, with one indicating the highest level of support (e.g., higher supervisory involvement) from the mentoring SLP, and five indicating the highest level of independence (e.g., lower supervisory involvement) by the clinical fellow. It is important to remember these coded values represent only ordinal information. While this indicates we can rightly associate greater degrees of independence with a response coded as a *five* compared to a response coded as a *two,* we cannot determine, with any degree of confidence, the exact value of one response compared to another.

Analyses

The Mann-Whitney test was used to compare mean rank responses for the mentoring SLP and clinical fellow groups. This nonparametric equivalent of the *t*-test was selected for two

reasons. First, the distribution of responses did not meet the tests for normality required for parametric analyses. Secondly, *t*-test analyses require interval data (Pett, 1997; Rovai, Baker, & Ponton, 2013).

Although the initial coded values (one through five) are lost in the process of the Mann-Whitney analysis, the expectation of high involvement from the mentoring SLP continues to be represented by low mean rank numbers, while the expectation of high levels of independence by the clinical fellow continue to be represented by high mean rank numbers. In other words, the higher the Mann-Whitney test statistic (and the higher the mean rank), the greater the expectation for the clinical fellow to work independently, regardless of whether the question was answered by a mentoring SLP or a clinical fellow. The Mann-Whitney mean ranks are included in the Results section of Table 3 and Table 5. The mean rank calculation differs from that of a statistical mean, first ordering responses and then assigning a ranked value based on position before calculating the mean based on the ranked value (Field, 2013). Nonetheless, mean rank values can be interpreted similarly to a statistical mean, as they convey a meaningful idea of the comparative responses.

Results

Both the Mann-Whitney test statistic and effect sizes were calculated for each question associated with assessment and treatment. The effect sizes reported for this study can be interpreted similarly to Pearson's correlation coefficient, *r,* in that it is a "standardized measure of the magnitude, or strength, of a relationship between variables" (Field, 2013, p. 79). A value of ±0.1 indicates a small effect, ±0.3 is a medium effect, and ±0.5 is a large effect (Ellis, 2010; Field, 2013). A complete summary of the Mann-Whitney U statistic, *z* scores, significance, and effect sizes can be found in Table 2 and Table 4.

While most questions uncovered statistically significant differences between mentoring SLPs and clinical fellows producing *p* values ranging from <.001–.038, there were a few areas where mentoring SLPs and clinical fellows were generally in agreement about the degree of mentoring and guidance that was appropriate. We will look at those specific tasks first.

As previously noted, the results were categorized by two of the primary areas assessed on the CFSI: assessment and treatment. We will discuss the findings for each of these two activities separately.

Assessment

First, in the area of assessment, as Table 3 below shows, mentoring SLPs and clinical fellows demonstrated similar expectations for mentoring SLP involvement preparing for assessment, using testing protocols, standardized assessment tools, and meeting with parents or guardians to discuss results. For each of these activities the differences in the frequency of responses were not statistically significant, with *p* values ranging from .155 to as high as .873.

Table 3. Mann-Whitney U Results for Assessment Activities.

Question	**Mann-Whitney U**	***Z***	***P***	***r* (effect size)**	**Agreement or Disagreement Regarding Level of Supervision**
When preparing for an assessment	346.5	-0.27	.787	0.04	Agree
Before the CF uses a specific testing protocol (standardized or informal)	351.0	-0.159	.873	-0.02	Agree

(continued)

While the CF utilizes standardized assessment tools	286.0	-1.421	.155	-0.19	Agree
While conducting an assessment using informal measures (language sample, observation, checklist, etc.)	213.0	-2.722	.006	-0.36	Disagree
When the CF interprets assessment results	191.0	-2.747	.006	-0.37	Disagree
When making recommendations	147.5	-3.55	.000	-0.5	Disagree
When writing reports	216.5	-2.234	.025	-0.3	Disagree
When the CF meets to discuss results with the parent/guardians	323.5	-0.171	.864	-0.02	Agree

However, for four other activities, we observed statistically significant differences in expectations for mentoring SLP involvement: (a) conducting assessments with informal measures, (b) interpreting assessment results, (c) making recommendations, and (d) writing reports. For these activities, clinical fellows indicated they were more comfortable with somewhat higher levels of autonomy. Also of note, the effect sizes associated with these differences all produced medium to high effects, with *r* values ranging from .3–.5.

