IDENTIFYING BENCHMARK COMPETENCY CRITERIA FOR A REHABILITATION COUNSELING CLINICAL SUPERVISION INSTRUMENT: A DELPHI STUDY

By

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To my parents Ken and Rose

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The purpose of this study was to identify and draw consensus on a comprehensive set of competency criteria useful for clinical supervision evaluation. An essential function of any counseling profession is to ensure that graduate students are personally and professionally competent to practice within a community setting. Although the rehabilitation counseling profession may provide general guidance for competency standards, the responsibility to ensure that students have attained the necessary knowledge and skill routinely falls to the training faculty. Consequently, training programs have a substantial amount of autonomy when developing these competency criteria. Even though some flexibility with these tasks is necessary for individual programmatic goals, considerable variability promotes inconsistently monitoring and evaluation of students. The clinical portion of the training programs is perhaps most vulnerable to these challenges due to the dual role of the supervisor, philosophical differences regarding the purpose of clinical training, supervisor preparedness, the supervisor's fear of litigation, and difficulties in measuring clinical competence. Despite these challenges, this research was intended to identify a variety of clinical skills, attributes, and behaviors to aid clinical supervisors measuring trainee's competency during clinical supervision. Using the

Delphi methodology, 21 rehabilitation counseling educators identified a variety of performance benchmarks useful for clinical supervision assessment. The study resulted in 185 items useful for clinical competency evaluation. Items represented an assortment of competency domains including general indicators of the counseling process, specific clinical process skills, case conceptualization items, treatment planning items, professional behaviors, professional development items, self care items, personal attributes, and items specific to the supervision process. Implications for education and public policy are discussed as well as future development of a clinical supervision instrument measuring trainee clinical performance.

CHAPTER 1
INTRODUCTION

Background

An essential function of any counseling profession is to ensure that graduate students are personally and professionally competent to practice within a community setting. In accordance with this fundamental principle, counseling educators develop appropriate curriculum and learning objectives to make certain that students receive the required training for professional practice. Although each counseling profession identifies the general knowledge domains and expectations for adequate trainee preparation, the responsibility to ensure that students have attained the necessary knowledge and skill normally falls to the training faculty (Robiner, Fuhrman, Ristvedt, 1993). The same professional standards that require students to be professionally competent provide only general guidelines regarding evaluation criteria and expectations of minimal student performance. Thus, faculty members typically rely on homegrown evaluation instruments that vary from program to program.

Further complicating the evaluation problem is the fact that training programs may have difficulty identifying and addressing their students' nonacademic limitations (Hahn & Molnar, 1991). More specifically, programs frequently struggle to identify and intervene with students who perform well academically, but may have character or psychological issues that interfere with their counseling ability (Bemak, Epp, & Keys, 1999). The challenges associated with personal suitability coupled with non-specific evaluation criteria may result in inconsistent evaluation of the student. Consequently, programs may be faced with the difficult decision of endorsing questionable trainees for certification or licensure. By allowing impaired trainees to graduate without remediation, counselor educators not only endanger their professional integrity, but more importantly jeopardize their service to the public.

Similar to other clinical counseling programs, the rehabilitation counseling field relies on professional organizations like the Commission on Rehabilitation Counselor Certification (CRCC) and the Council of Rehabilitation Education (CORE) to help guide trainee evaluation. However, these organizations provide only general guidelines regarding trainee competence and therefore rehabilitation counseling programs must develop additional criteria to supplement the existing standards. For example, CORE (2002) lists several requisite knowledge domains for the rehabilitation counseling profession. One domain, "Counseling and Consultation," (C.5) describes the general tasks for which a rehabilitation counseling trainee is expected to demonstrate competency within the counseling process. More specifically, the domain contains tasks such as: (a) conduct individual counseling sessions with consumers (C.5.1), (b) develop and maintain a counseling relationship with the individual (C.5.2), (c) recommend strategies to assist the consumer in solving identified problems that may impede the rehabilitation process (C.5.6).

While this information clearly facilitates the academic process and provides a general outline for assessing student competence, nowhere in the accreditation standards is competency operationally defined. Faculty members must therefore determine what constitutes "competence" and must also determine how to evaluate the student's rehabilitation counseling ability. Rehabilitation counseling programs have a substantial amount of autonomy when developing these criteria and procedures. Although some flexibility with these tasks is necessary to accommodate each program's goals, considerable variability between these programs may result in counseling programs inconsistently monitoring and evaluating students (Robiner et al., 1993).

Research on rehabilitation counselor roles and functions (Leahy, Shapson, & Wright, 1987; Muthard & Salomone, 1969; Rubin, Matkin, et al., 1984) might be a resource in determining the competencies upon which students should be assessed. However, these studies focus only on the general tasks of the rehabilitation counseling professional. While this research provides invaluable information pertaining to the professional identity of rehabilitation counselors, the studies examining the roles and functions of rehabilitation counselors provide limited information pertaining to the trainee's counseling ability. As Janikowski (1990) notes, the rehabilitation counseling literature has typically focused on the functions of the profession, rather than the competence of the professional. In this instance, Janikowski refers to function as the specific tasks or job duties related to occupation, whereas competency is the underlying characteristics of the professional that lead to occupational success.

For educational programs to consistently monitor and evaluate trainees, supervisors should define competencies that trainees should acquire and the standards that the trainees should reach, as well as the criteria used to evaluate those competencies and the thresholds at which trainees meet those standards (Robiner et al., 1993). Even though it is unlikely that uniform evaluation criteria will suit every program, the rehabilitation counseling profession could, as a first step, operationally define the concept of counseling competence and develop a comprehensive set of behaviors (e.g. ability to empathize, ability to reflectively listen, etc.) that will aid in trainee evaluation. By developing specific, behaviorally defined criteria, trainer feedback becomes more concise and faculty can more consistently evaluate whether the student meets program goals (Freeman, 1985). As Kerl, Garcia, McCullough, and Maxwell (2002) opine, objective evaluation helps faculty members communicate with their trainees as well as helps prevent capricious

evaluator judgment. Thus, rehabilitation counseling educators will strengthen the profession by ensuring programs produce appropriate counselors who demonstrate adequate counseling ability.

The Clinical Supervision Role

Even when trainee evaluation is continuous, many student limitations are more likely to be identified during the clinical portion of the program (Lamb, Presser, Pfost, Baum, Jackson, & Jarvis, 1987). Perhaps one area of counselor training most appropriate for identifying trainee competence is during clinical supervision. Unlike licensure exams or classroom tests, supervisors can assess how well the trainee applies classroom knowledge to a counseling session and they therefore have the unique ability to determine the trainee's skill and judgment (Robiner et al., 1993). Additionally, Pope and Kline (1999) recognize that within the counseling profession, the trainee's personal characteristics play an integral role during evaluation. Therefore, clinical supervision may offer the best opportunity for training faculty to identify and address the student's clinical skill and personal characteristics. During clinical work, trainees are interacting with real clients rather than in simulated classroom settings, and therefore faculty can better assess the trainee's professional and personal shortcomings that might not have been apparent during coursework.

The Need for a Standardized Instrument to Evaluate Rehabilitation Counseling Trainee Competency during Clinical Supervision

Clinical supervision is a basic component of counselor training that has developed into an independent body of theory and research (Bernard & Goodyear, 2004). However, within the rehabilitation counseling profession, clinical supervision research continues to be understudied (Herbert & Richardson, 1995; Herbert, Ward, & Hemlick, 1995; Maki & Delworth, 1995; Stebnicki, 1998). More specifically, the rehabilitation counseling literature has vastly overlooked trainee evaluation from the supervisor's perspective. Although Thielsen and Leahy

(2001) have identified “evaluation and assessment” as a critical knowledge domain for field-based clinical supervision, there is a paucity of rehabilitation counseling research regarding competency criteria for evaluating rehabilitation counseling trainees. In fact, when Koch, Schultz, Hennessey, and Conyers (2005) surveyed rehabilitation counseling educators, professionals, and students, they suggested that the “identification and assessment of clinical supervision competencies” was an area warranting further investigation in rehabilitation education (p.10). Despite this need, the rehabilitation counseling literature has focused on various other aspects of clinical supervision including identifying helpful supervisor practices (Stebnicki, Allen, & Janikowski, 1997), identifying current supervision methods use in rehabilitation counseling (Herbert, 2002), describing ethical considerations within clinical supervision (Blackwell, Strohmer, Belcas, & Burton, 2002; Tarvydas, 1995), describing models to ensure proper trainee due process (Michaelson, Estrada-Hernandez, & Wadsworth, 2003), identifying the need for masters level supervision training (Scott, Nolin & Wilburn, 2006), determining what knowledge is essential to provide effective supervision (Thielsen & Leahy, 2001), and developing supervision models for both the educational setting (Maki & Delworth, 1995; Schultz, Copple, & Ososkie, 1999) and public setting (Schultz, Ososkie, Fried, Nelson, & Bardos, 2002). Although this body of research greatly expands our understanding and conceptualization of clinical supervision, it fails to fully address what Bernard and Goodyear (2004) suggest may be the “nucleus” of clinical supervision - trainee evaluation.

In 1995, Maki and Delworth recognized the need to operationally define clinical supervision specifically for the rehabilitation counseling profession. Using Bernard and Goodyear’s (1992) definition as a foundation, Maki and Delworth stated that rehabilitation counseling supervision is “a distinct intervention, the use of which requires the trained supervisor

to have specific knowledge and skills in multiple domains, including, but not limited to, education, consultation, and counseling" (p.284). The authors hoped that this definition would help supervisors better characterize the relationship between the supervisor and trainee (Maki & Delworth, 1995).

Despite Maki and Delworth's (1995) effort to define clinical supervision relative to rehabilitation counseling, Stebnicki (1998) suggested that their definition was too general to encompass the unique characteristics of the profession. Therefore, Stebnicki proposed a more elaborate clinical supervision definition that sought to better reflect rehabilitation counseling. He defines clinical supervision as:

> a specialty area that facilitates a positive interpersonal relationship with supervisees using a diversity of supervisory styles and approaches in both an individual and group dynamic process and is facilitated using the roles of educator, consultant, and counselor to stimulate and increase the supervisee's (a) process skills and psychosocial rehabilitation counseling strategies to enhance positive and ethical client outcomes, (b) efficacy as a counselor being mindful of the supervisee's ongoing developmental and personal growth needs in the process, and (c) conceptualization of salient features concerning the client's disability and other critical aspects related to his or her problem issues (p.139-140).

Although each definition provides a general framework for rehabilitation counseling, both fail to mention the evaluative nature of clinical supervision. As Bernard and Goodyear (2004) state, "evaluation is implicit in the supervisors' mandate to safeguard clients, both those who will be seen by the supervisee and those who would be seen in the future" (p.11). Specifically, supervisors evaluate students to ensure they reach a minimal level of professionally competence and exhibit suitable personal characteristics for working with clients.

In general, trainee evaluation reveals a set of complex issues that permeate any evaluative process. As previously stated, clinical supervisors within the academic setting aid in trainee development, as well as limit impaired trainees from entering the counseling profession. Robiner et al. (1993, p.4) assert that these dual roles of "nurturant teacher" and "vigilant

gatekeeper" may serve as the primary source of supervisory conflict. A rehabilitation counselor, like any counselor or therapist, is trained to be non-judgmental and facilitate client growth. However, the qualities that make for a good counselor may also interfere with the supervisor's ability to evaluate a trainee. Hoffman, Hill, Holmes, and Freitas (2005) suggest that supervisors may feel uncomfortable when providing the trainee subjective feedback, particularly when it involves the trainee's personality or professional issues. In fact, Gizara and Forrest (2004) found that the personal impact for supervisors when dealing with an impaired trainee was an overwhelming concern. Specifically, the authors note that "none of the responses brought the participant group together so dramatically as inquiries about the personal impact of dealing with intern impairment" (p.136). As Bernard and Goodyear (2004) note, imagine a situation where the supervisor uses the trainee's progress as the critical indicator for evaluation. The trainee has worked hard and improved during the practicum, but continues to perform below program expectations. Now the supervisor must weigh the student's effort and progress against the ethical responsibility to the profession and potential clients (Bernard & Goodyear). Thus, trainee evaluation can lead to a "disturbing role shift" for supervisors (Hahn & Molnar, 1991, p.417), and cause them some level of personal discord if remediation and/or dismissal procedures are employed, particularly if a relationship with the student exists (Gizara & Forrest).

Similar to the personal struggle educators may face when evaluating a trainee, Gizara and Forrest (2004) found that supervisors may feel unprepared when dealing with problematic trainees. Specifically, the authors note that several participants felt ill-equipped to identify and address problematic trainees. Moreover, the authors note that supervisors may doubt their own ability to appropriately identify problematic trainees and in fact, may feel an increased sense of vulnerability when their own supervisory skills came to the forefront.

Another challenge to effective trainee evaluation is the fear that trainees may initiate legal action upon the supervisor, program, and/or school. Several authors (Frame & Stevens-Smith, 1995; Tedesco, 1982; Vacha-Haase, Davenport, & Kerewsky, 2004) suggest that litigation may account for the faculty member's reservations regarding trainee evaluation. In fact, Vacha-Haase et al. reported that fear of litigation was highest when students were terminated for a lack of interpersonal skills and supervision difficulties. Specifically, the authors note that, "it may be difficult to document more subjectively determined problematic behaviors adequately, whereas problematic behaviors with objective criteria may be easier for faculty to identify confidently and act on with more certainty" (Vacha-Haase et al., p.119). Despite the authors' assertion, several authors (Frame & Smith-Stevens; Knoff & Prout, 1985; Olkin & Gaughen, 1991; Kerl et al., 2002) note that various court decisions have upheld the program's right to dismiss students who exhibit personal or professional deficiencies. Although these precedents may support the counseling program's opinion, Knoff and Prout caution that these court rulings do require programs follow proper due process procedures.

Consequently, several authors (Baldo, Softas-Nall, & Shaw, 1997; Bemak, Epp, & Keys, 1999; Frame & Stevens-Smith, 1995; Lamb, Presser, Pfost, Baum, Jackson, & Jarvis, 1987; Lumadue & Duffey, 1999) have written specific remediation and dismissal procedures to ensure counseling and psychology programs provide adequate due process. Although the literature and professional organizations have recognized the importance of due process, approximately half of the programs continue to operate without these policies and procedures in place (Olkin, & Gaughen, 1991; Vacha-Haase et al., 2004). This may be, at least in part because programs that have comprehensive policies and procedures in place often find that the dismissal process can be

complicated and result in additional programmatic modifications (McAdams, Foster, & Ward, 2007).

A fourth challenge associated with trainee evaluation is the level of support a supervisor receives from the department and fellow faculty members may greatly impact the evaluation process (Gizara & Forrest, 2004). In fact, Vacha-Haase et al. (2004) found that training directors identified disagreement among faculty as the second biggest barrier to dismissing a student behind fear of litigation. In their qualitative study investigating the experiences of supervisors in dealing with impaired trainees, Gizara and Forrest found that the level of conflict within the supervisory group can impact the evaluation process. The authors found that supervisory disagreement can manifest in a variety of ways. For example, the way in which a supervisor conceptualizes the clinical process can impact the level of supervisory support. Specifically, one supervisor may view clinical supervision/internship to be a development process, while another supervisor may perceive that supervision is primarily a gatekeeping function whereby trainees must meet some minimal level of competence. In addition to differences in perception about the purpose of clinical supervision, Gizara and Forrest reported that supervisors also suggested that preexisting interpersonal conflict within the supervisory group can influence the evaluation process to the point where some supervisors revealed that they may filter the amount of information they provide when discussing their supervisees.

In addition to the challenges rehabilitation counseling educators face when evaluating a problematic trainee, a program's failure to adequately address the trainee's deficits can negatively impact other students in the training program. Oliver, Bernstein, Anderson, Blashfield, and Roberts (2007) surveyed graduate students in clinical psychology to examine their attitudes toward impaired peers. Among other things, the authors found that students may

not only resent problematic students for causing them additional work and lost opportunity, but may also resent faculty members who put off addressing a problematic trainee or simply allow him or her to proceed through the program without meeting some specified standard. Similarly, Mearns and Allen (1991) found that students viewed faculty members as being significantly less active than faculty viewed themselves when addressing an impaired graduate student. In addition, the authors found that students demonstrate a variety of emotions when confronted with an impaired peer. Specifically, students frequently reported feelings of angry, conflicted, frustrated, apprehensive, and concerned. Interestingly, Mearns and Allen found that faculty members tended to overestimate the number of students who sought to protect their impaired peer. In fact, when confronted with an impaired peer, students reported that "their feelings of ethical obligation and betrayal outweighed sentiments of loyalty to their problematic peers" (p.198). Additionally, Mearns and Allen found that although the overall incidence of perceived impairment and ethical improprieties was low, the reported incidence of problematic functioning negatively correlated with the climate of the program. Thus, the challenges associated with properly evaluating and remediating a problematic trainee not only impacts the faculty and trainee, but may also alienate other trainees from the program.

While the literature regarding clinical supervision may bring attention to problematic trainees, a consistent methodology for adequately measuring the trainee's counseling competency remains elusive. Bernard and Goodyear (2004) recognize that within clinical supervision, "the difficulty of establishing criteria for evaluation and the equally difficult task of measuring them is a professional reality (p.23)." According to Lamb, Cochran, & Jackson (1991), programs generally assess general student performance in three domains: (a) knowledge and application of professional standards, (b) competency, and (c) personal functioning.

Although the counseling and psychology literature is replete with articles and books describing various professional competencies and personal attributes appropriate for these domains (Corey, 2004; Cormier & Cormier, 1991; Hensley-Choate, Smith, & Spruill, 2005; Hill, 2004; Johnson & Campbell, 2002; McCarthy & Leierer, 2001; Miller & Rollnick, 2002; Nelson-Jones, 2005; Pope & Kline, 1999; Ragg, 2000; Shebib, 2002), the specific criteria used to evaluate the trainee among the programs is quite variable. As Robiner et al. (1993) state, until there is consensus regarding performance standards within specific competence domains, all evaluation is vulnerable to subjectivity.

In an effort to aid in trainee evaluation, several authors (Bernard, 1997; Eriksen, & McAuliffe, 2003; Hackney & Cromier, 1994; Lumadue & Duffey, 1999; Myrick & Kelly, 1971; Oetting & Michaels, 1982; Robiner, Fuhrman, Ristvedt, Bobbitt, & Schirvar, 1994) have developed instruments to measure the trainee's professional competency and character. Although each instrument provides an excellent resource for clinical supervisors, each one was developed for professions other than rehabilitation counseling. Additionally, no clinical assessment instrument has been validated using Modern Test Theory (MTT). Compared to Classical Test Theory (CTT), MTT techniques like Rasch analysis allow the researcher to examine the psychometric properties of an instrument at the item level, rather than at the instrument level (Bond & Fox, 2001). As a result, the Rasch analysis produces a set of unique psychometric statistics, such as an item hierarchy, that allows supervisors to determine the trainee's ability level based on specific performance behaviors arranged in hierarchal order from least to most difficult. In other words, the trainee's ability level is based on the types of items near his or her ability level, rather than simply relying on a sum of scores. Practically speaking, the supervisor knows what types of counseling behaviors are below, at, and above the trainee's

ability level. Thus, supervisors can simultaneously measure trainee competence and target specific interventions while documenting the trainee's professional development over the course of his or her academic career.

Methods for Identifying Competency Criteria

One method appropriate for identifying rehabilitation counseling competency criteria is the Delphi method. The Delphi method enables researchers to elicit anonymous expert opinion, and then refines this information for experts to reexamine their response(s) compared to the group response (Vazquez-Ramos, Leahy, & Estrada-Hernandez, 2007). The process consists of a minimum of three rounds with the ultimate goal of reaching consensus among the experts without the bias drawbacks of comparable techniques (Linderman, 1981). By identifying specific competency criteria related to professional skills and personal suitability, rehabilitation educators can ensure trainees are prepared to counsel people with disabilities.

Goals of Research

The primary goal of this research is to implement a Delphi study in order to identify specific competency criteria useful for the development of a rehabilitation counseling clinical supervision measure.

Research Question 1

What professional, personal, and clinical competency items are useful for the evaluation of rehabilitation counseling trainees?

CHAPTER 2
LITERATURE REVIEW

Defining Impairment

In order to understand the inherent difficulties associated with trainee evaluation, it is necessary to be familiar with the terminology that is often used to describe students who exhibit problematic professional and/or personal behaviors. Unfortunately, researchers usually do not operationalize these types of terms (Vacha-Hasse et al., 2004) and as a result, certain terms may be used generically or inappropriately to describe different sets of student issues (Elman & Forrest, 2007). Gizara and Forrest (2004) caution that without accurately identifying a student issue, the nature of the problem can be obscured. As a result, educators may not only use an ineffective strategy to address the issue, but also be unaware of the relevant literature that could be used to deal with the problem (Gizara & Forrest). Among all the counseling professions, only the psychology literature (Elman & Forrest, 2004; Forrest, Elman, Gizara, & Vacha-Hasse, 1999; Gizara & Forrest; Vacha-Haase et al.) continues to debate the appropriateness of certain terms associated with professional and personal behaviors. Although the rehabilitation counseling profession clearly recognizes the importance of endorsing only suitable trainees, dialogue about the appropriate use of certain words remains largely unexplored.

Although some counseling literature has referred to problematic students as "unsuitable" (Bernard, 1975; Biaggio, Gasparikova-Krasnec, & Bauer, 1983) or having "professional deficiencies" (Procidano et al., 1995), the most common term used to identify these types of students is *impaired* (Bemak et al., 1999; Boxley, Drew, & Rangel, 1986; Bradley & Post, 1991; Frame & Stevens-Smith, 1995; Lamb et al., 1987, Li, 2000; Mearns & Allen, 1991; Wilkerson, 2006; Woodyear, 1997). One of the earliest definitions of impairment is offered by Lamb et al. (p.598):

> An interference in professional functioning that is reflected in one or more of the following ways: (a) an inability and/or unwillingness to acquire and integrate professional standards into one's repertoire of professional behavior, (b) an inability to acquire professional skills in order to reach an acceptable level of competency, and (c) an inability to control personal stress, psychological dysfunction, and/or excessive emotional reactions that interfere with professional functioning.