While statistically significant differences were observed between mentoring SLPs and clinical fellows on specific tasks and responsibilities, it is important to note these differences are incremental rather than dramatic. To help illustrate this point, Table 4 contains the responses for each question associated with assessment activities that were selected most frequently by mentoring SLPs and clinical fellows. As you will see, the degree of variance between responses clusters around two sequential points. We did not observe mentoring SLPs on one end of the continuum of supervision and clinical fellows on the other. Instead, the variance in expectations about the level of support was subtle, indicating clinical fellows expected, or wanted, slightly more independence than mentoring SLPs were prepared to provide.

Table 4. Most Frequent Responses for Assessment.

Question	**Answer Selected Most Frequently by Supervisors**	**Answer Selected Most Frequently by Clinical Fellows**
When preparing for an assessment	Clinical fellows should ask any questions about the assessment plan *as needed* Mean Rank 28.11	Same response Mean Rank 26.37
Before the clinical fellows uses a specific testing protocol (standardized or informal)	Clinical fellows should ask the supervisor any questions regarding administration procedures *as needed* Mean Rank 28.36	Clinical fellows should read the manual to learn the administration procedures* Mean Rank 25.92

(continued)

While the clinical fellows utilizes standardized assessment tools	Clinical fellows should administer the test *independently* and *meet* with the supervisor *after each administration* Mean Rank 25.31	Same response Mean Rank 31.53
While conducting an assessment using informal measures (language sample, observation, checklist, etc.)	Clinical fellows should complete assessments *independently* and *meet* with the supervisor *after each assessment* Mean Rank 23.23	Clinical fellows should complete the assessment *independently* and *ask* the supervisor *specific questions as needed* Mean Rank 35.37
When the clinical fellows interprets assessment results	Clinical fellows should meet with the supervisor *to discuss the first few evaluations* Mean Rank 23.46	Clinical fellows should meet with the supervisor *if* an evaluation *is particularly difficult* Mean Rank 34.95
When making recommendations	Clinical fellows should meet with the supervisor to discuss recommendations *for the first few evaluations* Mean Rank 22.21	Clinical fellows should meet with the supervisor to discuss recommendations *if an evaluation is particularly difficult* Mean Rank 37.24
When writing reports	Clinical fellows should meet with the supervisor *to write the first few reports* Mean Rank 24.19	Clinical fellows should *periodically* meet with the supervisor to *review* written reports (7 clinical fellows)** Clinical fellows should *attempt* to write reports *independently* and *ask the supervisor questions as needed* (7 Clinical Fellows)** Mean Rank 33.61
When the clinical fellows meets to discuss results with the parent/guardians	Clinical fellows should *meet* with the supervisor to *discuss* how the results and recommendations will be conveyed for the first few assessments Mean Rank 27.24	Clinical fellows should be *accompanied* by the supervisor to parent/guardian meetings *if requested** Mean Rank 27.97

*Note. *Although the response selected by clinical fellows most frequently, was different from the supervisors' most frequent response, the difference was not statistically significant. **Clinical fellows responses to this questions exhibited a bi-modal distribution, with the two responses noted above selected equally often.*

Treatment

Expectations about the level of involvement from the mentoring SLP differed more widely between mentoring SLPs and clinical fellows for treatment activities. In fact, the two groups only agreed about the degree of independence on a single activity, reporting progress to teachers and other professionals. This particular activity produced the highest Mann-Whitney U value (256.0) of all treatment activities, indicating both mentoring SLPs and clinical fellows expected a high degree of independence while performing this function. As would be expected with a high level of agreement between the two groups, the difference was not statistically significant ($p = .118$) and the effect size was relatively small ($r = -0.21$).