Although this definition provides a comprehensive summary of various trainee issues (i.e. professionalism, development of counseling skills, personal suitableness), the term *impairment* was originally reserved for professionals whose performance regressed due to such issues as mental illness, substance abuse, or emotional problems (Forrest et al., 1999). The use of the same term in two very different contexts has prompted several authors (Elman & Forrest, 2007; Forrest et al.; Gizara & Forrest, 2004; Kutz, 1986) to call for a clearer delineation of these types of words. Specifically, these authors argue that the term *impairment* be reserved for situations where the trainee or practitioner first establishes a baseline of adequate performance and then reverts to an unacceptable level of performance. On the other hand, the term *incompetent* or *not competent* should refer to an individual who has not yet reached a minimum level of acceptable performance. In fact, the rehabilitation counselor code of professional ethics (CRCC, 2002) appears to align with this model by reserving the word *impairment* to identify professionals whose physical, mental, or emotional problems are likely to harm the client or others (D.1.i). Similarity, the code uses the term *competence* when referring to the professional's knowledge (D.1.a, D.1.c., D.1.h, F.5.a, G.1.c).

Ironically, Gizara and Forrest (2004) investigated, among other topics, how supervisors defined trainee *impairment,* rather than *incompetence*. The authors report that the participants clearly articulated three themes indicative of trainee impairment, while a fourth was fairly inconsistent. The three identifiable themes were: (a) the intern's behavior was professionally harmful or deficient, (b) the behavior was a clear pattern, and (c) the behavior was not resolving

(Gizara & Forrest). The ambiguous fourth theme centered on whether or not trainee's behavior required a noticeable shift in performance. During the interview, the respondents categorized impairment in two different groups. The first category related to the "diminished functioning" of the trainee and the second category related to trainee's "skill deficits" (Gizara & Forrest). This second category, "skill deficits," included a wide range of issues such as clinical skills, interpersonal difficulties, lack of self awareness, and lack of professional responsibility. The authors acknowledge that "the vast majority of examples of impairment offered spontaneously by these participants did not meet their original conception of a 'noticeable shift in performance' but rather were more illustrative of skill deficiency" (p.133). Hence, psychology intern supervisors appeared to associate the term *impairment* more closely with the trainee's skill development, personal suitability, and adherence to professional standards, rather than whether the trainee reverted back to an unacceptable level of performance.

Although the argument for the appropriate use and understanding of certain terms to describe different trainee issues is clearly valid, *impairment* appears to be the most common term found in the literature that relates to issues associated with the student's personal suitability and professional development. However, as Elman and Forrest (2007) illustrate, using the term impairment "overlaps with its use in the Americans with Disabilities Act (ADA; 1990) and the protections and guidance defined therein" (p. 502). Specifically, using the term impairment suggests the trainee has a physical or mental impairment that limits one or more major life activities, and therefore supervisors may be vulnerable to legal ramifications if they use the word impairment. Consequently, for the purposes of this study, this author will use the terms competency or competent to refer to a trainee's ability to adequately demonstrate counseling

skills, function in a personal appropriate manner, and follow the professional standards set forth by the rehabilitation counseling profession.

Rehabilitation Counseling Accreditation and Code of Ethics Literature

During the clinical portion of a student's training, rehabilitation counseling educators may be challenged to determine whether a trainee is qualified for professional endorsement. Unlike traditional coursework where students demonstrate their competency through classroom participation and assignments, clinical supervisors evaluate the trainee's ability to effectively counsel clients. Although this task is required by every counseling education program, the criteria used to evaluate a student during clinical supervision may vary considerably from program to program. This inconsistency is particularly noted during clinical supervision because trainee evaluation is largely subjective and therefore it may be more difficult to identify what characteristics and behaviors separate suitable trainees from impaired trainees.

The importance of proper trainee evaluation is evidenced in both the 2002 Council of Rehabilitation Education (CORE) accreditation standards and the 2002 Commission of Certified Rehabilitation Counseling (CRCC) code of professional ethics. CORE states that clinical faculty will review the progress of both practicum and internship students (D.1.7, D.2.4) as well as require a written procedure addressing problematic trainees (D.1.8, D.3.4). More explicitly, Section G.2.b of the CRCC code of professional ethics further identifies the evaluation role of faculty members:

> Rehabilitation counselor educators will clearly state, in advance of training, to students and internship supervisees, the levels of competency expected, appraisal methods, and timing of evaluation for both didactic and experiential components. Rehabilitation counselor educators will provide students and internship supervisees with periodic performance appraisal and evaluation feedback throughout the training program.

Additionally, both CORE (2002) and the CRCC (2002) recognize that trainee development transcends the acquisition of counseling skills and extends into personal suitability. CORE

defines a rehabilitation counselor as someone who possesses the knowledge, skill, and *attitudes* needed to collaborate with people with disabilities. Additionally, these accreditation standards are inundated with statements regarding the trainee's ability to empower the client, be self-aware, and understand the importance of a collaborative relationship. Likewise, Section G.3.a of the CRCC recognizes the importance of personal suitability:

> Rehabilitation counselors, through ongoing evaluation and appraisal, will be aware of the academic and personal limitations of students and supervisees that might impede performance. Rehabilitation counselors will assist students and supervisees in securing remedial assistance when needed, and will dismiss students or supervisees who are unable to provide competent service due to academic or personal limitations.

Despite the emphasis on trainee evaluation, neither CORE (2002) nor the CRCC (2002) provide guidance relative to specific evaluation criteria for trainees and students. In particular, the CORE accreditation standards list general competency domains composed of knowledge areas and trainee behaviors, but do not outline clear expectations for supervisors to evaluate trainee competency. For example, one competency domain, "Counseling and Consultation," lists 15 knowledge areas (i.e. counseling and personality theory, mental health counseling, interviewing and counseling skill development) followed by 15 behaviors that are indicative of that domain. Although these areas are behavioral, they are too broad to consider for evaluation criteria during clinical supervision. For instance, the behaviors include such items as: (a) "conduct individual counseling sessions with consumers" (C.5.1), (b) "develop and maintain a counseling relationship with the individual" (C.5.2), and (c) "assist consumers in modifying their lifestyles to accommodate individual functional limitations" (C.5.14). Practically speaking, how does a faculty member determine whether a student is adequately conducting an individual counseling session (C.5.1) without defining what behaviors reflect this process? Moreover, when does the trainee's ability level qualify him or her for professional endorsement? Without

more specific indicators of professional performance, clinical supervisors may be unable to determine whether a trainee is counseling effectively.

These general knowledge domains are particularly ineffective as evaluation criteria during clinical supervision because counseling is a coalescence of behaviors, skills, and attitudes that are continually evolving. During clinical work, the supervisor and trainee review and process counseling sessions and address other personal issues that may materialize. Although supervisors utilize various resources to evaluate the trainee and guide professional development, general evaluation criteria will ultimately lead to inconsistent evaluation of trainees.

Prevalence of Trainee Impairment and Dismissal Rates

Several studies (Biaggio et al., 1983; Boxley et al., 1986; Bradley & Post, 1991; Gallessich & Olmstead, 1987; Huprich & Rudd, 2004; Mearns & Allen, 1991; Olkin & Gaughen, 1991; Procidano et al., 1995; Schwebel & Coster, 1998; Tedesco, 1982; Vacha-Haase, 1995) have examined trainee impairment and/or dismissal rates among their respective professions. Although Forrest et al. (1999) believe that drawing conclusions from this literature is challenging because the authors of these studies requested data and reported findings differently, this literature does provide a general perspective on trainee impairment and dismissal trends among psychology and counseling programs.

In general, studies that examined trainee impairment rates found that the vast majority of programs regularly encounter an impaired student. In fact, Olkin and Gaughen (1991) found that over two-thirds (76%) of master's programs in mental health (e.g. clinical and counseling psychology, counselor education, community psychology) identified one to three problematic students per year and 24% identified four or more problematic students per year. Similarly, Procidano et al. (1995) found that 89% of responding psychology departments reported one or more instances of *non-academic* professional deficiency among their students within the last 5

years. Mearns and Allen (1991) found that 93% of faculty had perceived an impaired trainee within the last 5 years, while Schwebel and Coster (1998) reported that within the last 5 years, psychology programs averaged 2.55 impaired students. On the other hand, Huprich and Rudd (2004) reported that within the last 10 years, 98% of responding psychology doctoral programs and 68% of internship sites were aware of at least one impaired trainee. Current indications of trainee impairment suggested that 65% of doctoral programs identified one or more impaired students and 10% of internship sites identified one impaired student. Finally, Boxley et al. (1986) and Olkin and Gaughen found remarkably similar annual trainee impairment rates despite surveying different populations. Boxley et al. reported an annual trainee impairment rate of 4.6%, while Olkin and Gaughen found that the mean percentage of problematic students was 4.8%.

In addition to trainee impairment studies, several studies focused on trainee termination rates. As expected, the prevalence of trainee terminations among psychology and counselor education programs was lower than the reported student impairment rates. Tedesco (1982) surveyed 167 directors from APA approved internship sites and noted that within the last 5 years, 51 trainees did not complete their internship because they either left on their own (n=24) or were terminated by the site director (n=27). Furthermore, the internship directors considered an additional 89 trainees for termination. Biaggio et al. (1983) reported that 86% of doctoral programs and 75% of master's programs in clinical psychology had attempted at least 1 dismissal. Regarding annual termination rates, Gallessich and Olmstead (1987) found that over the past three years, counseling psychology programs have terminated an average of one student. Similarly, Vacha-Haase (1995) reported that 52% of responding clinical, counseling, and school psychology programs had at least one student dismissal within the last 3 years. On the other

hand, Bradley and Post (1991) indicated that within the last 5 years, counselor education programs had dismissed anywhere from zero to 30 students. Of the programs reporting at least one student dismissal in the last five years (81%), the average number of terminations was 5.7 students.

In sum, trainee impairment appears to be a common issue across psychology and counseling programs. Although the percentage of impaired trainees may appear relatively minor (4.6-4.8%) compared to the number of trainees in counseling programs, Biaggio et al. (1983) note that "it is a steady trickle that requires attention (p.19)." In particular, the amount of time counseling programs invest in impaired trainees is considerably higher than with a non-impaired student (Vacha-Hasse, 1995). Vacha-Hasse found that training directors may devote as much as 20 hours a month to impaired students, while faculty members may spend as much as 40 hours a month addressing student impairment issues. In reality, impaired trainees consume a disproportionate amount of faculty time and program resources. Although one of the goals of counselor training is to develop competent professionals, a supervisor's first priority is to ensure that trainees do not harm clients and others (Frame & Stevens-Smith, 1995). Therefore, it is necessary for counseling programs to identify the types of non-academic trainee impairment issues that may interfere with the student's development. By familiarizing themselves with these impairment traits, counseling programs can not only ensure they identify impaired trainees, but also fulfill their obligation to protect the client population at large.

Identifying Trainee Problems

Although identifying the rate of problematic students highlights the need for proper trainee evaluation, outlining what specific behaviors constitute trainee impairments can better prepare faculty members for evaluation and remediation procedures. By delineating various student issues, educators can simultaneously strengthen their professional gatekeeping process while

aiding in trainee development. Specifically, identifying the various trainee problems may improve faculty and student communication. Faculty may be more likely to effectively intervene with problematic students if they and trainees acknowledge that problems are likely to occur (Vacha-Haase et al., 2004).

As previously mentioned, the ability to identify and remediate a problematic trainee is a fundamental component for any counseling profession. Researchers from various counseling professions (Boxley et al., 1986; Huprich & Rudd, 2004; Li, 2001; Olkin & Gaughen, 1991; Procidano et al., 1995; Vacha-Haase, 1995) have investigated how training faculty and/or program directors classify problematic students. Collectively, these studies have identified several areas of trainee issues beyond the traditional academic coursework. Table 2-1 illustrates the most common non-academic trainee issues among counseling related programs. Despite this extensive research, drawing conclusions from these studies may be difficult because of differences in sampling, questioning, and categorization of trainee issues (Forrest et al., 1999). As first described by Forrest et al., studies solicited respondents from a variety of positions including chairpersons or training directors from psychology departments (Huprich & Rudd; Procidano et al.; Vacha-Haase), psychology internship program directors (Boxley et al.), CACREP academic units (Li), and chairpersons from clinically oriented master's programs in mental health (Olkin & Gaughen). In addition, the manner in which the researchers phrased the questions varies considerably in these types of studies (Forrest et al.). For example, Olkin and Gaughen provided a finite list of trainee problems and asked participants to rank the top four, whereas Huprich and Rudd asked an open ended question and reported only the five most frequent impairments. Finally, despite some overlap between the studies, several student issues (adjustment disorder, anxiety problems, intrapersonal problems, lied, marital problems, maturity

issues, misrepresented skills, and social problems) were reported in only one study. This may make comparison between studies particularly difficult because some specific problems from one study may be generic issues that are a part of a larger category in other studies (Forrest et al.). For example, Olkin and Gaughen used the category "intrapersonal" to comprise substance abuse issues, emotional problems, personality problems, rigidity, and immaturity, whereas Vacha-Hasse reported substance abuse, emotional problems, and personality issues as separate categories. The difference in methodologies makes direct comparison between the studies complicated.

Despite these variations, a review of this literature suggests that some trainee issues are more common than others. Based upon these studies, it would appear that "clinical skill deficits," "interpersonal problems," and "supervision difficulties" are consistently identified as the most prevalent, non-academic, trainee problems. Clinical skill deficits were cited in three of the six studies (Olkin & Gaughen, 1991; Procidano et al., 1995; Vacha-Hasse, 1995) and were identified as the most common trainee problem in all three studies (77%, 46%, and 65% respectively). Similarly, interpersonal problems were identified in three studies (Li, 2001; Olkin & Gaughen; Vacha-Hasse), and was ranked as the most prevalent trainee problem in one study (Li; tied with supervision difficulties), the second most prevalent issue in another study (Olkin & Gaughen,), and the third most prevalent impairment in a third study (Vacha-Hasse,). Finally, supervision difficulties ranked as the most identified trainee problem in one study (Li; tied with interpersonal problems) and the second most identified trainee issue in two other studies (Olkin & Gaughen; Vacha-Hasse). Supervision difficulties were included in three of the six studies.

Table 2-1. Frequencies of impaired trainee characteristics as reported by previous studies (select non-academic variables)

Impairment	Boxley et al. (1986)[a]	Olkin & Gaughen (1991)[b]	Vacha-Hasse (1995)[c]	Procidano et al. (1995)[a]	Li (2001)[e]	Huprich & (2004
Adjustment Disorder						14
Anxiety Problems						25
Clinical Skills Deficit		77	65	46		
Depression	31		29			23
Emotional Problems	31		40	34*		
Ethical		25*		8		
Fatigue or Burnout	19		27			
Inappropriate Boundaries					58	
Intrapersonal Problems		54				
Interpersonal Problems		70	42		73	
Lied					42	
Marital Problems	27					
Maturity	23					
Misrepresented Skills					36	
Personality Disorders	35		15	34*	31	19
Physical Illness	27	10	40			
Refused Counseling					36	
Social Problems	19					
Substance Disorders			10		15	4
Supervision Difficulties		58	52		73	
Unprofessional Behavior		25*	27			

*modified/expanded from Forrest, Elman, Gizara, & Vacha-Hasse (1999)

Note. Procidano et al. list “emotional problems” and “personality disorders” as one category. Note. Olkin and Gaughen listed “ethical” issues and rigidity, and “unprofessional behavior” as category and used “intrapersonal problems” to include substance abuse issues, emotional problems, personality disorders, immaturity. Note. Both Vacha-Hasse and Li are partial lists of trai impairments. [a]Respondents were asked to provide information on the cases they felt were representative of impaired trainees. bRespondents ranked their top four choices from a list of seven possibilities. [c]Respondents were asked to identify the frequency of current student difficulties. dRespondents were asked to affirm any nonacademic deficiencies within the last five years. [e]Respondents were asked to indicate how frequent an impairment indicator was used as a basis for remediation. fIndicates the five most commonly reported impairments for internship.

The absence of these issues from some of the studies is not surprising, as the way in which the authors define trainee deficiencies shaped how the participants responded to the questioning. Two studies (Boxley et al., 1986; Huprich & Rudd, 2004) did not include any of the three trainee problems; however, as previously mentioned, Huprich and Rudd focused only on the incidence of *psychological* impairments among trainees. Similarly, Boxley et al. defined trainee impairment as, "any physical, emotional, or educational deficiency that interferes with the quality of the intern's professional performance, education, or family life" (p.51). Using this specific definition, clinical skill deficits, interpersonal problems, or supervision difficulties may not have qualified as an academic issue. Additionally, Procidano et al. (1995) only examined general categories of trainee issues. The authors simply differentiated between clinical skills, emotional / personal problems, and ethical issues, thereby condensing the list of trainee issues.

In sum, when clinical skills deficits, interpersonal problems and supervision difficulties were included in a study, no other trainee issues were more prevalent. These three issues are directly associated with clinical supervision. Clinical supervisors directly facilitate the trainee's skill development as well as observe how the trainee interacts with their clients. This finding only reinforces the importance of proper trainee evaluation during clinical supervision and suggests the need for comprehensive evaluation tools.

Due Process Procedures

In 1975, Bernard suggested that counseling programs incorporate some general due process guidelines in order to protect themselves from potential lawsuits and ensure students are evaluated fairly. He recognized that due process procedures for addressing the trainee's personal inadequacies were unclear and outlined four principles for proper due process. Since Bernard's article, several authors (Knoff & Prout, 1985; Lamb et al., 1987; Miller, 1979; Miller & Rickard, 1983) have written and expanded upon the more prominent aspects of due process. The

following paragraph includes Bernard's original outline as well as additional contributions provided by other due process literature.

First, programs should provide students with written guidelines that outline what professional and personal behaviors are expected (Bernard, 1975; Lamb et al., 1987). These guidelines should include the specific procedures for student evaluation and a statement stipulating that students may be terminated for personal shortcomings (Bernard; Knoff and Prout, 1985). Second, faculty members should continually evaluate all students and provide them with written evaluations (Bernard; Lamb et al.; Knoff & Proutt; Miller, 1979; Miller & Rickard, 1983). Although Bernard suggests that faculty evaluate students at least once a year, other authors suggest more regular evaluations to ensure that programs identify and address student impairments within a reasonable timeframe. Third, if a problematic student is identified, the program should develop a written remediation plan that includes: (a) defining the problem (Knoff & Proutt; Lamb et al.), (b) identifying expected behavior (Bernard; Knoff & Proutt; Miller), (c) specifying remediation options (Knoff & Proutt), (d) identifying a reasonable timetable for completion (Bernard; Knoff & Proutt; Lamb et al), and (e) indicating clear consequences for failing to complete the remediation (Bernard). Finally, appeal procedures for students to challenge remediation or dismissal decisions should be in place (Bernard; Knoff & Proutt). As Knoff and Proutt note, although legal precedent does not require programs to have a formal appeal process, the hearing "does represent an important due process gesture, which again demonstrates a faculty's sincere effort to make the termination process fair and open" (p. 796).

In addition to general due process parameters, several authors (Baldo & Softas-Nall, 1997; Bemak, Epp, & Keys, 1999; Frame & Smith-Stevens, 1995; Lamb, Cochran, & Jackson, 1991; Lumadue & Duffey, 1999) have described student monitoring models to assist counseling

programs in identifying and remediating problematic trainees. As Vacha-Haase et al. (2005) state, an increased specificity in evaluation guidelines would alleviate the burden an individual program may face when deciding what to do with a problematic trainee. Although these models vary in approach, each one seeks to improve professional gatekeeping procedures by implementing extensive due process policies and protecting individual faculty members from the sole responsibility of student remediation.

In 1991, Lamb et al. expanded their previous work on due process by describing a specific monitoring model. Although originally conceptualized for counseling psychology programs, the authors contend that this model can be adapted to many academic programs and practicum sites. This model includes processes related to: (a) reconnaissance and identification of trainee issues, (b) discussion and consultation, (c) implementation and review procedures, and (d) anticipating and responding to individual and organizational responses. Within each section, Lamb et al. describe various strategies and discuss several questions for faculty members to consider during the remediation process. Noteworthy topics included differentiating between problematic behaviors and impairments, the importance of early identification and on-going review, and how a dismissed student can affect the program climate.

Lamb et al. (1991) describe problematic behaviors as, “an intern’s behaviors, attitudes, or characteristics that may require remediation, but are perceived as not unexpected or excessive for professional training” (p.292). In other words, problematic behaviors are situational deficiencies that trainees commonly exhibit throughout supervision (e.g. counseling performance anxiety). Immediately after identifying a problematic behavior, the authors recommend the supervisor discuss the concerns with other training personnel, promptly develop and implement an intervention strategy, and allow the trainee an opportunity to address the behavior. Therefore, if

the problematic behavior does become an impairment the documentation verifies the staff's proactive response and ensures the trainee was made aware of the problematic behaviors before more drastic measures were taken.

On the other hand, when training personnel are unable to remediate the student's problematic behavior, these deficiencies may develop into an impairment. According to Lamb et al. (1991), trainee impairments develop when most of the following occur (p.292):

> (a) the intern does not acknowledge, understand, or address the problematic behavior when it is identified, (b) the problematic behavior is not merely a reflection of a skill deficit that can be rectified by academic or didactic training, (c) the quality of service delivered by the intern is consistently negatively affected, (d) the problematic behavior is not restricted to one area of professional functioning, (e) the problematic behavior has potential for ethical or legal ramifications if not addressed, (f) a disproportionate amount of attention by training personal is required, (g) the intern's behavior does not change as a function of feedback, remediation efforts, of time, and (h) the intern's behavior negatively affects the public image of the agency.