For all other treatment activities, mentoring SLPs and clinical fellows disagreed about the level of involvement from the mentoring SLP, with Mann-Whitney U statistics ranging from

112.5–230.5. Further, the level of difference between the two groups was statistically significant for all seven other functions, with *p* values of .000–.042. Generally speaking, effective sizes were moderate, ranging from 0.28–0.58. Table 5 presents detailed findings for each of the eight treatment activities.

Table 5. Mann-Whitney U Results for Intervention and Treatment Activities.

Question	**Mann-Whitney U**	***Z***	***P***	***r* (effect size)**	**Agreement or Disagreement Regarding Level of Supervision**
When the clinical fellows formulates treatment goals	211.5	-2.351	.019	-0.32	Disagree
While planning therapy	112.5	-4.27	.000	-0.58	Disagree
While conducting therapy	228.0	-2.037	.042	-0.28	Disagree
In providing feedback to clients	230.5	-2.074	.038	-0.28	Disagree
While charting progress	172.5	-3.088	.002	-0.42	Disagree
In determining if the client is making progress	200.0	-2.589	.010	-0.35	Disagree
When reporting progress to parents	224.5	-2.203	.028	-0.3	Disagree
When reporting progress to teachers and other professionals (e.g., IEP meetings)	256.0	-1.562	.118	-0.21	Agree

Note. Effect size was calculated using the formula to convert a *z* score into an effect size $r = \frac{z}{\sqrt{n}}$.

Once again, although differences between mentoring SLPs and clinical fellows were statistically significant, the degree of difference was incremental. In other words, once again, the two groups did not appear on opposite ends of the continuum of supervision, but tended to be separated only by the degree associated with two sequential responses. By way of example, a careful examination of the most frequent responses, as shown in Table 6, shows that in general, mentoring SLPs expected *periodic* involvement, while clinical fellows more frequently indicated involvement from the mentoring SLP should occur on an *as needed* basis, only one step further along the continuum of supervision.

Table 6. Most Frequent Responses for Intervention and Treatment.

Question	**Answer Selected Most Frequently by Supervisors**	**Answer Selected Most Frequently by Clinical Fellows**
When the clinical fellows formulates treatment goals	Clinical fellows should be *accompanied* by the supervisor to *all parent/guardian meetings* Mean Rank 24.04	Clinical fellows should be *accompanied* by the supervisor to parent/guardian meetings *if requested* Mean Rank 33.87

(continued)

While planning therapy	Clinical fellows should meet *periodically* with the supervisor to review therapy plans for *specific* clients Mean Rank 21.21	Clinical fellows should plan therapy *independently* and ask the supervisor questions *as needed* Mean Rank 39.08
While conducting therapy	Clinical fellows should be *observed* by the supervisor for sessions *with specific clients* Mean Rank 24.51	Same response* Mean Rank 33.00
In providing feedback to clients	Clinical fellows should provide feedback and *ask* the supervisor questions *as needed* Mean Rank 24.59	Same response** Mean Rank 32.87
While charting progress	Clinical fellows should *periodically* review their system for charting progress with the supervisor Mean Rank 22.93	Clinical fellows *independently* chart client progress and ask the supervisor specific questions *as needed* Mean Rank 35.92
In determining if the client is making progress	Clinical fellows should meet *periodically* with the supervisor to review client progress Mean Rank 23.71	Clinical fellows should *independently* evaluate data and ask the supervisor specific questions *as needed* Mean Rank 34.47
When reporting progress to parents	Clinical fellows should report progress *independently* to parents and ask the supervisor questions as needed Mean Rank 24.41	Same response*** Mean Rank 33.18
When reporting progress to teachers and other professionals (e.g., IEP meetings)	Clinical fellows should report progress to teachers and other professionals *independently* and ask supervisor questions *as needed* Mean Rank 25.31	Same response Mean Rank 31.53

Note. *Although analysis of the mode shows supervisors and clinical fellows selecting the same response, Mann-Whitney analysis found a statistically significant difference because the clinical fellow responses exhibited a bi-modal distribution, with the response indicated in this table containing only one response more than the next option which indicated clinical fellows should act independently, only asking for assistance as needed. Further, 67% of the clinical fellows chose not to provide an answer on this question. **Similar to the note above, analysis of the mode shows supervisors and clinical fellows selecting the same response most frequently, but Mann-Whitney analysis shows a statistically significant difference. As is true in the note above, 67% of the clinical fellows chose not to provide an answer on this question. ***Once again, modal analysis shows supervisors and clinical fellows selecting the same response, while Mann-Whitney finds a statistically significant difference in responses. This is the third of three questions where the number of non-responses from clinical fellows is likely responsible for differences between the two tests.

Discussion

We attempted to capture perceptions of both the mentoring SLPs and clinical fellows, as this was deemed important as part of a successful supervisory process (Smith & Anderson, 1982a; 1982b). Overall, mentoring SLPs perceived their role in the CF process to be more involved at the beginning of the CF, while clinical fellows preferred to identify specific cases where they needed assistance from the mentoring SLP throughout the year. The mentoring SLP and clinical fellow appeared to be at different points on the Continuum of Supervision proposed by Anderson (1988); the mentoring SLPs viewed the clinical fellows in the transitional stage, needing support at the beginning, while clinical fellows viewed themselves closer to the self-supervision stage, generally capable of self-evaluation and determining when they need additional guidance.

Overall, there was more agreement between mentoring SLPs and clinical fellows in the area of assessment and more variance in the area of treatment. The majority of the differences occurred when the clinical fellow wanted to request help from the mentoring SLP *as needed* while the mentoring SLP felt that the clinical fellow needed help *early on* in the CF process or *periodically* throughout the year. Again, these differences are incremental in nature, and may indicate that in general, the clinical fellows who responded to this survey were more comfortable performing treatment than conducting assessments.

Assessment and treatment were the two areas of the CFSI on which we focused as part of the current study. In the area of assessment, mentoring SLPs preferred to meet with the clinical fellows at the beginning of the CF and transition the clinical fellows to a more independent state, while the clinical fellows felt that they were already at a self-evaluative state where they could inform the mentoring SLP when they needed assistance. In the area of treatment, the mentoring SLPs felt that the clinical fellows did not need as much assistance. The mentoring SLPs reported that they should meet with the clinical fellows periodically and for specific clients, while the clinical fellows reported that they wanted assistance as needed if they requested the help. While the mentoring SLPs and clinical fellows appeared to be at different points on the Continuum of Supervision, the clinical fellows wanted to have access to the mentoring SLP when they were unsure about specific cases.

One important factor that might possibly explain the mentoring SLPs' preference to meet more with the clinical fellows at the beginning which was not addressed in the current study is the experiences the mentoring SLP had with previous clinical fellows. There is a possibility that mentoring SLPs with positive experiences with previous clinical fellows are more likely to move toward the self-supervision end of the Continuum of Supervision faster than mentoring SLPs who have had less positive experiences with previous clinical fellows. Mentoring SLPs also do not know what sort of clinician the clinical fellow is at the beginning of the CF and also want to ensure that the clinical fellow is conducting appropriate assessments and treatment; one logical way to do this is to observe assessment and treatment sessions early in the CF and determine if the clinical fellow requires assistance early in the CF. This approach minimizes the chance of mentoring SLPs encountering unexpected difficulties later in the CF.