In situations where initial remediation attempts are unsuccessful, the authors recommend a systematic procedure whereby relevant personnel meet to discuss the specifics of the student's behavior and determine whether the behavior constitutes impairment. Lamb et al. recommend a more formal approach take place if training personnel deem the student impaired. Specifically, the student is notified, in writing, of the parameters surrounding the impairment as well as provided several ways in which to remediate the behaviors. The trainee then meets with all relevant training personnel to address the seriousness of the circumstances. Once the probation period begins, supervisors continually review the trainee's progress and inform the trainee about his/her performance. If the program decides to terminate a student, a letter is sent to the student outlining the probation terms, the student's actions, and the reasons for the dismissal. Finally, the trainee is given an opportunity to appeal the decision.

Regardless of whether the program successfully remediates or dismisses the student, Lamb et al. (1991) recognize that this process affects people beyond the trainee. Specifically, the

academic institution, other interns, and those specifically involved with identifying the impairment and implementing the remediation plan, can all be negatively affected. Despite these concerns, the authors conclude that if training personnel handle the remediation / dismissal process humanely, this process can benefit both the intern and staff members. For example, an intern may reexamine his/her professional development and avoid future difficulties. Concurrently, training staff and other interns may also reexamine their professional behavior (Lamb et al.).

Lamb et al. (1991) were one of the first to suggest a general model for student remediation/dismissal procedures. Although this article addresses many essential issues and raised several important questions, Frame and Stevens-Smith (1995) were one of the first to evaluate how a specific model affects trainee evaluation. These authors described a three-step model that was developed and implemented at the University of Colorado at Denver. Before classes begin, students reviewed the student handbook and signed a statement indicating that they will abide by all policies. Within the handbook, the faculty provide a policy statement that expressed, "the faculty's belief in the essential function of 'personal characteristics' in the development of ethical and competent counselors" (p. 124), and the Personal Characteristics Evaluation Form (PCEF), an assessment that includes expected trainee characteristics.

Each faculty member uses the PCEF to evaluate every student at the mid-term and end of the semester (Frame & Stevens-Smith, 1995). If a professor identifies a problematic student, he or she first discusses the student with the entire faculty and then discusses the evaluation and remediation (if any) with the student. If a student receives more than one evaluation in a semester, or receives a form from the same professor in back-to-back semesters, the student must meet with his/her graduate advisor to discuss additional remediation or possible reconsideration

in the program. Additionally, if a student receives three or more negative evaluations in one semester, the student will be required to meet with the faculty advisor and two other faculty members for possible program termination.

One year after implementing these procedures, faculty members and students evaluated the effectiveness of this model (Frame & Stevens-Smith, 1995). Although only 50% of the faculty surveyed felt that the evaluation process provided them with a concrete approach to student evaluation (25% were neutral), counseling educators stated that they had become "more intentional" about evaluating a student's personal characteristics (Frame & Stevens-Smith, p.126). In relation to the students surveyed, 82% indicated that they were aware of the evaluation process. Unfortunately, Frame and Stevens-Smith present no data indicating the student's thoughts about the evaluation process itself. The authors conclude that by utilizing due process procedures, programs can protect themselves from unfair student evaluation and more importantly protect future clients from harm (Frame & Smith-Stevens).

In response to the Frame and Smith-Stevens (1995) article, Baldo et al. (1997) believe that individual faculty members may be placing themselves into a situation of unnecessary hardship if they directly evaluate and remediate problematic students. Specifically, faculty members who identify and remediate problematic students may become the target of that student's aggression. Therefore, Baldo et al. assert that programs should include the entire faculty during the evaluation process, thereby protecting individual faculty members from any excessive duress.

In essence, this type of monitoring model allows faculty members, at any time, to discuss student concerns during regularly scheduled faculty meetings. Once a year, program faculty members meet to specifically review the student's progress. If the program faculty members believe the student's progress is unsatisfactory, the student's advisor, not the concerned faculty

member, meets with the student to discuss possible remediation, voluntary resignation, or dismissal.

If the faculty members do decide that remediation is necessary, the student, the student's advisor, and a retention committee develop a remediation plan. Once the plan is approved (or modified) by the program faculty, the student signs the plan and begins the necessary steps to fulfill the obligations. Near the re-evaluation date, the student will present all necessary documentation to the advisor and request that his/her current professors evaluate the progress. This information is then reviewed by the entire faculty and they decide whether the student: (a) continues in the program without remediation, (b) continues probation / remediation, (c) voluntary resigns, or (d) is dismissed. If the faculty members decide to dismiss a student, he or she is notified in writing and has 30 days to present a written request for re-evaluation. Upon receipt of the request, the faculty will allow the student to present his/her case. Following the presentation, the faculty members will re-evaluate the student and notify the student of their final decision. The authors conclude that involving the entire faculty ensures proper due process for both the faculty member(s) and student as well as helps prevent the possibility of an individual faculty member experiencing unnecessary stress.

Similar to the previous models, Bemak, et al. (1999) offer a five-step model that aids counselor training programs with the remediation and/or dismissal of impaired counseling students. The authors note that the most taxing concern facing counseling programs is how to properly evaluate and remediate students who present psychological or personality impairments, but otherwise perform basic counseling skills competently. Therefore, Bemak et al. suggest that counseling programs incorporate the idea of psychological adjustment throughout the training process. Step one requires that the faculty clarify and communicate program expectations before

the admissions process. Like previous models, the authors suggest that in addition to department standards that address traditional criteria like monitoring and dismissal procedures, an advisor should identify "sound mental health and personal development as critical aspects of professional suitability" (p.25). Once the policies are reviewed and agreed upon, step two requires the students sign a contract indicating their understanding of these procedures.

The third step, identifying trainee concerns, requires that faculty members use departmental criteria to evaluate a student's development. If a student exhibits any professional or personal deficits faculty members are to promptly contact the student's advisor. Subsequently, several department members, including faculty, supervisors, and the Department Chair, may convene to address the student issue(s). Once these faculty members discuss the concerns, a remediation plan is developed with the student (step four). Finally, faculty must monitor the student and continually provide feedback regarding his/her progress. If a student is unable to fulfill the requirements outlined in the remediation plan he or she may appeal according to the institution's appeal process. Bemak et al. (1999) conclude that this model offers several advantages to student monitoring including: (a) an ongoing student assessment, (b) increased faculty communication regarding student impairment, (c) timely feedback to students, (d) proper student due process, and (e) a clear process that outlines a faculty member's response to student impairment.

Lumadue and Duffey (1999) discuss the difficulties associated with student evaluation and the importance of properly implemented due process procedures. To improve upon the monitoring process, Lumadue and Duffey describe an evaluation instrument, the Professional Performance Fitness Evaluation (PPFE), which was developed by faculty at Southwest Texas State University (SWT). Unlike the PCEF (Frame & Smith-Stevens, 1995) that uses abstract

student characteristics, the PPFE utilizes specific student behaviors to evaluate trainee development. The authors contend that a specific behavioral criterion ensures greater consistency among evaluators (Lumadue & Duffey).

If a professor identifies an issue, the student and the professor meet to discuss the matter. Then, if the issue remains unresolved, the professor contacts the department chairperson and the student meets with a retention committee. The committee reviews the issues and makes one of three recommendations: (a) the student is fit to continue, (b) the student should undergo remediation, or (c) the student should be dismissed. If the student chooses to appeal the committee's decision, he or she must do so by writing a letter to the Department Chair. If the Chair upholds the committee's decision, then the student can re-appeal to the Dean of the college. However, if the Dean also upholds the decision, then the student can initiate legal action.

Although proper due process procedures protect the counseling program and student from capricious evaluation, a considerable number of programs continue to operate without these policies and procedures in place. Boxley et al. (1986) found that 66% of psychology internship programs reported "no adequate or judicious means of assuring the right of due process to interns who are dropped or deferred from continuing in the program" (p.51). In contrast, Procidano et al. (1995) found that 74% of doctoral programs in professional psychology reported some policy for addressing a student's professional deficiency; however, only two-thirds of these policies were in writing. In 1991, Olkin and Gaughen found that 45% of counseling oriented programs had no written policies for evaluating problematic students. Of the programs that did have a policy, over 40% did not generally give these policies to their students. Similarly, Vacha-Hasse et al. (2004) found that 53% of APA accredited psychology programs reported that they did not

have written policies for problematic students. Furthermore, these authors note that of the programs that did have a policy only 46% routinely supplied this information to their students. Finally, although Huprich and Rudd (2004) limited their questioning to psychological impairment, the authors found that only 58% of doctoral programs reported that they had a formal procedure to address these types of student issues. On the other hand, 84% of internship sites reported they had formal procedures in place to address a student's psychological impairment.

Despite some slight variability between these studies, a substantial number of programs are reported as not having written policies and procedures in place to address problematic students. As Vacha-Hasse et al. (2004) notes, the number of programs without these policies are, "somewhat surprising, given that programs without such guidelines may be vulnerable on several fronts, including compliance with accreditation requirements and explanation of due process" (p.118). Interestingly, accreditation bodies continue to allow programs to operate without proper due process procedures despite recognizing the need for programs to graduate personally and professionally competent trainees.

Clinical Supervision Evaluation Criteria

Without clearly identifying what skills are essential for clinical supervision, the process of deciding what skills are appropriate for evaluation is an imperfect process (Bernard & Goodyear, 2004). Fortunately, educators can examine the standards for their profession, the general counseling literature, and research to identify what specific skills they want to include for clinical evaluation. Although accreditation and professional standards literature is limited, it provides an excellent starting point for understanding the general types of items that should be included during evaluation. As previously mentioned, the rehabilitation counseling code of professional ethics suggests that faculty endorse only those students who demonstrate adequate

professional ability as well as are personally suitable to provide service to people with disabilities. In addition, the code outlines the professional standards which identify and define a rehabilitation counselor (e.g. ensuring client autonomy, A.1.d; respecting cultural diversity, A.2.a; promoting client empowerment, C.1.c). Given that the professional standards refer to three types of criteria (professional skill, personal suitability, and professional standards), it is perhaps fitting that definitions of impairment as well as clinical supervision instruments also typically include these general criteria. Although each respective counseling profession may address general categories of trainee impairment, individual programs are responsible for developing their own evaluation criteria as well as reviewing the professional literature to identify specific criteria that would aid in this process.

Perhaps the most prolific source of clinical evaluation criteria comes from reviewing the general counseling literature. The counseling literature is inundated with various books and theories (e.g. Chan, Berven, & Thomas, 2004; Corey; 2004; Cromier & Cromier, 1991; Hill, 2004; Miller & Rollnick, 2004) that identify basic and advanced counseling skills that help facilitate the counseling session. Although there is an exhaustive amount of information to draw from, books and theories can vary with regards to content and organization. For example, Cormier and Cormier provide an excellent overview of various skills ranging from basic listening responses to the use of advanced clinical techniques. On the other hand, Walborn (1996) opines that the specific counseling skills are less important than the common elements of counseling. Specifically, he suggests that four process variables are necessary for change: (a) the therapeutic relationship, (b) cognitive insight, (c) affective experience, and (d) appropriate client expectations. Therefore, although there are a variety of resources that identify a mixture of counseling skills, consensus regarding what skills are necessary for counseling varies.

In addition to counseling skills, the trainee's personal attributes are oftentimes considered necessary for clinical evaluation. Although not all homegrown or published clinical instruments may explicitly address the trainee's personal suitability, this issue has received increased attention within counseling training programs. More recently, supervision instruments have included sections to address the personal suitability of the student. For example, Bernard (1997) includes a "personalization skills" on an evaluation instrument. This section assesses the student's self-awareness, interpersonal and intrapersonal depth and flexibility, as well as how well the trainee works with others. Likewise, the evaluation instrument described by Kerl et al. (2002) includes a six question section dedicated to the maturity of the student. Despite the importance given to the trainee's personal suitability, programs may struggle identifying students with character or psychological issues (Bemak et al., 1999). This may be due to the fact that personal impairment is usually difficult to identify within the counseling session because it may manifest as a skill deficiency or other professional impairment. For example, if the trainee is an abnormally anxious person, he or she may ask only superficial questions. In this instance, the supervisor may focus on developing the student's use of open-ended questions or other probing techniques, rather than addressing the trainee's anxiety issue. Therefore, for the purpose of clinical evaluation, it is important to identify specific behaviors which are indicative of suitable personal functioning.

A third area less commonly found in clinical supervision criteria are the student's adherence to professional standards. As mentioned earlier, each respective counseling profession adheres to specific standards to help define and guide the profession. Within rehabilitation counseling, the professional standards address a variety of issues including the

principles of ethical behavior, confidentiality issues, as well as underlying professional themes such as client empowerment (CRCC, 2002).

In sum, establishing evaluation criteria may be challenging and perhaps the most labor-intensive part of the evaluation process (Bernard & Goodyear, 2004). Typically, clinical evaluation criteria include counseling skills (basic and advanced skills), personal suitability, and adherence to professional standards. Although these three areas appear to encompass different aspects of counselor training, each component can potentially relate with one another.

Supervision Models

In 1995, Maki and Delworth sought to improve a student's therapeutic competence and enhance client monitoring by describing a clinical supervision model for the rehabilitation counseling profession. Specifically, the authors developed the Structured Developmental Model (SDM) by modifying Stoltenberg and Delworth's Integrated Developmental Model (IDM, 1987). Basically, the IDM catalogs the counselor's progression through four levels of professional development (Level 1, Level 2, Level 3, and Level 3 Integrated) while simultaneously providing supervisors with strategies to facilitate the counselor's development. In order to assess the student's level of development, the supervisor examines the counselor's motivation, autonomy, and awareness relative to eight competency domains. For example, Stoltenberg and Delworth (1987) describe a level 1 counselor as highly motivated, highly dependent, and focused strictly on themselves rather than the client. These characteristics are indicative of a new counselor who is relying on the supervisor to find the "right" way to counsel a client. As the counselor develops, he or she becomes more independent and aware of both self and the client. Additionally, after vacillating between high and low levels of motivation (level 2), the counselor begins to show more consistent motivation and develops his/her own professional identify.

According to Stoltenberg and Delworth (1987), "vertical development, or movement ahead to the next level, is explicitly stressed, but the model in practice also attends to issues of horizontal development across domains" (p.36). In other words, the counselor not only progresses to higher stages of development, but does so across the domains. Although the authors believe that counselor development is generally irreversible, they recognize that counselors may periodically regress to earlier stages of development when faced with unfamiliar circumstances; however these regressions do not indicate that the counselor has reverted back to a previous stage (Stoltenberg & Delworth).

Using the IDM as a basis, Maki and Delworth (1995) reorganized the eight competence domains to develop the SDM. Unlike the IDM which conceptualized counselor development through eight simultaneous domains, the SDM categorized the domains into one of two groups: (a) primary domains, and (b) process domains. Primary domains, also known as meta-domains, include: (a) sensitivity to individual differences, (b) theoretical orientation, and (c) professional ethics and are continually examined during the counselor's development. The remaining domains, known as process domains, include: (a) interpersonal assessment, (b) client assessment within the environment, (c) case conceptualization, (d) treatment goals and plans, and (e) intervention strategies. These five process domains mirror the conventional service delivery sequence and are addressed within the context of the primary domains (Maki & Delworth). The authors contend that reorganizing the competence domains to better emulate the counseling process will aid in clinical supervision.

Despite the obvious advantages of a clinical supervision model, the debate over the usefulness of a developmental model, like the IDM, to explain counselor development has endured (Ellis, 1991; Holloway, 1987; Holloway, 1988; Stoltenberg & Delworth, 1988;

Stoltenberg, McNeil, & Crethar, 1995; Worthington, 1987). Many researchers (e.g. Chagnon & Russell, 1995; Murray, Portman, & Maki, 2003; Reising & Daniels, 1983; Wiley & Ray, 1986) began investigating the developmental supervisory process and supported the notion that trainees do exhibit identifiable characteristics across their development; however these differences were only evident when differentiating novice trainees from more advanced trainees. In conclusion, Bernard and Goodyear (2004) caution that although developmental models are intuitively appealing, they may mislead their supporters away from alternative explanations of supervision.

An alternative to the SDM (Maki & Delworth, 1995) is the Integrative Model of Supervision in Rehabilitation (Schultz et al., 1999). Recognizing that rehabilitation counselors work with a variety of populations in different environments, Schultz et al. suggest that any supervision model within the rehabilitation profession should be flexible enough to accommodate the differences. Therefore, the Integrative Model was based on rehabilitation principles rather than a specific personality theory or psychological process. The authors state that mastering the art of counseling before completing the clinical portion of the program is improbable; therefore, supervisees should be trained in multiple rehabilitation concepts, but not necessarily be expected to master every professional skill before graduation. As a result, supervisors become responsible for not only teaching counseling skills and fostering attitudes that allow the counselor to function independently, but also ensuring trainees understand that counselor development is a lifelong process (Schultz et al.).

In order for supervisors to fulfill their obligation, the Integrative Model of Supervision in Rehabilitation requires the educator be able to shift roles to or from teacher, counselor, and consultant (Schultz et al., 1999). Specifically, the authors reference Bernard's Discrimination Model (1997) where the supervisor adopts a different role depending on whether he or she

wishes to focus on the trainee's intervention skills (e.g. empathy, confrontation, etc.), conceptualization skills (e.g. identify themes, discriminate information, etc.), or "personalization" skills (e.g. personality, cultural influence, etc.). In addition, the supervisor assesses the trainee progression through 3 phases of development. Phase I (Technical), focuses the trainee on developing basic interpersonal skills such as empathy as well as appropriate attitudes, self-trust, and internal evaluation processes. Once the trainee transitions to Phase II (Integrative), he or she will focus on more advanced counseling skills such as case conceptualization, treatment manual utilization, research activities, and explore different service delivery modes. Finally, as the student moves into Phase III (Consultation), he or she seeks to continue to develop the ability to self evaluate and acquire new skills. Schultz et al. acknowledge that transitioning from Phase I to Phase II is crucial and should not necessarily coincide with the student progressing from practicum to internship. Although the authors note that prematurely transitioning a student to an advance stage may result in the counselor being "overwhelmed," while delaying this transition for an able student will result in "apathy" or "frustration," the practicum and internship timelines are reasonable (p.329).

In sum, both the SDM and Integrative Model offer an excellent resource for rehabilitation counseling educators and students. Specifically, these models help organize the supervision process and provide supervisors a means to understanding their role(s) in facilitating trainee development. Despite these advantages, both models are limited in terms of trainee evaluation. Specifically, these supervision models only describe a theoretical pattern of trainee development, rather than specifying evaluation guidelines. Although the development of trainees cannot be forced, supervisors are still faced with the reality of whether or not the trainee has earned a

passing grade or has demonstrated some minimum level of competency worthy of professional endorsement.

Additionally, each supervision model provides little empirical evidence pertaining to the actual sequence of counseling skill development. Without a thorough understanding of skill and characteristic development, these models are limited by offering only a *description* of trainee development. Although a development sequence of counseling skill and attitudes may appear intuitive, empirical evidence outlining a clearer understanding of skill development will ensure the appropriate skills are being required of novice and advanced students.

Moreover, trainees do not necessarily develop basic skills before advanced counseling skills. Focusing novice counselors on "basic" counseling skills may be intuitively appealing, however students will come into the supervision process with varying levels of ability in all aspects of counseling, particularly counseling skills, personal suitability, and professionalism. Therefore, supervisors would be better suited to identify several factors (i.e. interpersonal skills, integrating theory, case conceptualization skills) and simultaneously evaluate the trainee. As a result, supervisors will be able to better evaluate the trainee and meet the trainee's need for supervision.

Clinical Supervision Instruments

Bernard and Goodyear (2004, p.28) state that, "there are as many evaluation instruments as there are training programs in the helping professions." Because the professional literature provides only general evaluation guidelines, counseling programs oftentimes rely on homegrown instruments to evaluate trainee performance. As Eriksen & McAuliffe (2004) point out, many evaluation instruments have not been subjected to rigorous validity or reliability checks, and may require the evaluator to provide only general impressions of student performance. Moreover, the authors identify several other shortcomings common to most evaluation instruments. First,

although expert opinion appears to be the most accurate indicator of trainee competence, some instruments rely solely on client feedback to determine the student's ability level. Additionally, the authors note that many evaluation instruments require the supervisor to simply record how often the student demonstrates a skill, rather than how effective he or she is in utilizing the skill during a counseling session. Finally, Eriksen and McAuliffe note that many supervision instruments simply use dichotomous scales when evaluating a trainee, thus hindering the precision of specific and meaningful feedback.

In addition to homegrown instruments, there are also a number of published evaluation instruments. Unfortunately, they are highly variable regarding structure, types of items, and psychometric information. Several authors (Eriksen & McAuliffe, 2003; Kerl et al., 2002; Myrick & Kelly, 1971; Oetting & Michaels, 1982; Robiner et al., 1994) have described various published instruments that help counseling faculty members evaluate a student's counseling performance. The following is a brief overview of several supervision instruments developed within the last 35 years. One of the earliest published supervision instruments, the Counselor Evaluation Rating Scale (CERS), was developed by Myrick and Kelly (1971) to address the need for an instrument which could help supervisors evaluate a trainee's clinical performance. After reviewing the literature, the authors selected 27 items to represent three areas of student development: (a) the understanding of the counseling rationale, (b) counseling practice with clients, and (c) exploration of self and the counseling relationship. These items were then organized into a counseling performance domain (13 items), a supervision domain (13 items), and one global item regarding the supervisor's overall recommendation. Each item is rated on a 7-point Likert type scale. Once the scores from the counseling and supervision domains are totaled with the global recommendation, the composite score represents the trainee's overall

counseling effectiveness. Myrick and Kelly report a split-half correlation coefficient of .95. Additionally, when correlating the counseling and supervision domain together, the authors reported a coefficient of .86.

In 1983, Oetting and Michaels developed a unique supervision tool, the Oetting/Michaels Anchored Rating for Therapists (OMART), to help supervisors develop comprehensive evaluations of trainee performance, and to serve as a communication device for supervisors and students. The OMART consists of 34 counseling related items (i.e. relationship with client, exploring issues, exploring feelings). The authors then described various types of trainee behaviors that represent different ability levels for each item. In other words, each counseling item had a corresponding hierarchy of behaviors that reflect various levels of trainee development from needing remediation to professional therapist. Unfortunately, Oetting and Michaels provide no psychometric validity or reliability information. Additionally, because of the OMART's size, Bernard and Goodyear (1992) suggest that some may view the instrument as too lengthy.

Unlike the OMART (Oetting & Michaels, 1983), the Minnesota Supervisory Inventory (MSI, Robiner et al., 1994) has undergone a more extensive validation and reliability testing than most instruments. The MSI includes 112 items and a 3-point rating scale. The items represent seven trainee performance areas: (a) assessment, (b) psychotherapy and intervention, (c) consultation, (d) professional and ethical behavior, (e) supervision, (f) case conference/professional presentations, and (g) site-specific functioning. When developing the MSI, Robiner et al. reviewed the feedback from other University of Minnesota Psychology Internship Consortium (UMPIC) supervisors, examined the job analysis of psychologists, and appraised instruments from other internships. Despite its comprehensiveness, Robiner et al. note

that the MSI focuses on the trainee's skills and professionalism rather than personal characteristics. The authors report adequate internal consistency within each of the seven domains (r_s=.61 to r_s=.83). With regards to inter-rater reliability, Robiner et al. note that the findings were lower than expected (r_s=-.31 to r_s=.28), however test-retest reliability after one week ranged between .91 and 1.00. In addition to psychometric scrutiny, Robiner et al. surveyed internship supervisors to compare their current evaluation instrument with the MSI. Interestingly, the authors note that general reactions to the MSI were favorable, but interest in using the instrument varied. Unfortunately, the authors provide no further explanation as to this finding.

A fourth instrument, the Professional Counseling Performance Evaluation (PCPE, Kerl. et al., 2002), was developed by faculty at Southwest Texas University to aid in due process procedures. Originally referred to as the Professional Performance Fitness Evaluation (PPFE, Lumadue & Duffey, 1999), the PCPE helps faculty members evaluate students and provides them with feedback on several areas of professional and personal development. Although the PCPE was not designed specifically for supervision, Kerl et al. note that the instrument is appropriate for every course. Moreover, the instrument includes items related to counseling performance. In all, the instrument contains 38 items arranged in five competency areas: (a) counseling skills, (b) professional responsibility, (c) competence, (d) maturity, and (e) integrity. The evaluator identifies whether the student consistently meets, minimally meets, or does not meet the listed criteria. Although the PCPE contains areas of professional and personal development, the instrument has not been psychometrically validated.

Finally, in an effort to develop a validated instrument for the counselor education field, Eriksen and McAuliffe (2003) modified the Skilled Counseling Scale ([SCS] Urbani et al., 2002)

to create the Counseling Skills Scale (CSS). To improve the validity and reliability of the instrument, the CSS went through an immense transformation that included: (a) addressing item and rating scale issues, (b) establishing content and face validity by soliciting feedback from relevant professors, and (c) pilot testing the CSS to obtain inter-rater reliability and construct validity. The final instrument contains 22 items that represent six areas of counseling performance. The rater evaluates the student on each item along a 5-point Likert type scale that ranges from "well developed" to "major adjustment needed." To score the CSS, the evaluator averages only those items that were used by the trainee during the session. Once each subscale is averaged, the student's counseling competence is determined by totaling the six subscales together. Using only 29 participants, the authors report a Cronbach's alpha of .90 and significant pre- and postcourse change (construct validity) in the total score as well as on five of the six subscales. Regarding item analysis, Eriksen and McAuliffe concluded that 11 items actually correlated higher with another subscale than with its own, leading the authors to conclude that the scales do not represent true factors.

In conclusion, the development of efficient and precise clinical supervision evaluation tools remains a challenge for various psychology and counseling professions. Although several clinical supervision instruments have been published, the majority of instruments contain a limited amount of psychometric information or rely on summed scores to indicate the trainee's clinical performance. The usefulness of summed scores may be minimal because every counseling skills is considered to all contribute to the trainee development equally. However, particular skills or items are undoubtedly more or less difficult for a trainee to develop. Identifying a clear item hierarchy that outlines the trainee's skill development will provide a more useful indicator of counseling performance. However, identifying what skills a trainee is

most likely able to perform in the early stages of clinical training compared to the latter stages is complicated. Intuitively, certain basic counseling skills (i.e. simple reflection) are easier to perform than other more advanced skills (i.e. positive confrontation), but for the vast majority of counseling skills, educators may disagree over a clear item hierarchy of skill development. This variability poses a practical challenge for educators when they develop their standards for clinical evaluation.

In order to address these and other evaluation shortcomings, a clearer understanding of trainee skill development must be understood empirically. Rather than continuing to rely on a predominately theoretical understanding of trainee skill and attitude development, researchers might be better served to study the typical progression of these concepts. Once a better understanding of skill and attitude is empirically achieved, counseling educators might be better able to establish and enforce a minimum standard of ability relative to specific timetables. Undoubtedly, trainees will develop at various rates, however students who have been endorsed by a counseling program should have acquired a minimum level of skill and personal suitability in order to practice in the community. Therefore, it is imperative that the rehabilitation counseling profession identify specific counseling skills and professional behaviors representative of competent rehabilitation counseling trainees.

Additionally, the empirical understanding of counselor development not only ensures that minimum criteria standards are accurate, but also allows supervisors and students to catalog their development independent of practicum or internship. Therefore, educators can identify realistic expectations that are just beyond the trainees' current ability, as well as pinpoint specific interventions. In order to better understand trainee development and improve trainee evaluation, researchers must rely on innovative research methods to construct instruments. On such method,

Rasch analysis, can address these and other measurement challenges associated traditional data analysis techniques.

The Rasch Model

Rasch theory is based on a logistic model within Item Response Theory (IRT) that uses probabilities and item difficulty calibrations to *measure* the person's ability level on some trait. Unlike classical test theorists who *assume* that the ordinal data is interval, Rasch analysts believe that in order to satisfy the fundamental rules of measurement, these raw scores must first be converted into an actual interval scale (Rasch, 1960; Wright, 1997; Wright & Linacre, 1989). This conversion is necessary because according to Wright and Linacre, a "score" on a test is nothing more than the frequency count of events, but is oftentimes mistakenly treated as a measure of ability. For example, a person who correctly answers more math items on a test than another test taker would be considered to have more math ability. However, simply counting a correct response as "one more," erroneously implies that every math item is an equal unit of measurement. According to Wright and Linacre (1989), "the events counted are specific rather than general, concrete rather than abstract, and thus varying rather than uniform in their import" (p.858). In other words, certain items are indicative of more or less of an ability. Therefore, "one more" can imply a different increment, and thus raw counts are insensitive to this detail (Wright & Linacre).

In order to *measure* the ability of people, Rasch analysts suggest that measures should mirror the instruments found in the physical sciences (e.g. ruler, scale, time). Specifically, raw, ordinal data must first be converted into a linear, interval scale to allow the researcher to examine the psychometric properties of specific items rather than the instrument as a whole. In order to achieve equidistant scaling, Rasch experts rely on an alternative paradigm for analysis. Unlike Classical Test Theory (CTT) and other IRT models, Rasch experts believe that data

obtained should not dictate the measurement model, but rather the measurement model should first be established and then use data that conform to the model (Wright, 1997). As Wright explains, a model should not imitate or accept any kind of data, but should be constructed to define measurement.

The Rasch equation in its simplest form is as follows:

$\text{Log}\ [P_{ni} / 1 - P_{ni}] = B_n - D_i$

where

P_{ni} = the probability of person "n" passing an item

$1 - P_{ni}$ = the probability of person "n" failing an item

B_n = ability of person "n"

D_i = difficulty of item "i"

The left side of the equation represents the transformation of raw scores into an interval measure whereby the probability of a person passing an item is divided by the probability of a person failing an item. Conversely, the right side of the equation represents the various facets of the measurement model. In its simplest form, the Rasch equation for dichotomous data utilizes two facets: the ability of the person (B_n) minus the difficulty of the item (D_i).

As Bond and Fox (2001) point out, "taking the natural log of the odds of successfully passing an item results in the direct comparison between a person's ability and an item's difficulty" (pp.202-203). Thus, by arranging people and items on the same linear continuum, the Rasch model has generated parameter separation whereby the creation of a measure estimates a person's ability independent of the specific test items and similarly estimates the difficulty of items independent of the specific sample (Bond & Fox, 2001). In other words, the Rasch model has created a measure that is both sample-free and test-free. Originally conceptualized by Thurstone (1927, 1928), the concept of sample-free measurement refers to the idea that a

measurement scale should transcend any particular sample (Figure 2-1), just as a large ruler can measure various people no matter what their height (Wright; 1997). On the other hand, test-free refers to the ability to omit several questions from different levels of the measurement without affecting the person's score (See Figure 2-1; Wright, 1997). This would be similar to measuring the height of an adult who is approximately six foot without having to first determine whether he or she exceeds the one, two, three, four, or five foot mark. In essence, requiring subjects to answer an entire set of questions is unnecessary when determining their ability.

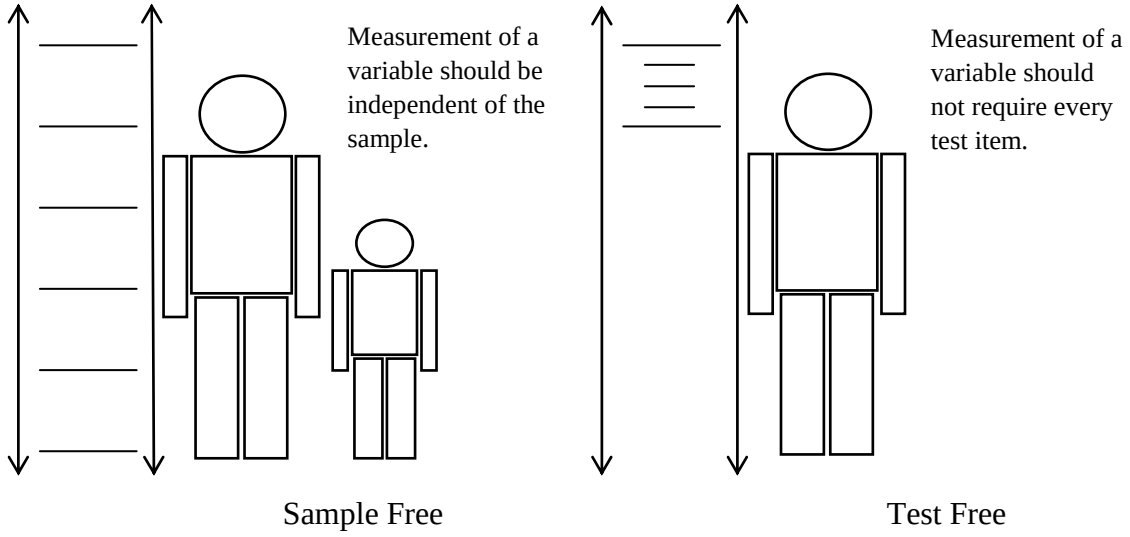


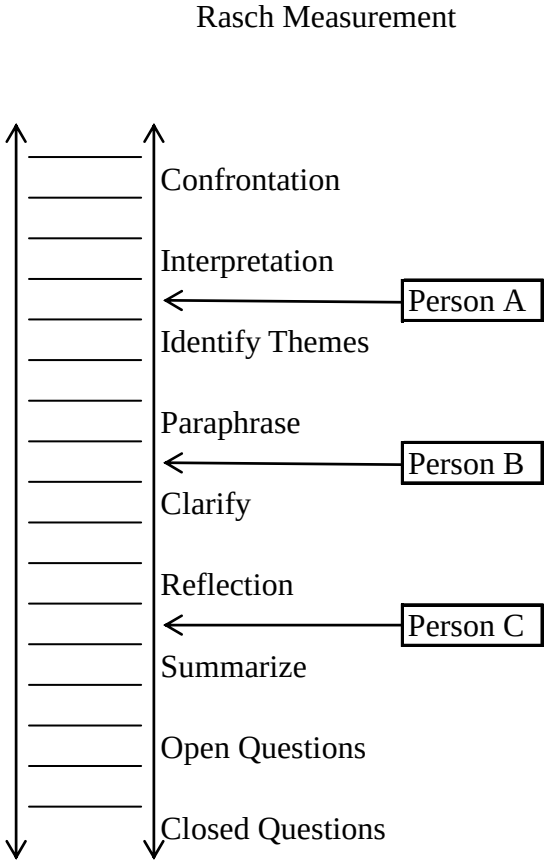
Figure 2-1. Sample free and test free related to height

When using the Rasch formula, the most information about a person's ability level is obtained when the person has a 50 percent probability of passing an item (Smith, 1994). If an item is well below the person's ability, the probability of him or her correctly answering it increases (i.e. 90 percent). Conversely, if the item is too difficult, then the person has a much lower probability of passing the item (i.e. 10 percent). The most information about people is obtained when one can match the types of items associated with their ability level.

By converting ordinal data into an interval scale, the Rasch model can examine the psychometric properties of the individual items. One such property, an item / person measure, arranges the items on a hierarchy from least to most difficult while simultaneously determining the subject's ability level based on the types of questions he or she correctly answers. Conceptualizing a person's ability level on a hierarchy, as opposed to relying on the summation of correct answers, can provide clinical supervisors more useful information about the student because the person's ability is attached to specific items or behaviors related to whatever constructs one is measuring. A supervisor can then catalog what skills the student has the capacity to demonstrate verses the skills that the student has mastered or has yet to demonstrate at all. In other words, the quantitative nature of measurement would be understood more qualitatively. The student score would finally be associated with specific counseling behaviors and allow for a clearer organization of training and development. This information would be useful for measuring change in the student's performance as well as improving communication between the supervisor and the student. During clinical work, the supervisor would not only be able to identify their students' counseling abilities by the types of items they can do, but also target specific behavioral interventions that were not too easy nor too hard for the student.

Furthermore, because the Rasch hierarchy could determine a person's counseling ability without requiring him or her to demonstrate every skill or behavior, the Rasch measurement model is a useful tool for clinical supervision. Depending on the nature of the practicum or internship site, students may not need to demonstrate every counseling skill or behavior. However, a traditional instrument that relies on total scores may unfairly penalize a trainee for not demonstrating a particular skill, even if the skill was unnecessary or did not affect his/her overall counseling ability. Figure 2 illustrates that regardless of what types of skills

demonstrated, the trainee's ability is more accurately determined by considering the difficulty of the skill. It is interesting to note that when using the total score method, persons B is considered to have more counseling ability despite being unable to adequately perform more difficult skills.



Total Score

	A	B	C
Confrontation	NA	1	NA
Interpretation	4	2	2
Identify Themes	4	2	2
Paraphrase	4	4	3
Clarify	NA	4	1
Reflection	5	5	4
Summarize	4	5	4
Open-Ended Ques	5	4	4
Closed-Ended Ques	5	5	4
TOTAL SCORE	**31**	**32**	**28**

Figure 2-2. Hierarchy of counseling ability compared to total score

Finally, a minimum level of performance related to clinical skills, professional standards, and personal suitability could be established to ensure that rehabilitation counseling programs are endorsing only those students who have met these requirements. The development of several hierarchies related to rehabilitation counseling performance will clearly organize what behaviors and abilities are expected from counseling trainees. With this understanding, clinical supervisors

and trainees are better equipped to promote the trainee's professional and personal development as a rehabilitation counselor.

CHAPTER 3
METHODOLOGY

Within the rehabilitation counseling profession, little is known about what competency criteria are appropriate for a clinical supervision evaluation measure. Therefore, the purpose of this study was to establish expert consensus regarding what specific competency indicators were useful for clinical assessment. This researcher employed the Delphi research method to identify these competency criteria. Specifically, participants partook in a three round Delphi procedure designed to establish consensus among rehabilitation educators regarding the appropriateness of specific performance indicators for clinical evaluation.

Research Question 1

What professional, personal, and clinical competency items are useful for the evaluation of rehabilitation counseling trainees?

Study Design

To answer this research question, participants participated in a three round Delphi study to identify the critical items necessary for clinical supervision evaluation. Originally developed by the RAND Corporation for determining the likely targets of Soviet nuclear attacks, the Delphi technique has become a widely used method for measuring, predicting, and decision making in an array of disciplines (Rowe & Wright, 1999). The Delphi procedure allows researchers to elicit and converge anonymous expert opinion by providing systematic feedback through a series of questionnaires (Vázquez-Ramos, Leahy, & Hernández, 2007). The first questionnaire asks an open-ended question(s) regarding the topic of interest. Once participants complete this questionnaire, the researcher combines the panel's responses and creates the second round of questions. In Round 2, participants are asked to rate the importance of all the Round 1 responses on a Likert-type scale. After this information is returned and tabulated, the researcher develops

the Round 3 questionnaire. During this round, participants are provided their rating responses as well as the statistical group data from Round 2 and allowed the opportunity to compare and revise their previous responses. Ultimately, the goal of the Delphi procedure is to achieve overall consensus or level of agreement among experts (Williams & Webb, 1994). This technique builds on the expert's qualitative responses, while measuring the group's responses quantitatively (McBride, Pates, Ramadan, & McGowan, 2003).

The Delphi methodology offers several advantages over other comparable techniques. First, because the experts participating in this study are anonymous, any one member of the panel can not overly influence the responses of other participants. According to Williams and Webb (1994), this method encourages participants to offer their honest opinion because not only are they uninhibited when responding, but junior participants are free to challenge more senior participants anonymously. In general, this method eliminates any confrontation issues that may be associated with similar techniques (Vázquez-Ramos et al., 2007). Additionally, because the Delphi technique offers feedback in successive rounds, participant views can be "retracted, altered, or added with the benefit of considered thought" (Williams & Webb, p. 181). Thus, panel members have the opportunity to rethink and reflect on the feedback from other panel members before submitting their final opinion. According to Rowe and Wright (1999), the multiple iterations of the Delphi method may allow panel members to change their judgments while saving face in the eyes of the other group members. A third advantage of this methodology is the statistical nature of the process. Panel members receive statistical feedback (i.e. mean, median, standard deviation, interquartile range) in between rounds, but final consensus is determined using preset statistical criteria (Hakim & Weinblatt, 1993; Rowe & Wright). The use of statistical feedback and preset standards for defining statistical consensus

ensures that researchers are not arbitrarily determining expert consensus based on personal impressions. Finally, the Delphi approach allows researchers to collect data from a diverse panel in terms of geographic location, experience, gender, and education. Particularly when developed for online distribution, this type of survey is easily accessible to experts throughout the country.

Sampling

According to Williams and Webb (1994), determining the appropriate sample size for a Delphi study is unclear; there are no established guidelines regarding appropriate sample size. Delphi studies have typically included as few as three participants and as many as 80 participants (Rowe & Wright, 1999). This trend is also evident within the rehabilitation counseling profession where studies have ranged from 18 panel members (Thielsen & Leahy, 2001) to 111 panel members (Hakim & Weinblatt, 1993). Additional rehabilitation counseling Delphi studies have included round 1 sample sizes of 23 (Rubin, McMahon, Chan, & Kamnetz, 1998), 44 (Currier, Chan, Berven, Habeck, & Taylor, 2001), and 31 (Shaw, Leahy, Chan, & Catalano, 2006). Although there is no generally accepted numbers of participants, Okoli & Pawlowski (2004) suggest that a Delphi panel size is typically modest, ranging between 10-18 experts.

In addition to the ambiguity over the appropriate number of participants, Hasson, Keeney, and McKenna (2000) report that the controversy over a Delphi sample size extends to the difficulty in defining who qualifies as an "expert". In fact, few studies report any specific criteria used to differentiate experts from non-experts (Williams & Webb, 1994). Within the rehabilitation counseling literature, there are no specific definitions differentiating rehabilitation counseling clinical supervision experts from non-experts. Therefore, this researcher defined a rehabilitation counseling supervision expert as:

- Have supervised at least 15 rehabilitation counseling students during practicum or internship,

- Have supervised at least three semesters of practicum or internship, and
- Have supervised at least three students during practicum or internship within the last three years.

Further complicating the sample size issue is the fact that the Delphi procedure includes several rounds, therefore researchers must account for the potential decline in response rate (Hakim & Weinblatt, 1993). In fact, several of the rehabilitation counseling Delphi studies reported a decline in response rate from one round to the next. Therefore in order to account for a reduced response rate and ensure the number of panel experts in the final round remains at an acceptable level, this researcher targeted a minimum of 23 participants for the Delphi study.

Potential participants were contacted through the National Council of Rehabilitation Education (NCRE) listserv. The NCRE is the premier professional organization representing rehabilitation educators who are dedicated to improving the lives of people with disabilities through education and research (NCRE, 2007). After NCRE research committee approval, the survey was made available to participants online. Collecting data through a Web-based survey has several advantages including a reduced response time, lowered costs, ease of data entry, and format flexibility (Granello & Wheaton, 2004).

The SurveyMonkey® software program was used to distribute the questionnaire. SurveyMonkey allows the user to collect and analyze data through a wide range of export and statistical analysis functions (SurveyMonkey, 2007). In addition, this program provides a means for immediately obtaining participant data through the internet as well as storing information on a secure server.

Delphi Procedure

This investigator brainstormed with rehabilitation counseling educators to develop a question strategy to identify what behaviors are appropriate/useful for the evaluation of trainees

during the clinical portion of their program. This open-ended question seeks to elicit trainee behaviors that are indicative of rehabilitation counseling ability. Specifically, the question asks participants to list behaviors that are reflective of three rehabilitation counseling trainees' areas: (a) personal suitableness, (b) professional appropriateness, and (c) clinical ability (Appendix A).