Recommendations

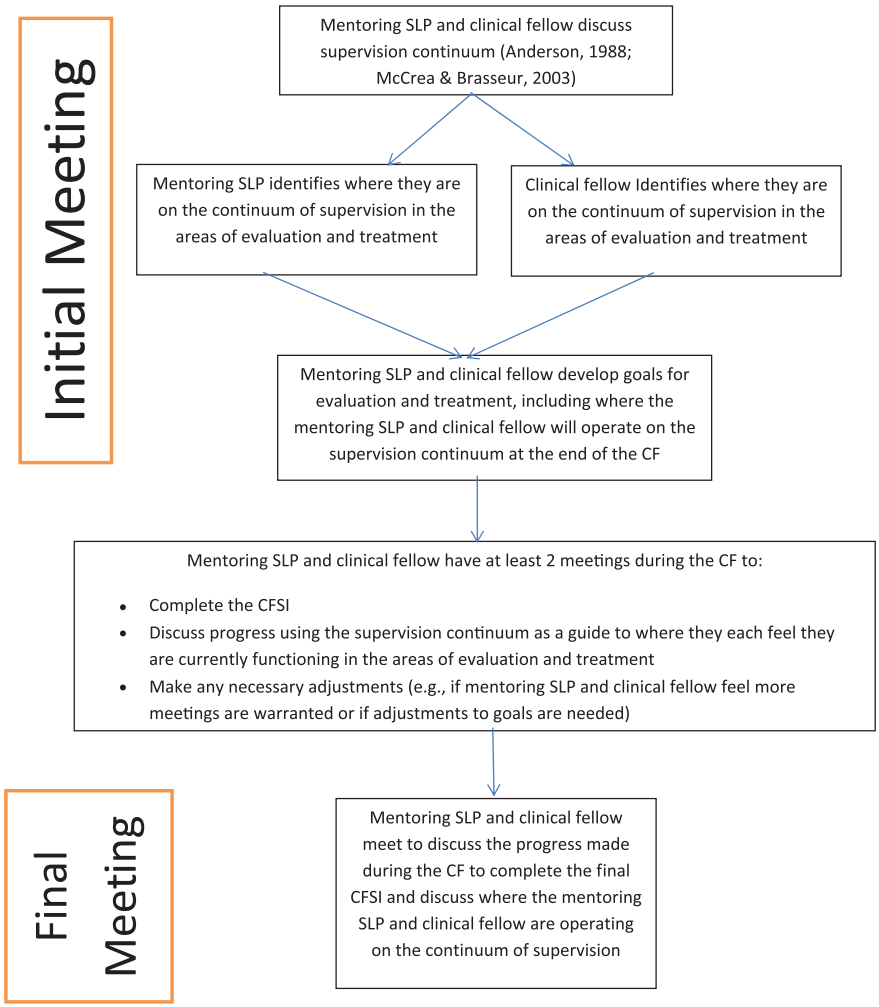
We are not suggesting these differences indicate changes need to take place during the CF, but rather, the differences indicate the importance of communication between the mentoring SLP and clinical fellow. Clinical fellows complete assessments and treatment under the license of the mentoring SLP in the state of Texas, where we conducted our survey. In the state of Texas, "the supervisor is responsible for all client services performed by the licensed intern" (State Board

of Examiners for Speech-Language Pathology and Audiology About the Profession - Position Statement, 2016, p. 1). Because mentoring SLPs in the current study accept responsibility for the work the clinical fellow completes, mentoring SLPs may want to ensure that the clinical fellow is conducting assessments and treatment appropriately and applying best practices before allowing the clinical fellow to be more independent. Therefore, the mentoring SLP's reported desire to meet with the clinical fellow at the beginning of the CF and then transition the clinical fellows to a more independent state is understandable in the state of Texas. Mentoring SLPs likely want to ensure that clinical fellows are conducting appropriate assessments. Since assessments occur for a much shorter amount of time than treatment, the mentoring SLP may feel a greater need to observe the clinical fellow conducting the first few assessments. This higher degree of involvement may be necessary for the mentoring SLP to have more confidence that the clinical fellow will continue to conduct assessments appropriately. This confidence in the clinical fellow's abilities to conduct assessments may allow the mentoring SLP to feel comfortable having the clinical fellow conduct assessments with more independence as the CF progresses. If communication takes place early on in the CF, the mentoring SLP and the clinical fellow might know they are both working toward the same goal of having the clinical fellow at the self-supervision end of the Continuum of Supervision (Anderson, 1988).