Delphi round 1

As previously described, potential subjects were contacted via an email (Appendix B) through the NCRE listserv. Prior to beginning the study, rehabilitation counseling educators were notified of the purpose of the study, the general study procedure, their rights as participants, potential risks and benefits of participating, and contact information of the primary investigator. Subjects agreeing to participate in the study confirmed their understanding of the informed consent information electronically (Appendix C). If a participant failed to consent their rights, the survey closed and the participant did not see the questionnaire. At the end of the survey, the respondents were instructed to submit their responses. A friendly reminder email was sent to the panel experts two weeks following initial contact (Appendix D).

Once the data was received, this researcher engaged in the process of microanalysis. This process involves a creative, unstructured analysis of the data whereby the researcher generates initial concepts and deeper meaning by examining the data line-by-line (Strauss & Corbin, 1998). Throughout the analysis process, the researcher utilized analytic tools such as questioning and comparative analysis in order to identify separate, substantially distinct items. As new data were observed, this researcher *constantly compared* all of the data to look for similarities and differences among the items (Corbin & Strauss, 1990). This process requires the researcher to engage in several iterations of data analysis whereby incoming data are compared to existing data.

Although the Delphi procedure is not typically considered a qualitative methodology, certain elements of this process are conceptually similar to this type of data analysis process (e.g. constantly comparing data). Therefore, in order to ensure a level of trustworthiness and credibility in the data analysis process, this researcher has included an "audit trail" outlining the round 1 data analysis (Appendix E). Specifically, the audit trail captures the researcher's decision making process when grouping conceptually similar items. For example, conceptually similar items such as "paraphrasing," "know how and when to paraphrase," and "ability to paraphrase" were condensed into the item "paraphrase client statements." In this instance, the researcher identified each item as being related to one's ability to paraphrase and therefore combined the items.

On the other hand, items that appeared conceptually similar but determined to be substantially different were separated into two distinct items. For example, the item "confidence in approaching any interpersonal session with clients, site supervisor, or faculty supervisor" was separated into "confident in approaching any interpersonal session with clients" and "confident in approaching any interpersonal session with site or faculty supervisors." In this instance, the researcher deemed the interpersonal interactions between the trainee/client and the trainee/supervisor to be substantially distinct items. In other words, the level of confidence the trainee exhibits during a counseling session was determined to be independent of the level of confidence the trainee might exhibit with a supervisor. As a result, this one item was conceptualized as two discrete items and separated accordingly.

Once the text was reviewed and some concepts were identified, this researcher then categorized the data into theoretical competency domains. According to Strauss and Corbin (1998), the analyst eventually realizes that previously conceptualized data can be grouped into

higher, more abstract concepts know as categories. The purpose of categorizing data are twofold. First, it allows the researcher to work with a reduced number of data units which makes the data analysis process more efficient. Second, by creating categories, the data now has the potential to explain and predict (Strauss & Corbin).

Since the purpose of this research question is to generate items and competency domains to be included on a rehabilitation counseling supervision measure, specific behaviors related to the trainee's clinical ability, personal suitability, and professional adherence were identified and used to develop the items for Round 2 of the Delphi Study.

Delphi round 2

Following the same methodology used in the original questionnaire, an email was sent to all panel experts directing them to the Round 2 survey (Appendix F). Round 2 of the Delphi study consisted of a series of closed-ended questions in which participants were asked to rate the usefulness of each item generated from round 1. Within the instructions for round 2, the term "useful" was further defined as any item related to rehabilitation counseling performance that might help clinical supervisors evaluate a trainee (Appendix G). Participants rated each item on a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). In addition to the item ratings, participants had the opportunity to respond with specific comments regarding the items in Round 2. Like the previous round, a friendly reminder email was sent to the experts one week following initial contact (Appendix H).

Once the Round 2 questionnaires were received, the data was analyzed in order to provide each panel expert feedback about the group norms. Typically, researchers conducting Delphi studies prepare a variety of information for each panel member including: (a) feedback about their own ratings, (b) a statistical analysis of the group data, and (c) a summation of the comments provided in Round 2 (Vázquez-Ramos et al., 2007). In order to provide appropriate

feedback, each item was analyzed using the Statistical Package for the Social Sciences software (SPSS Inc., 2001) and a summary of participant comments was developed.

Although there are no specific rules regarding what specific statistics should be calculated, Rowe and Wright (1999) state that researchers typically report at least one measure of central tendency (i.e. mean, median) and one measure of dispersion (i.e. standard deviation, interquartile range). For the purposes of this study, this researcher calculated and reported the mean and standard deviation for each item. According to Cramer and Howitt (2004), the arithmetic mean is the numeric average of scores and may or may not be the most common score. Although the mean may be heavily influenced by outlying data, participants in this study are rating items on a 5 point Likert-type scale and therefore the undue influence of outliers on the calculation of the mean will be minimal. In addition to the mean, this researcher calculated and reported the standard deviation. The standard deviation is a common measure of variability appropriate for interval data (Norman & Streiner, 2000). Specifically, the standard deviation is the square root of the average of the squared deviations of each number from the mean of all the numbers (Norman & Streiner, 2000). The closer the item ratings cluster around the mean (e.g. the smaller the standard deviation gets), the smaller the variability and thus the larger the consensus.

Delphi round 3

Once the data from round two was calculated, the third round of the questionnaire was developed and sent to the expert panel. This questionnaire consisted of the participant's original item ratings along with group statistical norms (i.e. mean, standard deviation) and qualitative feedback. Following the same methodology for rounds 1 and 2, an email was sent to all the experts directing them to the round 3 survey (Appendix I). Round 3 instructions (Appendix J) specifically asked participants to examine the group statistical data, consider the participant comments, and re-evaluate their original item ratings. More specifically, the participants were

asked to re-rate only those items they decided to change. Similar to previous rounds, a friendly reminder email was sent to the experts two weeks following initial contact (Appendix K).

Once all the data was collected and item statistics were calculated, this researcher determined what items met the criteria for group consensus. Currently, there are no universal standards for establishing consensus (Fink, Kosekcoff, Chassin, & Brook, 1984; Williams & Webb, 1994). In fact, many researchers may not set a level of consensus prior to the study, resulting in an arbitrary level of agreement (Webb & Williams). According to Webb and Williams, "unless a [consensus] value is stipulated, the notion of a 'high' level of consensus could almost be a movable feat which is unilaterally decided upon by the researcher" (p.183-184). Hakim and Weinblatt (1993) suggest that in order to determine consensus

For the purposes of this study, the standards for "high" expert consensus were defined according to two criteria:

- The mean difference between the second and third rounds cannot exceed plus or minus 1 (stability), and
- The standard deviation for each item after round 3 will be equal to or less than 1 (convergence)

In addition, for the purposes of this study, the standards for "moderate" expert consensus were defined according to two criteria:

- The mean difference between the second and third rounds cannot exceed plus or minus 1 (stability), and
- The standard deviation for each item after round 3 will be equal to or less than 1.5 (convergence)

Pilot Testing

Once the initial Delphi question was developed and placed online, five rehabilitation counseling educators associated with two universities were requested to complete the

questionnaire and provide any additional feedback regarding the survey. A summary of the participant feedback, test findings, and actions taken are provided in Table 3-1.

Table 3-1. Pilot test findings and revisions

Comments	Action Taken
Provide an comprehensive list of each rehabilitation counseling school with its associated CORE region	Each school was listed with its corresponding CORE region
Delphi Round 1 question did not extract an exhaustive list of trainee clinical, personal, or professional behaviors	Delphi was reworded to elicit more comprehensive responses and the introduction was reworded to encourage participants to provide an exhaustive list of competency items

The first comment was in reference to the demographics page of the survey, in which participants are asked to identify what CORE region their program is affiliated. The comment suggested that many participants may erroneously select the wrong region or may not be aware of their school's specific designation. Moreover, the questionnaire could be improved if such a designation were clearer. To address this matter, this researcher reorganized the region options designated in the survey. Rather than just listing the region, each school affiliated with CORE was added to the survey under each specified region.

Next, in relation to the Delphi question, it was revealed that respondents did not provide an exhaustive, detailed list of trainee clinical skills, professional attributes, or personal attributes relative for a clinical supervision assessment tool. Responses only ranged from 3-8 items and included broader items rather than specific skills or behaviors. To address this issue, this researcher carefully rewrote the question to help invoke participant responses. Specifically, this researcher added examples representative of the three evaluative areas, as well as added a prompt to help supervisors better conceptualize the types of behaviors and skills useful for clinical supervision evaluation. Additionally, this researcher reworded the introduction to emphasize the

nature of this study and encourage participants to provide a comprehensive list of trainee competency items.

In sum, this study is designed to use qualitative methods to explore the inherent challenges associated with student impairment and to identify specific performance indicators useful for clinical assessment. Once this research study is completed, it is hoped that rehabilitation counselors can more holistically conceptualize trainee competence during clinical supervision. Furthermore, it is anticipated that the clinical supervisors could use the findings from this research to help develop comprehensive measures of clinical competence (e.g. a Rasch validated clinical supervision measure) that help establish clear performance expectations and allow for more transparent evaluation.

CHAPTER 4
RESULTS

Delphi Study

Panel Demographics

Of the rehabilitation counseling educators solicited for this study, 21 participated in Round 1. Participants averaged 14 semesters of practicum/internship supervision experience and had supervised an average of 59 students throughout their career (Note: when participants estimated the number of supervised students and/or semesters with a "+," this researcher used the most conservative estimate for the calculation; one participant did not offer a numeric value when asked the number of students supervised and was therefore not included in the calculation). Additional information describing the participants is described in Table 4-1.

Participants held a variety of academic positions including professor emeritus (4.8%), full professor (14.3%), associate professor (23.8%), assistant professor/tenured track (42.9%), and assistant professor/non-tenured track (14.3%). Moreover, participants represented several CORE academic regions. Specifically, participants were from regions I (14.3%), III (4.8%), IV (47.6%), V (9.5%), VI (14.3%), VII (4.8%), and X (4.8). Regions not represented by the participants included regions II, VIII, and IX. In addition to supervision experience and location, participants held a variety of licenses and credentials. As outlined in Table 4-2, the majority of participants were (9.5%) respectfully. Furthermore, the sample was comprised of a certified disability management specialist, a certified psychiatric rehabilitation practitioner (pending), a licensed clinical psychologist, licensed independent social worker, an occupational therapist registered/licensed, and a registered mental health counselor intern.

Table 4-1. Participant demographics

Factor		Number	Frequency %
Position			
	Professor Emeritus	1	4.8
	Full Professor	3	14.3
	Associate Professor	5	23.8
	Assistant Professor/Tenured Track	9	42.9
	Assistant Professor/Non-Tenured Track	3	14.3
Region			
	I	3	14.3
	II	0	0
	III	1	4.8
	IV	10	47.6
	V	2	9.5
	VI	3	14.3
	VII	1	4.8
	VIII	0	0
	IX	0	0
	X	1	4.8

Delphi Round 1

Experts responded to Round 1 of the Delphi with 188 substantially different items to consider when evaluating a rehabilitation counseling trainee during clinical supervision (Tables 4-3 through 4-7). These responses were based on an open-ended question which prompted participants to think about their students who demonstrated either exceptional or poor counseling ability and then list any specific counseling skills, characteristics, abilities, or attributes they believed were useful or appropriate for evaluating trainees during clinical supervision.

Table 4-2. Participant credentials

Credential	Abbreviation	Number	Frequency (%)
American Board of Vocational Experts	ABVE	1	4.8
Certified Disability Management Specialist	CDMS	1	4.8
Certified Life Care Planner	CLCP	2	9.5
Certified Psychiatric Rehabilitation Practitioner	CPRP	1	4.8
Certified Rehabilitation Counselor	CRC	20	95.0
Certified Vocational Evaluator	CVE	2	9.5
Licensed Clinical Psychologist	---	1	4.8
Licensed Independent Social Worker	LISW	1	4.8
Licensed Professional Counselor	LPC	2	9.5
National Certified Counselor	NCC	2	9.5
Occupational Therapist Registered/Licensed	OTR/L	1	4.8
Registered Mental Health Counselor Intern	RMHCI	1	4.8

Delphi Round 2

For the second round of the Delphi, 18 of the original 21 participants responded with their level of agreement to whether each of the 188 items listed in Table 5 were “useful” for clinical supervision evaluation. The term useful was defined as an item representative of some aspect of rehabilitation counseling performance and could potentially help the supervisor evaluate the trainee. The mean and standard deviation were calculated for each item and reported in Tables 4-3 through 4-7. These results correspond to the following five point Likert scale used to measure the agreement for each item: 1=strongly disagree, 2=disagree, 3=neutral, 4=agree, and 5=strongly agree. Following Round 2 data collect, 179 of the 188 items demonstrated a high level of consensus. This was evident due to the fact that these items had a standard deviation less than 1. In other words, 95 percent of the items rated by participants demonstrated high consensus with respect to level of agreement. In addition, as indicated by a standard deviation above 1, but lower than 1.5, 7 of the 188 items demonstrated moderate consensus.

Delphi Round 3

For the third round, 17 participants reevaluated their level of agreement to whether each of the 188 items listed in Tables 4-3 through 4-7 were useful when evaluating trainee clinical performance during clinical supervision. Like the previous round, means and standard deviations ranges were reported as well as item stability. Of the 188 total items, 106 (56%) resulted in a greater consensus than previously achieved during Round 2. Evidence of this increase in consensus was seen in the greater convergence (decrease) of the standard deviation. Sixty eight of the remaining 69 items demonstrated either equal consensus or minimum divergence (.02 or less increase in standard deviation) from Rounds 2 to 3. In addition, all 188 items fell within the acceptable stability criteria. As described in Chapter 3, acceptable stability criteria was defined as the mean difference between Rounds 2 and 3 being equal to or less than 1.

Round 3 resulted in 184 of the 188 items reaching "high" consensus. The remaining four items that demonstrated "moderate" consensus include: "Healthy" (1.00), "Capable" (1.01), "Diagnose (with some assistance)" (1.06), and "Pleasure to work with" (1.20). At the conclusion of Round 3, 145 items (77%) resulted in a mean score between 4 (agree) and 5 (strongly agree) (Tables 4-3 and 4-4). Item include, but are not limited to "Active listening," (5.00); "Builds rapport," (4.94); and "Recognizes limits of competency," (4.53). In addition, 40 of the 188 items (21%) resulted in a mean score between 3 (neutral) and 4 (agree) (Tables 4-5 and 4-6). These items include, but are not limited to "Confident in approaching any interpersonal session with site or faculty supervisor," (3.94); "Working within a theoretical approach," (3.76); "Balance the needs of the faculty supervisor and site supervisor," (3.53); and "Diagnose (with some assistance)," (3.59). Lastly, 3 of the 188 items (1.6%) resulted in mean score below 3 (neutral). These items include "Ebullient/happy," (2.88); "Extroverted," (2.71) and "Introverted" (2.59) (Table 4-7).

Table 4-3. Items with means between 4.50 and 5.00 arranged according to consensus

Round 1	Round 2		Round 3		
Item	Mean ($\bar{X}_1$)	Convergence (s.d.)	Mean ($\bar{X}_2$)	Convergence (s.d.)	Stability ($\bar{X}_2$) - ($\bar{X}_1$)
Active listening (e.g. attending to client; listening and responding)	4.94	0.24	5.00	0.00	0.06
Builds rapport	4.83	0.38	4.94	0.24	0.11
Dependable / reliable	4.94	0.24	4.94	0.24	0.00
Empathetic / Convey empathy to clients	4.89	0.32	4.88	0.33	-0.01
Genuine	4.89	0.32	4.88	0.33	-0.01
Non verbal skills (e.g. eye contact, body position, voice tone, gestures, facial expressions, physical distance, and appropriate touch)	4.78	0.55	4.82	0.39	0.04
Clearly explains limits of confidentiality to client	4.83	0.38	4.82	0.39	-0.01
Demonstrates respect for client's values/beliefs	4.83	0.38	4.82	0.39	-0.01
Individualized treatment planning (i.e. plan interventions and services that will assist the client in his or her goal)	4.72	0.46	4.82	0.39	0.10
Understands/practices in ethical manner (i.e. confidentiality, representation of competence/qualifications, dual relationships, informed consent)	4.83	0.38	4.82	0.39	-0.01
Approachable / Non-threatening demeanor	4.84	0.38	4.82	0.39	-0.02
Develops trust	4.61	0.61	4.76	0.44	0.15
Assess accuracy of interpretations with the clients	4.56	0.51	4.76	0.44	0.20
Identify client problems	4.78	0.43	4.76	0.44	-0.02
Focuses on client rather than themselves in counseling sessions	4.78	0.43	4.76	0.44	-0.02
Sets realistic, attainable goals	4.67	0.49	4.76	0.44	0.09
Non-judgmental	4.78	0.43	4.76	0.44	-0.02
Orients client to the counseling process	4.56	0.51	4.71	0.47	0.15
Interviewing skills	4.72	0.46	4.71	0.47	-0.01

Table 4-3. (continued)

Item	Round 1 Mean ($\bar{X}_1$)	Round 2 Convergence (s.d.)	Round 3 Mean ($\bar{X}_2$)	Round 3 Convergence (s.d.)	Stability ($\bar{X}_2$) - ($\bar{X}_1$)
Gather pertinent information from the client and relevant others through assessments, observations, and facilitative questions	4.67	0.49	4.71	0.47	0.04
Assess client strengths and weaknesses	4.61	0.50	4.71	0.47	0.10
Ability to reflect on one's practice	4.61	0.50	4.71	0.47	0.10
Willingness to continue to learn and develop professionally	4.61	0.61	4.71	0.47	0.10
Open minded	4.72	0.46	4.71	0.47	-0.01
Flexible/adaptable	4.67	0.49	4.71	0.47	0.04
Respectful	4.72	0.46	4.71	0.47	-0.01
Suicide risk assessment	4.67	0.59	4.71	0.47	0.04
Sets clear boundaries with client	4.62	0.50	4.65	0.49	0.03
Observation skills	4.61	0.50	4.65	0.49	0.04
Reflect feeling of client statements	4.56	0.51	4.65	0.49	0.09
Use open ended questions	4.61	0.50	4.65	0.49	0.04
Assess client self-efficacy	4.56	0.51	4.65	0.49	0.09
Prioritize client problems	4.50	0.71	4.65	0.49	0.15
Identify goals that reflect the client's perspective	4.61	0.50	4.65	0.49	0.04
Regularly evaluates client progress	4.61	0.50	4.65	0.49	0.04
Non-defensive /receptive to clinical supervision	4.67	0.59	4.65	0.49	-0.02
Participates in supervision	4.67	0.49	4.65	0.49	-0.02
Evaluates relevance, value, and meaning of supervisory feedback	4.56	0.62	4.65	0.49	0.09
Understands the challenges to communication with persons with hearing, visual, or cognitive impairments	4.56	0.51	4.65	0.49	0.09
Aware of client's cultural differences/influences	4.56	0.62	4.65	0.49	0.09
Assess client motivation	4.50	0.51	4.59	0.51	0.09

Table 4-3. (continued)

Item	Round 1 Mean ($\bar{X}_1$)	Round 2 Convergence (s.d.)	Round 3 Mean ($\bar{X}_2$)	Round 3 Convergence (s.d.)	Stability ($\bar{X}_2$) - ($\bar{X}_1$)
Continues to move session toward the therapeutic goal	4.61	0.50	4.59	0.51	-0.02
Identify and explore options with client	4.50	0.51	4.59	0.51	0.09
Provide accurate feedback	4.56	0.51	4.59	0.51	0.03
Demonstrates genuine motivation to become a competent and ethical rehabilitation counselor	4.56	0.51	4.59	0.51	0.03
An ability to engage in critical self-reflection rather than focusing solely on the mistakes of others when they participate in clinical training, practicum and internship experiences	4.50	0.71	4.59	0.51	0.09
Demonstrates emotional stability	4.39	1.04	4.59	0.51	0.20
Warm	4.61	0.50	4.59	0.51	-0.02
Crisis Management	4.61	0.50	4.59	0.51	-0.02
Paraphrase client statements	4.44	0.62	4.53	0.51	0.09
Clarify client statements	4.50	0.51	4.53	0.51	0.03
Allows client to elaborate	4.50	0.51	4.53	0.51	0.03
Identifies and meets the client's needs	4.56	0.51	4.53	0.51	-0.03
Summarize	4.50	0.51	4.53	0.51	0.03
Critical thinking ability	4.50	0.51	4.53	0.51	0.03
Identify short and long term goals	4.44	0.51	4.53	0.51	0.09
Prepares for supervision	4.56	0.62	4.53	0.51	-0.03
Incorporates supervisor feedback into practice	4.44	0.62	4.53	0.51	0.09
Identifies own strengths and weakness related to counseling performance/competency	4.56	0.51	4.53	0.51	-0.03
Sets personal learning goals	4.50	0.51	4.53	0.51	0.03
Ability to handle client's strong emotions (e.g. crying)	4.50	0.51	4.53	0.51	0.03

Table 4-3. (continued)