Similar recommendations follow for treatment. Mentoring SLPs in the current study appear to feel that the clinical fellows are at the transitional stage and require periodic meetings with the mentoring SLP. This difference in results between assessments and treatment might be due to the nature of treatment services. The clinical fellow has more opportunities to meet with the clients who are receiving treatment; therefore, the mentoring SLP can observe how the clinical fellow is delivering treatment services periodically over time, rather than needing to observe an assessment that occurs only one time for 1–2 hours. Since the mentoring SLP is ultimately responsible for the treatment services provided by the clinical fellow in the current study, periodic observation can help to reassure the mentoring SLP that appropriate treatment services are provided and implemented by the clinical fellow. Similar to assessment, the communication between the mentoring SLP and clinical fellow can help both individuals understand that they are working toward the same goal: the clinical fellow working at the self-supervision end of the Continuum of Supervision (Anderson, 1988).

Based on the results of the current study, we developed a model that mentoring SLPs and clinical fellows may use as a guide that closely follow the Continuum of Supervision (Anderson, 1988; McCrea & Brasseur, 2003; see Figure 1). We incorporated discussion of goal setting (Gillam, Roussos, & Anderson, 1990; Shapiro & Anderson, 1989) and the Continuum of Supervision (Anderson, 1988; McCrea & Brasseur, 2003) during the initial meeting where both the mentoring SLP and clinical fellow identify where they currently view themselves on the Continuum of Supervision. Both the mentoring SLP and clinical fellow work to develop goals as proposed by several researchers (Gillam, Roussos, & Anderson, 1990; Shapiro & Anderson, 1989) using Anderson (1988)'s Continuum of Supervision as a point of reference. Progress for the goals of both the mentoring SLP and clinical fellow can be discussed at two meetings during the CF; open discussions about goals have proven to be helpful in the CF process (Summers, Resendiz, & Ruiz-Felter, 2014). If changes are needed, the mentoring SLP and clinical fellow can both work together and discuss why the specific changes might be needed in the supervision process (Summers et al., 2014). The Continuum of Supervision can again be used as a guide for where the mentoring SLP and clinical fellow believe they should each be providing or receiving guidance from the mentoring SLP. At the end of the CF when the final ratings are determined, the mentoring SLP and clinical fellow can again use the Anderson (1988) Continuum of Supervision as a point of reference and evaluate progress and performance for the CF.

Figure 1. Proposed Model of Clinical Fellowship.



Based on the results of our study, separate goals are recommended for assessment and treatment, since there are perceived differences both by the mentoring SLP and clinical fellow regarding how much support the clinical fellow requires. Clearly outlining the goals for the CF will allow both the mentoring SLP and clinical fellow to understand what is expected during the CF.

Limitations

The findings of the current pilot study should be interpreted with caution because of the small sample size and limited demographic information. The preliminary results of the current study serve as a starting point for evaluating the perceptions of both mentoring SLPs and clinical fellows during the CF. Future studies that address some of the gaps in the current study have the potential to inform best practices during the CF within and across settings.

Future studies should aim to have a larger and more diverse sample. The survey can be provided to individuals wishing to conduct the survey in additional settings and geographic

locations by contacting the authors of the current study. We focused on mentoring SLPs and clinical fellows completing a CF in school-based settings in the areas of assessment and treatment to have a focused and manageable study (McCrea & Brasseur, 2003). In the future, mentoring SLPs and clinical fellows completing their CF in a medical setting or rehabilitation facility should be included. Additionally, individuals from different states should be included in a survey for geographical diversity as well as to account for differences in state requirements for individuals completing the CF.

In the future, studies that include different settings and additional skill areas will add to the field of mentoring during the CF based on patterns or lack thereof that are found within and across settings. Additionally, evaluating the effectiveness of the proposed model using Anderson's (1988) Continuum of Supervision as a reference point throughout the CF experience by both mentoring SLPs and clinical fellows will help us modify our model to assist mentoring SLPs and clinical fellows to benefit maximally from the experience of the CF. Perceptions of mentoring SLPs and clinical fellows in the areas of interpersonal skills and management skills should also be evaluated in future studies. These additional areas are also key components of the CF, as evidenced by their inclusion in the evaluation when using the CFSI.

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