Round 1	Round 2		Round 3		
Item	Mean ($\bar{X}_1$)	Convergence (s.d.)	Mean ($\bar{X}_2$)	Convergence (s.d.)	Stability ($\bar{X}_2$) - ($\bar{X}_1$)
An awareness of when their own personal issues are interfering with their ability to learn and practice in a professionally and ethically responsible manner	4.56	0.70	4.71	0.59	0.15
Asks effective questions	4.56	0.62	4.65	0.61	0.09
Recognizes how their personal limitations, biases, and beliefs impact the counseling relationship	4.56	0.62	4.65	0.61	0.09
Attentive	4.61	0.61	4.65	0.61	0.04
Uses appropriate language/terminology (e.g. person first language; avoids heterosexist, ablest, racist, and sexist language)	4.56	0.62	4.59	0.62	0.03
Manage own mental health disabilities	4.33	1.14	4.56	0.62	0.23
Utilize simple techniques grounded in counseling theory	4.44	0.70	4.53	0.62	0.09
Providing client with choices	4.56	0.51	4.53	0.62	-0.03
Preparation of written reports and progress notes (accuracy, clarity, organization, professional presentation)	4.33	0.77	4.53	0.62	0.20
Fosters a therapeutic environment	4.56	0.70	4.59	0.71	0.03
Establishes a working alliance	4.50	0.79	4.53	0.72	0.03
Willingness to change when their own biases and beliefs that interfere with their ability to learn how to function as competent and ethical rehabilitation counselor	4.50	0.71	4.53	0.72	0.03
Recognizes limits of competency	4.56	0.70	4.53	0.72	-0.03
Demonstrates unconditional positive regard	4.50	0.71	4.53	0.72	0.03
Understanding the impact of disability	4.56	0.78	4.70	0.77	0.14
Trustful	4.61	0.78	4.65	0.79	0.04

Table 4-4. Items with means between 4.00 and 4.49 arranged according to consensus

Round 1	Round 2		Round 3		
Item	Mean ($\bar{X}_1$)	Convergence (s.d.)	Mean ($\bar{X}_2$)	Convergence (s.d.)	Stability ($\bar{X}_2$) - ($\bar{X}_1$)
Elicits motivating statements from client	4.00	0.69	4.06	0.43	0.06
Keeps client focused	4.28	0.46	4.30	0.47	0.02
Flexible with counseling skills (when necessary)	4.33	0.49	4.35	0.49	0.02
Applies structure to the counseling process (e.g. rapport building, exploration, treatment, termination)	4.39	0.50	4.35	0.49	-0.04
Reflects on the counseling session	4.22	0.65	4.35	0.49	0.13
Appropriately uses silence	4.39	0.50	4.35	0.49	-0.04
Ability to be insightful	4.39	0.50	4.35	0.49	-0.04
Clear understanding of theory(s)	4.28	0.67	4.35	0.49	0.07
Understanding of family and interpersonal dynamics	4.39	0.50	4.35	0.49	-0.04
Enhance or help client to increase his or her self-esteem	3.83	0.86	4.00	0.50	0.17
Controls own feelings and personal thoughts about clients to increase understanding and to decrease interference in the counselor relationship	4.50	0.51	4.47	0.51	-0.03
Appropriately uses confrontation	4.44	0.62	4.47	0.51	0.03
Understanding of and ability to develop accommodation strategies	4.44	0.62	4.47	0.51	0.03
Redirects client (when appropriate)	4.39	0.50	4.41	0.51	0.02
Conceptualize the client's life (i.e. psychosocial, vocational, etc.)	4.44	0.51	4.41	0.51	-0.03
Willing to research and explore counseling resources (i.e. journal articles, books, etc.)	4.22	0.73	4.41	0.51	0.19
Deals directly and appropriately with conflict rather than avoiding it.	4.39	0.50	4.41	0.51	0.02
Recognition of the importance of self care	4.17	0.62	4.18	0.53	0.01
Confident (but not arrogant)	4.11	0.68	4.18	0.53	0.07

Table 4-4. (continued)

Item	Round 1 Mean ($\bar{X}_1$)	Round 2 Convergence (s.d.)	Round 3 Mean ($\bar{X}_2$)	Round 3 Convergence (s.d.)	Stability ($\bar{X}_2$) - ($\bar{X}_1$)
Use close ended questions (when appropriate)	4.17	0.70	4.29	0.59	0.12
Disagreeing as needed, while maintaining a respectful and supportive attitude	4.28	0.75	4.29	0.59	0.01
Ability to recognize when they are responding to supervisors, clients, students and other professionals in a manner that puts their own needs before those of their clients	4.28	0.67	4.29	0.59	0.01
Utilize advanced techniques grounded in counseling theory	4.22	0.65	4.12	0.60	-0.10
Manages the time of the session appropriately	4.28	0.75	4.35	0.61	0.07
Reframes client statements	4.33	0.59	4.35	0.61	0.02
Uses self-disclosure appropriately	4.22	0.73	4.35	0.61	0.13
General ability to conceptualize	4.39	0.61	4.35	0.61	-0.04
Manage/work on personal issues that arise during counseling or supervision session	4.28	0.75	4.35	0.61	0.07
Use and understand solution skills (giving advice, information, and directive)	4.00	0.69	4.00	0.61	0.00
An ability to use counseling skills intentionally/purposefully	4.50	0.62	4.47	0.62	-0.03
Reflect meaning of client statements	4.39	0.98	4.47	0.62	0.08
Intervenes in a ways that produce client progress in achieving his or her behavioral and/or emotional goals.	4.44	0.62	4.47	0.62	0.03
An awareness of when to seek supervision	4.50	0.62	4.47	0.62	-0.03
Completes supervision tapes/reposts on time	4.44	0.62	4.47	0.62	0.03
Respects other professionals	4.44	0.62	4.47	0.62	0.03
Willingness to seek out professional counseling for themselves when it is needed in order for them to function ethically and professionally	4.44	0.70	4.47	0.62	0.03

Table 4-4. (continued)

Round 1	Round 2		Round 3		
Item	Mean ($\bar{X}_1$)	Convergence (s.d.)	Mean ($\bar{X}_2$)	Convergence (s.d.)	Stability ($\bar{X}_2$) - ($\bar{X}_1$)
Non-defensive	4.50	0.62	4.47	0.62	-0.03
Manages resources	4.39	0.70	4.41	0.62	0.02
Patient	4.39	0.61	4.41	0.62	0.02
Uses confirmations/affirmations	4.39	0.61	4.41	0.62	0.02
Requests guidance as needed (during supervision)	4.44	0.62	4.41	0.62	-0.03
Appropriate dress	4.22	0.65	4.24	0.66	0.02
Interprets client statements	4.28	0.67	4.29	0.69	0.01
Assess client interests, skills, and aptitudes	4.17	0.86	4.29	0.69	0.12
An understanding of and belief in the importance of supervision	4.39	0.70	4.29	0.69	-0.10
Comfortable with client	4.28	0.67	4.29	0.69	0.01
Willing to experiment or take risks in session	4.00	0.77	4.12	0.70	0.12
Maintains awareness of personal feelings, limitations, and experiences during the counseling session	4.45	0.78	4.41	0.71	-0.04
Ability to be objective (lose their subjective thought)	3.94	0.87	4.00	0.71	0.06
Avoids countertransference	4.33	0.77	4.24	0.75	-0.09
Group counseling skills	4.06	0.80	4.06	0.75	0.00
An ability to articulate why the counseling skills they learn are crucial to all the roles and functions (e.g., vocational rehabilitation counselor, case manager, job developer, vocational evaluator) of rehabilitation counselors	4.17	0.92	4.29	0.77	0.12
Positive	4.17	0.79	4.12	0.78	-0.05
Goal Oriented	4.06	0.87	4.12	0.78	0.06
Fiscal Management	4.06	0.87	4.00	0.79	-0.06
Motivating	4.17	0.79	4.18	0.81	0.01
Kind/thoughtful/caring	4.22	0.81	4.24	0.83	0.02

Table 4-4. (continued)

Round 1	Round 2		Round 3		
Item	Mean ($\bar{X}_1$)	Convergence (s.d.)	Mean ($\bar{X}_2$)	Convergence (s.d.)	Stability ($\bar{X}_2$) - ($\bar{X}_1$)
Conceptualize a case within a theoretical frame of reference	4.06	0.87	4.06	0.83	0.00
Intuitive/perceptive	4.00	0.84	4.06	0.83	0.06
Mature	4.28	0.83	4.30	0.85	0.02
Displays common sense	4.28	0.89	4.35	0.86	0.07
Conscientious/prudent	4.17	0.86	4.12	0.86	-0.05
Honest	4.44	0.86	4.41	0.87	-0.03
Avoids advice	4.00	0.91	4.00	0.87	0.00
Demonstrates respect for the expertise of supervisors	4.11	0.90	4.00	0.87	-0.11
Hard-working	4.06	0.87	4.00	0.87	-0.06
Altruistic	3.94	0.94	4.00	0.94	0.06
Capable	4.11	1.02	4.18	1.01	0.07

Table 4-5. Items with means between 3.50 and 3.99 arranged according to consensus

Round 1	Round 2		Round 3		
Item	Mean ($\bar{X}_1$)	Convergence (s.d.)	Mean ($\bar{X}_2$)	Convergence (s.d.)	Stability ($\bar{X}_2$) - ($\bar{X}_1$)
Functions at any level of the helping relationship, from limited to intense	3.89	0.68	3.88	0.33	-0.01
Seamless delivery of the counseling skills	3.94	0.73	3.82	0.53	-0.12
Creative	4.00	0.69	3.94	0.56	-0.06
Able to convey an appropriate level of ease with colleagues and supervisors	3.72	0.57	3.76	0.56	0.04
Sets career goals	3.61	0.78	3.76	0.56	0.15
Confidence in approaching any interpersonal session with clients	3.78	0.65	3.88	0.60	0.10
Humorous	3.61	0.78	3.53	0.62	-0.08
Educates client regarding referral information	3.94	0.64	3.94	0.66	0.00
Evaluates progress toward own goals	3.89	0.83	3.94	0.66	0.05
Ability to write and state a disclosure statement	4.00	0.77	3.94	0.66	-0.06
Ability to change client's emotional arousal levels	3.56	0.92	3.65	0.70	0.09
Humble	3.67	0.77	3.59	0.71	-0.08
Succint	3.56	0.78	3.53	0.72	-0.03
Uses multiple techniques (i.e. eclectic style)	3.89	0.76	3.82	0.73	-0.07
Job development and placement skills	3.83	0.99	3.82	0.73	-0.01
Above average verbal and written expression	4.00	0.77	3.94	0.75	-0.06
Avoids sympathy	3.67	0.77	3.76	0.75	0.09
Commitment to social justice	3.89	0.76	3.76	0.75	-0.13
Assertive	3.83	0.86	3.76	0.75	-0.07
Closes cases appropriately	3.94	0.80	3.88	0.78	-0.06
Knowledge of career development	4.00	0.77	3.88	0.78	-0.12
Energetic	3.72	0.89	3.59	0.80	-0.13
Direct	3.67	0.91	3.53	0.80	-0.14

Table 4-5. (continued)

Item	Round 1 Mean ($\bar{X}_1$)	Round 2 Convergence (s.d.)	Round 3 Mean ($\bar{X}_2$)	Round 3 Convergence (s.d.)	Stability ($\bar{X}_2$) - ($\bar{X}_1$)
Confident in approaching any interpersonal session with site or faculty supervisor	3.83	0.92	3.94	0.83	0.11
Working within a theoretical approach	3.83	0.86	3.76	0.83	-0.07
Timely/opportune	3.83	0.86	3.76	0.83	-0.07
Calming/soothing	3.78	0.88	3.71	0.85	-0.07
Just	4.00	0.91	3.88	0.86	-0.12
Logical	3.83	0.92	3.76	0.90	-0.07
Intelligent/wise	3.67	0.91	3.71	0.92	0.04
Team player	3.72	0.96	3.71	0.92	-0.01
Balance the needs of the faculty supervisor and site supervisor	3.56	1.10	3.53	0.94	-0.03
Healthy	3.61	1.10	3.65	1.00	0.04
Diagnose (with some assistance)	3.56	1.15	3.59	1.06	0.03
Pleasure to work with	3.56	1.20	3.53	1.18	-0.03

Table 4-6. Items with means between 3.00 and 3.49 arranged according to consensus

Item	Round 1 Mean ($\bar{X}_1$)	Round 2 Convergence (s.d.)	Round 3 Mean ($\bar{X}_2$)	Round 3 Convergence (s.d.)	Stability ($\bar{X}_2$) - ($\bar{X}_1$)
Has faith in intuitive responses	3.33	0.84	3.41	0.80	0.08
Develop ability to supervise others	3.50	0.86	3.41	0.80	-0.09
Experienced	3.44	0.78	3.41	0.80	-0.03
Moderating/judging	3.17	1.10	3.00	0.87	-0.17
Takes good notes during session	3.44	1.04	3.41	0.94	-0.03

Table 4-7. Items with means below 3.00 arranged according to consensus

Round 1	Round 2		Round 3		
Item	Mean ($\bar{X}_1$)	Convergence (s.d.)	Mean ($\bar{X}_2$)	Convergence (s.d.)	Stability ($\bar{X}_2$) - ($\bar{X}_1$)
Ebullient/happy	3.00	0.97	2.88	0.86	-0.12
Extroverted	2.78	0.94	2.71	0.92	-0.07
Introverted	2.67	0.97	2.59	0.94	-0.08

CHAPTER 5
DISCUSSION

Introduction

This study involved identifying and obtaining consensus on a variety of items useful for clinical supervision evaluation. This chapter is divided into four sections, which discuss the findings presented in the previous chapter. The first section includes an overview of the significant findings from Delphi Study. The second section describes limitations of this study. The third section discusses implications of the findings for education and public policy. The final section includes recommendations for further research and development of the findings of this study.

Overview of Significant Findings

Differences in Participant Response Sets

Of the educators who were solicited for this study, 21 completed the first round of the Delphi. Educators were instructed to provide a comprehensive list of specific skills, behaviors, and attributes that were useful/appropriate for clinical supervision evaluation. Round 1 data collection included 410 items, with individual response sets ranging from 6 to 51 items, which were later collapsed into 188 substantially distinct items. As expected, many rehabilitation educators listed unique items that were occasionally identified by other participants (e.g. “willing to research and explore counseling resources,” “continues to move session toward the therapeutic goal”). However, several items fundamental to the therapeutic process were only occasionally identified by the participants. For example, of the 21 participants, only six suggested “empathetic/convey empathy to clients” as useful/appropriate for clinical supervision evaluation. Similarly, nine rehabilitation educators suggested “active listening (e.g. attending to client;

listening and responding)" as useful/appropriate for clinical supervision evaluation, while only three participants listed "build rapport" and "paraphrase client statements".

In addition to item variability, participant response sets also varied. While participants were not expected to provide identical items, entire response sets differed considerably from expert to expert. This phenomenon may relate to what Gizara and Forrest (2004) characterize as fundamental differences between supervisors regarding the purpose of clinical training. They report that some supervisors may believe that the clinical supervision process/internship strictly serves as a vehicle for the trainee's professional development, while other supervisors may believe the clinical process functions as a gatekeeping mechanism (Gizara & Forrest). In addition, individual programs and supervisors may have considerable flexibility when evaluating trainee competence during clinical supervision (Robiner et al., 1993). This may be due to the lack of specificity provided by professional organizations and standards highlighting what supervisors should be evaluating during clinical supervision.

High variability among response sets in this study may suggest that supervisors conceptualize trainee competency differently. Consequently, trainees are evaluated against vastly different criteria which may lead to discrepancies in trainee preparedness and ultimately in rehabilitation counseling performance. If one supervisor believes the trainee should be personally fit to counsel, actively continue their professional development, and sufficiently demonstrate certain clinical skills and treatment planning activities, while another supervisor simply evaluates the trainee's personal suitability and *potential* to develop adequate clinical skills, trainees may be unfairly subjected to different performance standards. Supervisor opinions regarding trainee performance will invariably differ from supervisor to supervisor; however, allowing supervisors to use arbitrary criteria to evaluate trainee performance will

unnecessarily complicate the evaluation process and all but guarantee trainees will be held to different performance standards.

Item Identification

A comprehensive set of clinical skills, behaviors, and attributes representative of several theoretical competency domains compose the final item list. The majority of items on this newly constructed list are identical or conceptually similar to items commonly found in performance instruments and in the counseling literature (Bernard, 1997; Chan et al., 2004; Corey; 2004; Cromier & Cromier, 1991; Eriksen, & McAuliffe, 2003; Hackney & Cromier, 1994; Hill, 2004; Lumadue & Duffey, 1999; Miller & Rollnick, 2004; Myrick & Kelly, 1971; Oetting & Michaels, 1982; Robiner et al., 1994). These findings further emphasize the compatibility of the rehabilitation counseling field with other counseling related professions.

While rehabilitation counseling is closely related to other counseling professions, there is an emphasis on working with people with disabilities and reintegrating these clients into society. Due to this emphasis it was expected that the experts would identify several items fundamental to the rehabilitation counseling profession that are not commonly found on other instruments. The experts in this sample listed items such as “understanding the impact of disability,” “knowledge of career development,” “job development and placement skills,” and “understanding of and ability to develop accommodation strategies”. The identification of these rehabilitation counseling items highlights the uniqueness of our field and the importance of creating measures that can wholly account for the work of rehabilitation counselors.

Although an abundance of items were initially gathered through the Round 1 investigation (188 items), there were several items not identified by the experts that may be useful for clinical supervision evaluation. The items that were not reported but expected to be found are ones listed on other counseling performance measures, such as “student demonstrates

an awareness of power differences in the therapeutic relationship, and manages these differences therapeutically" (Kerl et al., 2002), "evoking and punctuating client strengths" (Erikson & McAuliffe, 2003), "improve client confidence/self-efficacy regarding change behavior" (Milner & Rollnick, 2004), "counselor refrains from using social conversation" (Hackney & Cormier, 2004), "counselor helped client to develop action steps for goal attainment" (Hackney & Cormier), and "counselor provided an opportunity for client to practice or rehearse action step" (Hackney & Cormier). Due to the closely related nature of rehabilitation counseling with other counseling fields, future investigations into supervision measures might consider items that are already being used on instruments from other counseling professions.

Items Consensus

As previously noted in Round 3, 106 of the 188 items (56%) resulted in a greater consensus than had been achieved during Round 2. Sixty eight of the remaining 69 items demonstrated either equal consensus or minimal divergence (.02 or less increase in standard deviations) from Rounds 2 to 3. Only one item, "Provides client with choices" demonstrated an increase in standard deviation greater than .02 (.07). This may be partially explained by the fact that this item had a Round 2 mean value almost directly in between 4 (Agree) and 5 (Strongly agree) (4.56). Therefore, more participants most likely decided to simply change their ratings from "Strongly agree" to "Agree."

Although the vast majority of items demonstrated "high" consensus, four items demonstrated only "moderate" consensus. These items include: "Healthy" (1.00), "Capable" (1.01), "Diagnose (with some assistance)" (1.06), and "Pleasure to work with" (1.20).

Three of the four items ("Capable," "Pleasure to work with," and "Healthy") were all personal characteristics. Participants may believe that these terms are too general and interpreting their meaning may be futile. One participant commented that:

> I don't know what many of these words mean. I know what I mean by them, but I don't know what others may mean by them. The shades of meaning of many of these words are too variable for me to interpret-and therefore they are not useful (to me).

The vast majority of the items identified in this study represent specific skills or behaviors for which participants may have a basic understanding. However personal characteristics are more likely to manifest in various ways through out clinical supervision and therefore participants are more likely to define these terms subjectively.

In addition, the term "Healthy" carries a certain connotation that may be less palatable to rehabilitation counselors who almost exclusively work with people with disabilities. Health is particularly variable and could imply several types including mental health, physical health, and/or functional capacity. Additionally "Capable" may imply that the trainee should reach a certain level of ability before successfully completing their clinical training. Supervisors may view the clinical portion of the training as developmental (Gizara & Forrest, 1999) and therefore may disagree that this item is useful for clinical evaluation. Finally, participants did not reach "high" consensus on the term "Pleasure to work with." In particular, this item appears to be highly subjective and therefore participants may believe this term is not useful for clinical supervision evaluation. Clinical supervisors recognize that the trainee's clinical competency is independent of whether they feel the student was a pleasure to work with. Quite simply, supervisors and trainees may not work well together, but this relationship should not necessarily determine the trainee's clinical ability.

The fourth item that demonstrated "moderate" consensus is "Diagnose (with some assistance)." Interestingly, not only did this item exhibit moderate consensus, but the item also had a Round 3 mean value of 3.59. This item may exhibit moderate consensus for a variety of reasons. First, some clinical supervisors may believe that diagnosing is not a basic function of rehabilitation counseling. Traditionally rehabilitation counselors focus in the vocational

assessment and placement arena. Although some clients may show signs of mental health disorders, some participants may not believe it is the role of rehabilitation counselors to "diagnose" a client. On the other hand, some participants may be affiliated with rehabilitation counseling programs that serve as vehicle for licensed professional counselors or mental health counselors. Therefore, this item may simply reflect the overall diversity of the rehabilitation counseling profession.

While some items remained at "moderate" consensus, five items increased from "moderate" consensus in Round 2 to "high" consensus in Round 3. Of these items, only "Manages own mental health disabilities" and "Demonstrates emotional stability" also increased their mean average from Round 2 to Round 3. The increased mean score in Round 3 suggests that more participants agreed that these items are useful for clinical supervision evaluation. Other items related to the trainees' self care, "Recognize the importance of self care," "An awareness of when their own personal issues are interfering with their ability to learn and practice in a professionally and ethically responsible manner," and "Willingness to seek out professional counseling for themselves when it is needed in order for them to function ethically and professionally," reached "high" consensus before Round 3. Interestingly, the three items that demonstrated initial "high" consensus do not suggest that the trainee *should* manage any mental health or emotional issues, but rather that the student simply be *aware* of and be *willing* to seek help for these issues. In other words, some participants may have initially believed that it is adequate for students to be seeking professional help for these issues, but that these issues did not necessarily have to be resolved in order to receive professional endorsement.

Section G.3.a of the CRCC code of professional ethics (2002) clearly states that educators should be aware of the student's personal limitations that might affect performance and help

secure remedial assistance when needed, and dismiss students whose personal limitations cause them to be unable to provide competent service. Ironically, of all the items identified in this study, it would appear that "Manages own mental health disabilities" and "Demonstrates emotional stability" should have demonstrated initial "high" consensus because they are the most closely related to any evaluation guidelines stated in the rehabilitation counseling professional. Ultimately, both "Demonstrates emotional stability" and "Manages mental health disabilities" achieved both "high" consensus (.51 and .62 respectively) and a high mean (4.59 and 4.56 respectively). These findings reinforce the fact that rehabilitation counseling educators are bound by professional ethics to ensure that trainees manage their mental health issue and are emotionally stable.

Unlike the previous two items, the remaining three items ("Balance the needs of the faculty supervisor and site supervisor," "Moderating/judging," and "Takes good notes during session") had mean scores that decreased from Round 2 to Round 3. Additionally, the mean value for each of these three items fell between 3 (neutral) and 4 (agree). Thus, participants agreed that these items were less useful for clinical supervision evaluation.

More specifically, clinical supervisors may believe it is inappropriate for trainees to be responsible for addressing any conflicts between the department and training site and therefore feel that the trainee should not balance the needs of their faculty supervisor and site supervisor. Moreover, many supervisors may feel that this item is simply not representative of clinical performance. Regarding the item "Moderating/judging," participants may interpret this term differently. The term carries a strong connotation with which many educators may disagree. Specifically, some participants may interpret the term as "judging the client," which conflicts with the fundamental principles of rehabilitation counseling. On the other hand, other

participants may see the value of judging certain situations (e.g. a client situation). In these instances, the trainee is not judging the person per se, but is making judgments about information. Lastly, the item "Takes good notes during session" may have achieved "high" consensus, but a lower mean rating, because more participants may have felt that note taking is inappropriate during the counseling session. Clinical supervisors may view note taking as an unnecessary distraction to the trainee, while others may simply feel that writing is simply not related to clinical performance.

Limitations

The first limitation to this study is the rehabilitation counseling educator sample size. This Delphi study solicited rehabilitation educators through the National Council of Rehabilitation Education (NCRE) listserv. The NCRE is the leading professional association for rehabilitation educators and represents over 90 higher education institutions and 600 individual memberships (NCRE, 2008). While it is unrealistic to identify the exact number of NCRE members who would qualify for this study, it was anticipated that a sizeable number of NCRE members met the inclusion criteria and would participate. Although it is unrealistic to identify the specific number of rehabilitation counseling educators who were eligible to participate in this study, a smaller sample size was attained than expected.

Of the five rehabilitation counseling Delphi studies found within the literature review, only two (Rubin et al., 1998; Thielsen & Leahy, 2001) had a Round 1 sample size near or below the sample size attained in this investigation (23 and 18 respectively). Rubin et al. targeted 23 experts with a Round 1 response rate of 100%; whereas Thielsen and Leahy targeted 20 experts with a Round 1 response rate of 90%. Unlike this present study, both Rubin et al. and Thielsen and Leahy initially identified a select number of experts to participate in Round 1 of their studies. Other rehabilitation counseling Delphi studies have included Round 1 sample sizes of

31 (Shaw et al., 2006), 44 (Currier et al., 2001), and 111 (Hakim & Weinblatt, 1993). While the Round 1 sample size for this study may appear small, Okoli & Pawlowski (2004) suggest that the size of a Delphi panel typically ranges between 10-18 experts. Therefore, the final number of panel experts in this study is consistent with a typical Delphi study.

In addition to the Round 1 sample size, Delphi studies are inherently susceptible to participant attrition. Because the Delphi procedure requires experts to respond to several iterations of questions over time, it is uncommon for all participants to complete every round. For this study, 18 of the 21 experts from Round 1 completed Round 2 (85.7% response rate), and 17 of the 18 participants from Round 2 completed Round 3 (94.4% response rate). Participant attrition between evaluation rounds (here reported as rounds 2 and 3) may be of particular concern because of its effect on item stability calculations (i.e. the item mean difference between evaluation rounds). When high attrition rates occur between these rounds item stability becomes less reliable. In comparing the response rate between evaluation rounds of this study to other rehabilitation counseling Delphi studies, the results are encouraging. This study resulted in a response rate between evaluation rounds of 94.4%, whereas other rehabilitation counseling Delphi studies have yielded response rates of 68.8% (Currier et al., 2001), 71.4% (Shaw et al., 2006), 80.2% (Hakim & Weinblatt, 1993), 89.0% (Thielsen and Leahy, 2001), and 90.0% (Rubin et al., 1998). Even though participant attrition is always a concern during Delphi studies, the level of attrition for this study is comparable to other Delphi studies in the rehabilitation counseling literature. However, the attrition level from Round 2 to Round 3 may have slightly impacted the standard deviation calculations. Because the standard deviation calculation is effected by the size of the sample, 17 participants (rather than 18) may result in small, but naturally occurring change in standard deviation. Therefore, any small incremental change in

standard deviation (e.g. plus or minus .02) may be the result of the decreased sample size rather than item convergence or divergence.

In addition, only seven of the 10 CORE defined regions are represented in this study. However, since regions are defined according to geographical location, different regions contain an unequal number of rehabilitation education institutes. Of the three regions not represented, region II contains 10 schools, region VIII contains three schools, and region IX contains seven schools. Therefore the potential number of eligible participants from a particular region may be considerably smaller than other regions. Lastly, 10 of the original 23 participants (47.6%) in this study were from region IV (southeast). This region also has more rehabilitation counseling education programs (22) than any other region. Although an abundance of participants from one region may typically cause alarm, it is not apparent why participants from this region (or any other region) would respond in a manner that is inconsistent with other rehabilitation counseling supervisors. Therefore, it is believed that an over representation of participants from this region would not necessarily bias the results.

Implications

Education

Clinical competency dimensions and benchmarks

Within the rehabilitation counseling profession, researchers have extensively written about professional competence in a variety of arenas (e.g. multicultural). However, one area that has received little attention from the educator's perspective is clinical supervision. With the exception of two clinical supervision models (Maki & Delworth, 1996; Schultz, Copple, & Ososkie, 1999), the rehabilitation counseling literature offers little related to clinical supervision competency criteria.

Because the clinical portion of rehabilitation counseling training reflects how the trainee will most likely perform in the field, it is perhaps the best opportunity for the supervisor to evaluate the trainee's interpersonal and intrapersonal functioning. Thus, the rehabilitation counseling profession will be well served to identify a comprehensive list of trainee skills, personal characteristics, and other professional attributes useful for clinical supervision evaluation. The findings from this study will have considerable implications for evaluating trainee competence during clinical supervision, as well as building upon existing rehabilitation counseling supervision models.

During the clinical portion of the program, supervisors must fulfill administrative and evaluative duties as well as address the trainee's inter- and intrapersonal characteristics that manifest throughout clinical training (Falvo & Parker, 2000). When students begin practicum or internship, professional and personal expectations should be clear (Falvo &Parker). To help clinical supervisors fulfill these and other supervisory roles, an extensive list of skills, behaviors, and attributes will allow clinical supervisors to conceptualize and evaluate trainee performance across multiple competency dimensions. According to Kaslow, Rubin, Bebeau, Leigh, Lictenberg, Nelson et al., 2007, "benchmarks can capture the minimal level of each competency for each stage of professional development and guide our conceptualization of competent and problematic performance" (p.481).

Therefore, the general language used by CORE and CRCC to ensure rehabilitation education programs endorse professionally competent and personally suitable trainees can be further understood as specific competence dimensions, and more importantly specific competency criteria. For example, the findings suggest that clinical supervisors may find it useful to examine several dimensions including the trainees' general counseling skills (e.g.

ability to present open-ended questions; reframing; affirmation), critical thinking skills (e.g. identifies client themes), intervention skills (e.g. establishes clear, measureable goals; evaluates interventions), counseling session management (e.g. provides purpose of counseling session; exhibits control of session), behavior during clinical supervision (e.g. appropriate case notes; open to supervisory feedback), personal attributes exhibited during the counseling session (e.g. genuine; non-judgmental), and professional behaviors (e.g. has appropriate boundaries; empowers the client).

Much of the recent force behind identifying, training, and assessing professional competence comes from the psychology literature (Elman, Illfelder-Kaye, & Robiner, 2005; Kaslow, 2004; Kaslow, Borden Collins, Forrest, Illfelder-Kaye, Nelson et al., 2004; Kaslow, Leigh, Smith, Bebeau, Lictenberg, Nelson, Portney, et al., 2007; Rubin, Bebeau, et al., 2007; Kaslow, Rubin, Forrest, Elman, Van Horne, Jacobs, et al., 2007). As a whole, this body of literature offers a series of ideas, principles, and proposals to aid psychology programs in assessing and improving current and future professional competence. Although the overall focus of the literature relates to assessing a set of foundational, core, and specialty competencies throughout the breadth of psychologists' professional development, many of the proposed standards are applicable to a more narrowly defined area of training such as clinical supervision.

According to several researchers (Kaslow, 2004; Kaslow, Rubin, Bebeau, et al., 2007), optimal assessment of professional competence includes a multi-trait approach. Multi-trait analysis refers to concurrently assessing the trainee's knowledge, skills, attitudes, performance, and ability to integrate these components across all competence domains. According to Kaslow, Rubin, Bebeau, et al., the assessment process should include the evaluation of individual and integrated competencies with multiple traits being evaluated simultaneously. When applying the

concept of multi-trait evaluation to the area of rehabilitation counseling clinical supervision, the findings from this study identify a variety of competency dimensions as well as specific performance criteria and personal attributes that will allow clinical supervisors to holistically assess the trainee's counseling competency.

Although these clinical dimensions are apparent, albeit theoretical, they provide a comprehensive framework for evaluating how students have integrated and applied their training to the counseling session. Furthermore, the performance indicators identified from this study provide specific behaviors and attributes which represent those dimensions. Thus, these research findings target, arguably, the most fundamental aspect of rehabilitation counseling training: the counseling session. With better defined dimensions of counseling competence, rehabilitation counseling programs can ensure that trainees are held to the highest standards of the profession, thus improving the gate-keeping process for their profession and ensuring novice rehabilitation counselors are meeting the needs and expectations of their future clients.

In addition to general evaluation applications, the findings from this study can also be used to supplement existing rehabilitation counseling supervision models. Currently, the rehabilitation counseling literature offers two clinical supervision models that describe the interaction between counseling trainee and supervisor. First, Maki and Delworth's Structured Developmental Model (SDM) helps the supervisor catalog the trainees' professional development by comparing his or her motivation, autonomy, and awareness relative to eight competency domains. By conceptualizing these internal processes against the various competency domains, the supervisor can classify the trainees' progress according to one of four developmental stages (Level 1, Level 2, Level 3, and Level 3 Integrated). Depending on the

level of development, the model suggests various strategies to help supervisors facilitate the counselor's development.

The findings from this study can be used to supplement the eight competence domains found in the SDM. Specifically, the SDM categorizes the domains into one of two groups: (a) primary domains, and (b) process domains. Primary domains, also known as meta-domains, include: (a) sensitivity to individual differences, (b) theoretical orientation, and (c) professional ethics and are continually examined during the counselor's development. The remaining domains, known as process domains, include: (a) interpersonal assessment, (b) client assessment within the environment, (c) case conceptualization, (d) treatment goals and plans, and (e) intervention strategies (Maki & Delworth, 1995). While these domains are clearly organized to reflect the various professional and personal processes found within a counseling session, they fail to provide specific criteria useful for clinical competency evaluation. However, the findings from this study can be used to help expand the eight competency domains to include specific, behavioral criteria. Once each domain is defined by a cohesive set of specific competency criteria, supervisors can more accurately and consistently evaluate the trainees' professional development.

Like the SDM, the Integrated Model for supervision proposed by Schultz et al. (1999), provides a thorough and practical model for the novice or expert supervisor. Because the working alliance between supervisor and trainee is critical, the Integrated Model for supervision proposes that the supervisor adopt a particular supervisory role (teacher, counselor, and consultant) to suit the needs of the trainee as well as foster the professional development of the student. Generally, the supervisor focuses on three areas of trainee competence (intervention skills, conceptualization skills, and personalization skills) across three Phases of professional

development (technical, integrative, and consultative). The amount of attention each competence domain receives depends on the specific developmental phase of the trainee. For example, Phase I (Technical), focuses on intervention and personalization skills such as client centered techniques as well as appropriate attitudes, self-trust, and internal evaluation processes, but conceptualization skills are generally reserved for advanced phases of development. Unlike the SDM (Maki & Delworth, 1995), the Integrative Model for Supervision (Schultz et al., 1999) provides some specific competency criteria for trainee evaluation. However, most of the specific competency criteria pertain to the trainee's personal attributes (e.g. willingness to experience, develop trust in self, enhance internal evaluation, demonstration of unconditional positive regard, acceptance, and accurate empathy), while clinical skills are described more as generic domains (e.g. counseling micro skills, case conceptualization). Therefore, the findings from this study can not only supplement the existing competency criteria (particularly micro counseling skills and case conceptualization), but also allow the supervisor to assess the trainee's professional development across more competency domains.

Supervision evaluation continuity

Although supervisors rely on a variety of sources to evaluate a trainee (e.g. site supervisor evaluation), they typically depend on more direct observations such as reviewing counseling session tapes and clinical supervision exchanges to evaluate the trainee's professional development. The evaluation process is largely dependent on two separate, yet related, components: (a) the criteria used to evaluate trainees, and (b) the supervisor's opinion regarding trainee performance. While supervisory opinion is inherently variable, the criteria used to evaluate trainee performance can be made relatively consistent throughout various training programs. Rather than supervisors using arbitrary criteria or criteria developed by their program

to evaluate clinical competency, a set of empirically based competency criteria, standards, and expectations might provide a foundation to ensure increased continuity across programs.

Establishing a comprehensive set of competency criteria not only provides all supervisors a theoretical framework to evaluate the trainee's clinical performance holistically, but also helps to ensure evaluation continuity between supervisors. Currently, rehabilitation education programs are free to develop their own competency criteria to define the parameters of professional competence and personal suitability. Although some differences in evaluation criteria are necessary to accommodate the specific goals of the program, the rehabilitation counseling profession would be better served to first identify specific clinical expectations of trainee performance (Robiner et al., 1993) and then allow individual programs to build upon those fundamental criteria with additional skills to suit their program needs and goals. Regardless of which rehabilitation counseling program trainees attend or which clinical site they complete their practicum or internship; trainees could be evaluated against the same minimal set of competency criteria. Therefore, professional organizations, like CORE, can use the findings from this study as a foundation for expanding the concepts of minimal professional performance and personal expectations as well as offer additional benchmark items for continued professional development.

Improving communication between supervisor and trainee

In addition to potentially improving evaluation continuity among supervisors, the findings from this research study could positively impact the supervision process. Lehrman-Waterman and Ladany (2001) found that the processes of effective goal setting and feedback positively correlated with the supervisor/trainee working alliance, trainee self efficacy, and the trainees' overall satisfaction with supervision; leading the authors to state that "new and current approaches (to supervision) may need to reassess and highlight the importance of goal setting

and feedback" (p.175). Supervisors who provide feedback based on explicit expectations or criteria (i.e. clearly describing specific behaviors) have the potential to be better understood and received by students (Freeman, 1985), while supervisors who provided vague, global, and/or abstract feedback have been considered "lousy" (Magnuson, Wilcoxon, & Norem, 2000).

Clinical supervision typically requires the supervisor to engage in two types of evaluation processes: (a) formative and (b) summative (Robiner et al., 1993). Formative evaluation is the process whereby supervisors provide direct feedback to the trainees during supervision to help foster their professional development. On the other hand, summative evaluation is the more administrative process where the supervisor assesses the trainees' overall competence to ensure the student qualifies for professional endorsement. The authors note that supervisors and trainees oftentimes view summative evaluation with apprehension and consequently dislike the summative evaluation process (Robiner et al., p.4). However, Bernard and Goodyear (2004) caution that all aspects of clinical supervision, including the formative evaluation process, have inherent evaluative undertones. For example, during formative evaluation, supervisors continuously send spoken and unspoken evaluative feedback to students; "some of the supervisor's evaluative comments are deliberately sent (encoded) by the supervisor to the trainee; others are received (decoded) by the trainee and may or may not be an accurate understanding of the supervisor's assessment" (Bernard & Goodyear, p.20).

To improve the formative and summative evaluation processes, supervisors should communicate clear competency criteria to the trainee during supervision. Therefore, the findings from this study can directly impact the supervisory process by improving the level and clarity of supervisor feedback and establishing clear expectations for student performance. Supervisors can use the findings from this research study to identify a comprehensive list of specific trainee

skills and attributes from a variety of competency domains. Once identified, supervisors can communicate these criteria to students prior to clinical supervision. Therefore, trainees will have a clearer understanding of what is expected of them during clinical supervision and supervisors will be able to communicate clear feedback to the student.

Public Policy

Association of American Colleges and Universities / Council for Higher Education Accreditation

In addition to specific educational implications, the findings from this study may also have broader implications in shaping public policy. As part of their 2008 agenda, the Association of American Colleges and Universities (AAC&U) and the Council for Higher Education Accreditation (CHEA) state that it is imperative for the higher education community to improve the quality of education in the United States so that graduates are "prepared to contribute to society as knowledgeable, engaged, and active citizens" (p.1). In order to aid universities and colleges to monitor the quality of student development, the organizations outlined a series of principles and actions to help ensure that the collegial experience is challenging for students, and assist higher education institutes in becoming more accountable and transparent.

AAC&U and CHEA posit that although the responsibility to establish better standards in higher education is shared among a variety of organizations, associations, and governing bodies, it is the colleges and universities themselves that must set a precedent in helping the American higher education system maintain its designation as one of the world's foremost leaders. Specifically, AACH and CHEA propose that the various organizational tiers within each university (i.e. university, college, department, division) "should develop ambitious, specific, and clearly stated goals for student learning appropriate to its mission, resources, tradition, student body, and community setting" (p.2). As such, the findings from this research study will

help various counseling and psychology programs establish clearer expectations and higher standards for student performance.

Specifically, an exhaustive list of specific counseling skills, personal attributes, and professional behaviors will allow programs to conceptualize the various aspects of counselor development more holistically. Thus, supervisors and trainees alike will have a clearer understanding of what specific skills and attributes are being evaluated. Furthermore, by identifying a comprehensive list of evaluation criteria, clinical supervisors will be able to develop higher standards for student performance. Programs could begin to identify the specific skills and behaviors related to various levels of student performance. Simply stated, counseling programs can move toward the vision of AAC&U and CHEA by evaluating trainee performance across specific counseling skills, personal attributes, and professional behaviors; thus ensuring clear, ambitious goals for student performance as well as program accountability.

Council on Rehabilitation Education / Commission on Rehabilitation Counseling Certification

While the principles and actions set forth by AAC&U and CHEA call for universities and colleges to lead the way in maintaining America's global position in higher education, perhaps professional organizations and specific accrediting bodies also have an obligation to assist in identifying reasonable expectations and rigorous standards for professional development. As previously discussed, the Council on Rehabilitation Education (CORE) and the Commission on Rehabilitation Counseling Certification (CRCC) both acknowledge the need for rehabilitation counseling trainees to demonstrate a level of professional competence and personal suitability. Whereas the CORE accreditation standards basically outline a series of general curriculum requirements, knowledge domains, and educational outcomes for student performance, the CRCC code of professional ethics addresses the educator's responsibility to be aware of the

student's academic and personal limitations. Although this literature acknowledges the educator's role in trainee development and provides a basic foundation for assessing rehabilitation counselor ability, both are limited in terms of trainee evaluation. Specifically, the performance outcomes provided by CORE are too general for clinical supervisors to truly evaluate a rehabilitation counseling trainee. Furthermore, neither CORE nor CRCC define any criteria related to personal suitability; thus this concept is left to broad interpretation.

Although the policies of CORE and CRCC are limited, the findings from this study could have implications for how the rehabilitation counseling profession conceptualizes and defines trainee competence. With a clearer understanding of the skills, attitudes, and behaviors rehabilitation counseling educators feel are useful for clinical supervision evaluation, professional organizations like CORE and CRCC can reexamine existing performance outcomes to assure that key components of counseling competency are captured with their criteria and also provide programs guidance about how to assess rehabilitation counseling performance and personal suitability. Furthermore, these research findings may initiate dialogue among rehabilitation counseling educators regarding the minimum skills and behaviors a trainee should be able to demonstrate in order to qualify for professional endorsement.

Overall, the findings from this study can have implications for organizations at both the national and professional levels. On the one side, rehabilitation counseling programs can uphold the ideals of AAC&U and CHEA by ensuring trainees are subjected to clear, rigorous standards, and on the other side, rehabilitation counseling organizations can improve trainee evaluation and make sure people with disabilities are being served by competent, well-rounded individuals.

Future Research

As outlined in chapter 2, rehabilitation counseling educators face a variety of challenges when evaluating a trainee during clinical supervision. Moreover, professional organizations such

as the Council on Rehabilitation Education and the Commission on Rehabilitation Counseling Certification provide little guidance for evaluating clinical competency. Thus, rehabilitation counseling programs have developed and relied upon in-house instruments to evaluate trainee performance. Consequently, clinical competency standards may vary from program to program resulting in inconsistent trainee evaluation.

The findings from this study resulted in a comprehensive item bank of skills, behaviors, and personal attributes to consider when evaluating rehabilitation counseling trainees during clinical supervision. This item bank will allow rehabilitation counseling educators to have a thorough understanding of specific activities relating to the clinical performance. As such, professionals should be able to refer to this item bank for use in future research on clinical supervision evaluation. Although 10 theoretical competency domains were formed based on a content analysis of the data, a factor analysis is necessary to determine whether the generated items are actually representative of rehabilitation counseling clinical performance as well as whether separate clinical competency constructs exist. Such an investigation will allow for the creation of a measure for evaluating trainee clinical competency.

A validated clinical supervision instrument could help make the clinical supervision evaluation process more consistent as well as assist educators and trainees to catalog the student's professional development. Although clinical supervision instruments have been previously developed, researchers have yet to validate a clinical supervision instrument using Item Response Theory methodologies. To accomplish this task, supervisors should evaluate trainee performance using the items identified in this study. Next, a factor analysis should be performed to empirically determine if the items make up a unidimensional construct or multiple constructs. Item response methodologies, such as Rasch analysis, would then be applied to each

construct to determine item fit and the hierarchal ordering of the items. Determining multiple developmental hierarchies of clinical performance will provide a basis for understanding trainee development. Once the instrument is fully developed, its usability and helpfulness can be tested among supervisors.

In addition to developing a clinical supervision instrument, future research could be conducted to examine how a validated and reliable instrument impacts the clinical supervision experience. More specifically, a clinical supervision instrument can help supervisors establish appropriate learning goals and provide specific feedback to trainees about their performance. As previous research has suggest, these two practices have been positively correlated with improving the supervisory working alliance, enhancing the trainee's self efficacy, and increasing the trainee's overall satisfaction with supervision (Lehrman-Waterman & Ladany, 2001). Building upon this research, the researcher can test how a Rasch validated clinical supervision instrument impacts the supervisory relationship as well as trainee performance.

Conclusion

Although the clinical supervision process is a critical component of student preparation and affords educators the opportunity to identify unsuitable trainees, rehabilitation counseling literature and professional organizations provide little guidance related to specific performance expectations and evaluation criteria. Consequently, training programs may rely solely on the supervisor's own clinical judgment or use unstandardized, in-house evaluation instruments to evaluate clinical performance. As a result, trainee evaluation during clinical supervision may differ from program to program.

Despite this variability, rehabilitation counseling educators have identified and obtained consensus on 183 items representative of clinical performance. These items were subsequently organized into 10 theoretical competency domains including general counseling session items,

process skills, conceptualization/assessment items, identifying goals/treatment planning, personal attributes, supervision items, self care items, professional behavior, general professional development, and other items. With the identification of an exhaustive list of clinical performance items, supervisors can better conceptualize trainee competency, offer specific, behaviorally defined feedback to the trainee, and establish realistic goals to aid in the trainee's professional development.

While identifying items for clinical assessment can improve the supervision process, future research is needed to validate a clinical supervision instrument. Although a variety of clinical supervision instruments exist, no instrument to date has been validated with Item Response Theory (IRT) methods (e.g. Rasch analysis). The advantage of these methodologies compared to classical validation methods is considerable. Rather than relying on a total score, IRT validated instruments do not require the student to demonstrate each item and therefore is flexible enough to accommodate all levels of students who train at various practicum/internship sites. Moreover, an IRT validated instrument would arrange items within each competency domain on a hierarchy from least to most difficult, thereby allowing supervisors to have an empirical understanding of trainee development.

APPENDIX A
DELPHI ROUND 1 SURVEY

Dear Rehabilitation Counseling Educators,

The Rehabilitation Science Program at the University of Florida is conducting a research study titled, "Identifying Benchmark Competency Criteria for a Rehabilitation Counseling Clinical Supervision Instrument: A Delphi Study." Clinincal supervision is vital to professional gatekeeping and has emerged as an independent entity with its own theories, standards, and research. Despite the importance of the supervision process, various accrediting bodies and standards of practice provide little guidance regarding specific competency criteria for trainee evaluation, thus rehabilitation counseling programs have considerable latitude when evaluating graduate level trainees. This discrepancy complicates trainee evaluation/remediation and may hinder supervisors from identifying underdeveloped students in rehabilitation counseling programs. Therefore, the purpose of this study is to aid rehabilitation counseling educators and trainees during clinical supervision by identifing and reaching consensus on specific counseling skills, personal attributes, and professional behaviors that are useful/appropriate for clinical supervision evaluation. Rehabilitation counseling educators agreeing to participate will complete an online, three round Delphi study.

Participants will be asked to complete a three round, online Delphi study. The Delphi procedure allows researchers to elicit and converge anonymous expert opinion by providing systematic feedback through a series of rounds. The first round of the Delphi study is included as part of this initial survey. This round asks participants to provide an exhaustive list of specific counseling skills, personal attributes, and professional behaviors that would be "useful/appropriate" for a clinical supervision evaluation instrument. Once the Round 1 data has been collected and analyzed, the participants will receive a second round of questions where they simply rate the usefulness/appropriateness of all responses identified from the first round on a five point Likert scale. After the Round 2 ratings have been collected and analyzed (means and standard deviations), the Round 3 questionnaire will be developed. Round 3 of the Delphi will include the overall group calculations, as well as the participant's original ratings (participants will not receive other participant's personal ratings, only their own). Participants will then compare their original ratings against the group statistics and have the opportunity to re-rate their original responses (Round 3). Upon completion of the Round 3 ratings, final responses will be calculated and compared to pre-determined consensus criteria.

This study involves collecting the expert opinion of rehabilitation educators who supervise graduate students during their practicum and/or internship. If you agree to take part in this study, you will be asked to participate in an anonymous, 3 round Delphi study. It is anticipated that the total amount of time to complete all 3 rounds of the Delphi will not exceed 3 hours (Round 1 - 1.5 hours; Round 2 - 1 hour; Round 3 - .5 hours). However, when considering the time associated with recruiting participants, analyzing the data, and allowing participants time to complete each round, the entire Delphi process may take up to 3 months. There are no risks or discomforts by participating on this study and participants may withdraw at any time without consequence. There will be no compensation offered for your participation. Although there will be no direct benefits for participating in this study, rehabilitation counseling educators will contribute to the greater good of the profession by helping to improve the clinical supervision assessment process and aiding in the professional development of trainees.

Additionally, only authorized persons from the University of Florida involved in this research study have the legal rights to review the research records and will protect the confidentiality of those records to the extent by law or court order. If the results of the research are published or presented, all expert identities will remain anonymous. For questions regarding this study, please contact Michael Moorhouse, MHS, CRC at (352) 273-6491 or Linda Shaw, Ph.D at (352) 273-6045. If you have any questions regarding your rights as a research subject, you may contact the Institutional Review Board (IRB) office at (352) 392-0433.

In order to be eligible for this study, participants must satisfy three inclusion criteria. First, educators should have supervised a minimum of 15 rehabilitation counseling students during practicum or internship. Next, educators should have supervised at least three semesters of practicum or internship. Finally, educators should have supervised at least three students during practicum or internship within the last three years.

*** By signing your name below (electronically), you acknowledge that you have read and understood the informed consent and wish to proceed with the survey. If however you decide that you no longer wish to participate now or at anytime during the survey, you may exit the survey without consequence.**

*** Please enter your email address (required)**

Please identify your position

- ◯ Assistant Professor/Tenured Track
- ◯ Assistant Professor/Non-Tenured Track
- ◯ Associate Professor
- ◯ Full Professor
- ◯ Professor Emeritus
- ◯ Adjunct Faculty
- ◯ Other

Please identify the region your school is associated with.

- ◯ Region I (Assumption, Boston, Salve Regina, Springfield, U. of Maine-Farmington, U. Mass-Boston, U. of Souther Maine)
- ◯ Region II (Cornell, Hilbert, Hofstra, Hunter, SUNY-Albany, SUNY-Buffalo, St. John's, Syracuse, U. of Medicine & Denistry of NJ, U. Puerto Rico, Pontifical Catholic U. of Puerto Rico)
- ◯ Region III (Coppin St., East Stroudsberg, George Washington, Pennsylvanis State, U. Maryland, U. Maryland Eastern Shore, U. of Pittsburgh, U. Scranton, Virginia Commonwealth, West Virginia)
- ◯ Region IV (Auburn, East Carolina, Florida Atlantic, Florida State, Fort Valley State, Georgia State, Jackson State, Mississippi St., North Carolina Agricultural & Technical St., South Carolina St., Thomas, Troy State, U. Alabama, U. Florida, U. Kentucky, U. Memphis, U. North Carolina-Chapal Hill, U. North Florida, U. of South Carolina, U. South Florida, U. Tennessee, Winston-Salem St.)
- ◯ Region V (Bowling Green, Illinois Institue of Technology, Kent St., Michigan St., Minnesota St.-Mankato, Northeastern Illinois, Northern Illinois, Ohio St., Saint Cloud St., Southern Illinois-Carbondale, U. Illinois, U. Wisconsin-Madison, U. Wisconsin-Milwaukee, U. Wisconsi-Stout, Wayne St., Western Michigan, Wilberforce, Wright St.)
- ◯ Region VI (Arkansas St., Arkansas Tech., East Central, Langston, Louisiana St., Southern, Stephen F. Austin St., Texas Tech, U. Arkansas-Fayetteville, U. Arkansas-Little Rock, U. North Texas, U. Oaklahoma, U.Texas-Austin, U. Texas-Pan American, U. Texas Southwestern Medical Center, Western New Mexico)
- ◯ Region VII (Drake, Emporia St., Maryville U. St. Louis, U. Iowa, U. Missouri)
- ◯ Region VIII (Montana St.-Billings, U. Northern Colorado, Utah St.)
- ◯ Region IX (Cal St.-Fresno, Cal St.-Los Angeles, Cal St.-Sacramento, San Diego St., San Francisco St., U. Arizona, U. Hawaii-Manoa)
- ◯ Region X (Portland St., U. Idaho, Western Oregon, Western Washington)

Please identify all your certifications and licenses.

- ☐ CAP
- ☐ CCM
- ☐ CDMS
- ☐ CLCP
- ☐ CRC
- ☐ CVE
- ☐ LMHC
- ☐ LPC
- ☐ NCC

Other (please specify)

Please identify the total number of master's level rehabilitation counseling students have you supervised during their practicum or internship?

Please list the total number of semesters you have supervised master's level rehabilitation counseling students?

Have you supervised at least 3 master's level rehabilitation counseling students during practicum or internship within the last 3 years?

◯ Yes ◯ No

Think about some of your previous students over the years who demonstrated either exceptional or poor counseling ability. With these students in mind, please write an exhaustive list of specific counseling skills (basic and advanced), trainee characteristics, abilities, or attributes that would be useful or appropriate for evaluating a rehabilitation counseling trainee during clinical supervision.

In addition to your responses, please feel free to add any comments or elaborate on any of your responses. Your comments will remain anonymous but may be included in the Round 2 survey to help clarify items and/or aid other participants in their decision making.

APPENDIX B
ROUND 1 EMAIL TO REHABILITATION COUNSELING EDUCATORS

Dear Rehabilitation Counseling Educators,

The Rehabilitation Science Program at the University of Florida is pleased to announce a new research study titled, "Identifying Benchmark Competency Criteria for a Rehabilitation Counseling Clinical Supervision Instrument: A Delphi Study." As part of this study, we are soliciting the opinions of Rehabilitation Counseling educators who currently supervise or have previously supervised master's level trainees during practicum and/or internship. More specifically, we are looking to identify and draw consensus on an extensive list of counseling skills, behaviors, and personality traits that clinical supervisors would find useful and/or appropriate for a Rehabilitation Counseling clinical supervision instrument.

If you agree to take part in this study, you will be asked to participate in an anonymous, 3 round Delphi study. There are no risks or discomforts by participating on this study and participants may withdrawal at any time without consequence. There will be no compensation offered for your participation. Although there will be no direct benefits for participating in this study, rehabilitation counseling educators will contribute to the greater good of the profession by helping to improve the clinical supervision assessment process and aiding in the professional development of trainees.

The research team has been approved by both the National Council of Rehabilitation Education and The University of Florida Institutional Review Board. This research project has obtained permission to gain access to the NCRE membership for purposes of furthering the mission of the association. Additionally, only authorized persons from the University of Florida involved in this research study have the legal rights to review the research records and will protect the confidentiality of those records to the extent by law or court order. If the results of the research are published or presented, all expert identities will remain anonymous.

In order to be eligible for this study, participants must satisfy three inclusion criteria. First, educators should have supervised at least 15 rehabilitation counseling students during practicum or internship. Next, educators should have supervised at least three semesters of practicum or internship. Finally, educators should have supervised at least three students during practicum or internship within the last three years.

Your participation in this study is greatly appreciated. We understand your time limitations as a Rehabilitation Counseling educator and seek to conduct this study in a thorough and efficient manner. It is anticipated that the total amount of time to complete all 3 rounds of the Delphi will not exceed 3 hours (Round 1 - 1.5 hours; Round 2 - 1 hour; Round 3 - .5 hours). However, when considering the time associated with recruiting participants, analyzing the data, and allowing participants time to complete each round, the entire Delphi process may take up to 3 months.

If you are interested in participating, you may access the first round of the Delphi study at:

https://www.surveymonkey.com/s.aspx?sm=4263bzaxK7LtvuCwmk51pg_3d_3d. For questions regarding this study, please contact Michael Moorhouse, MHS, CRC at (352) 273-6491 or Linda Shaw, PhD at (352) 273-6045. If you have any questions regarding your rights as a research subject, you may contact the Institutional Review Board (IRB) office at (352) 392-0433.

APPENDIX C
INFORMED CONSENT

This study involves collecting the expert opinion of rehabilitation educators who supervise graduate students during their practicum and/or internship. If you agree to take part in this study, you will be asked to participate in an anonymous, 3 round Delphi study. It is anticipated that the total amount of time to complete all 3 rounds of the Delphi will not exceed 3 hours (Round 1 - 1.5 hours; Round 2 - 1 hour; Round 3 - .5 hours). However, when considering the time associated with recruiting participants, analyzing the data, and allowing participants time to complete each round, the entire Delphi process may take up to 3 months. There are no risks or discomforts by participating on this study and participants may withdraw at any time without consequence. There will be no compensation offered for your participation. Although there will be no direct benefits for participating in this study, rehabilitation counseling educators will contribute to the greater good of the profession by helping to improve the clinical supervision assessment process and aiding in the professional development of trainees.

Additionally, only authorized persons from the University of Florida involved in this research study have the legal rights to review the research records and will protect the confidentiality of those records to the extent by law or court order. If the results of the research are published or presented, all expert identities will remain anonymous. For questions regarding this study, please contact Michael Moorhouse, MHS, CRC at (352) 273-6491 or Linda Shaw, Ph.D at (352) 273-6045. If you have any questions regarding your rights as a research subject, you may contact the Institutional Review Board (IRB) office at (352) 392-0433.

In order to be eligible for this study, participants must satisfy three inclusion criteria. First, educators should have supervised a minimum of 15 rehabilitation counseling students during practicum or internship. Next, educators should have supervised at least three semesters of practicum or internship. Finally, educators should have supervised at least three students during practicum or internship within the last three years.

*** By signing your name below (electronically), you acknowledge that you have read and understood the informed consent and wish to proceed with the survey. If however you decide that you no longer wish to participate now or at anytime during the survey, you may exit the survey without consequence.**

APPENDIX D
ROUND 1 FRIENDLY REMINDER EMAIL

Dear Rehabilitation Counseling Educators,

This is a remind email to follow up on a research study being conducted by the Rehabilitation Science Program at the University of Florida titled, "Identifying Benchmark Competency Criteria for a Rehabilitation Counseling Clinical Supervision Instrument: A Delphi Study." As part of this study, we are soliciting the opinions of Rehabilitation Counseling educators who currently supervise or have previously supervised master's level trainees during practicum and/or internship. More specifically, we are looking to identify and draw consensus on an extensive list of counseling skills, behaviors, and personality traits that clinical supervisors would find useful and/or appropriate for a Rehabilitation Counseling clinical supervision instrument.

If you agree to take part in this study, you will be asked to participate in an anonymous, 3 round Delphi study. There are no risks or discomforts by participating on this study and participants may withdrawal at any time without consequence. There will be no compensation offered for your participation. Although there will be no direct benefits for participating in this study, rehabilitation counseling educators will contribute to the greater good of the profession by helping to improve the clinical supervision assessment process and aiding in the professional development of trainees.
The research team has been approved by both the National Council of Rehabilitation Education and The University of Florida Institutional Review Board. This research project has obtained permission to gain access to the NCRE membership for purposes of furthering the mission of the association. Additionally, only authorized persons from the University of Florida involved in this research study have the legal rights to review the research records and will protect the confidentiality of those records to the extent by law or court order. If the results of the research are published or presented, all expert identities will remain anonymous.

In order to be eligible for this study, participants must satisfy three inclusion criteria. First, educators should have supervised at least 15 rehabilitation counseling students during practicum or internship. Next, educators should have supervised at least three semesters of practicum or internship. Finally, educators should have supervised at least three students during practicum or internship within the last three years.

Your participation in this study is greatly appreciated. We understand your time limitations as a Rehabilitation Counseling educator and seek to conduct this study in a thorough and efficient manner. It is anticipated that the total amount of time to complete all 3 rounds of the Delphi will not exceed 3 hours (Round 1 - 1.5 hours; Round 2 - 1 hour; Round 3 - .5 hours). However, when considering the time associated with recruiting participants, analyzing the data, and allowing participants time to complete each round, the entire Delphi process may take up to 3 months.

If you are interested in participating, you may access the first round of the Delphi study at:

https://www.surveymonkey.com/s.aspx?sm=4263bzaxK7LtvuCwmk51pg_3d_3d. For questions regarding this study, please contact Michael Moorhouse, MHS, CRC at (352) 273-6491 or Linda Shaw, PhD at (352) 273-6045. If you have any questions regarding your rights as a research subject, you may contact the Institutional Review Board (IRB) office at (352) 392-0433.

APPENDIX E
AUDIT TRIAL

May 29, 2008

Combined the terms/phrases “empathy,” “empathetic,” “ability to convey empathy to clients,” “conveying empathy,” “feeling,” and “empathetic,” into “Empathetic / Convey empathy to clients”

Combined the terms/phrases “rapport building,” “building rapport,” and “develop rapport” into “Build rapport”

Split the phrase “engaging the client in the counseling process through attending and orienting” into two sections: “engaging the client in the counseling process through attending” and “orienting”

Split the phrase “being able to educate clients regarding what to expect out of the session and any referral information” into “being able to educate clients regarding what to expect out of the session” and “educates client regarding referral information”

Combine the terms/phrases “orienting,” “explains the counseling process to client,” and “being able to educate clients regarding what to expect out of the session” into “orient client to the counseling process”

Split “basic attending and observation skills” into two sections: “basic attending skills” and “observation skills”

Combined the terms/phrases “basic attending skills,” “listener,” “good attending,” “listening and responding,” “engaging the client in the counseling process through attending,” “demonstrating active listening,” “attending skills,” “active listening,” and “attending skills training” into “Active listening (e.g. attending to client; listening and responding)”

Combined the terms/phrases: “excellent observation skills,” “attention to detail,” “observation skills” and “good observational skills” into “Observational skills/attention to detail”

Combined the terms/phrases “non-verbal behavior” and “trainees must know how to use good non-verbal skill: eye contact, body position, attentive silence, voice tone, gestures, facial expressions, physical distance, touch” but took out “attentive silence” because it was not physical

Combined the terms/phrases “attentive silence,” “appropriate use of silence,” “good uses of silence,” and “appropriately uses silence” into “Appropriately uses silence”

Combined the terms/phrases “knowing how to set boundaries appropriately,” “appropriate boundaries,” and “set clear boundaries with client” into “Set clear boundaries with client”

Combined the terms/phrases “paraphrasing,” “know how and when to paraphrase” and “ability to paraphrase” into “Paraphrase client statements”

Interpret “non directive approaches to goal setting” as working with the client to set goals

Split the phrase “set attainable short and long term goals in accordance with client wishes” into three sections: “set attainable goals,” “set short and long term goals” and “set goals in accordance with client wishes”

Combine the terms/phrases: “set attainable goals” and “establishes goals that are measurable and realistic” into “Sets realistic, attainable goals”

Combined the terms/phrases: “identifies goals with client,” “goal setting that reflects the client’s perspective on wants and needs,” “set goals in accordance with client wishes” and “non-directive approaches to goal settings” into “Identify goals that reflect the client’s perspective”

Combined the terms/phrases “goal setting,” “trainees need to know how to implement constructive goal setting,” “developing goals,” “obtaining goals” and “set short and long term goals” into “Identify short and long term goals”

Split the phrase “controls and explores own feelings and personal thoughts about clients to increase understanding and to decrease interference in the counselor relationship” into “explores own feelings and personal thoughts about clients to increase understanding and to decrease interference in the counselor relationship” and “controls own feelings and personal thoughts about clients to increase understanding and to decrease interference in the counselor relationship”

Combined the terms/phrases “explores own feelings and personal thoughts about clients to increase understanding and to decrease interference in the counselor relationship,” “identified personal values and beliefs that may impact on ability to fulfill role of rehabilitation counselor,” “recognizes personally sensitive areas in counseling content and/or process,” “awareness of their own limitations, biases, and beliefs and how these impact the counseling relationship” and “lack of self awareness and impact on others” into “Recognizes how their personal limitations, biases, and beliefs impact the counseling relationship”

Split the phrase “recognition of the importance of self care and ready willingness to seek out professional counseling for themselves when it is needed in order for them to function ethically and professionally” into “recognition of the importance of self care” and “willingness to seek out professional counseling for themselves when it is needed in order for them to function ethically and professionally”

Split the phrase “actively keep in touch with and working on their own issues” into “actively keep in touch with own issues” and “actively work on own issues”

Split the phrase “personally knowing their own baggage and dealing with it” to “personally knowing with their own baggage” and “deal with own baggage”

Combined terms/phrases “actively keep in touch with and working on their own issues,” “self-awareness,” engages in self exploration,” “an awareness of when their own personal issues are interfering with their ability to learn and practice in a professionally and ethically responsible manner,” “demonstrates personal insight,” “personally knowing with their own baggage,” and “willingness to explore discomfort honestly” into “An awareness of when their own personal issues interfere with their ability to learn and practice in a professionally and ethically responsible manner”

Combined the terms/phrases “do self-work on issues that arise in counseling and supervision,” “emotional stability,” “actively work on own issues,” “self-care,” “ability to manage personal issues or make determinations regarding whether they should be in a master's program at this time in their lives,” “keep own personal problems out of counseling session,” and “deal with own baggage” to “Manage/work on personal issues that arise during counseling or supervision sessions”

Interpreted the phrase “an ability to demonstrate that their motivation for participating in required clinical learning experiences is not simply that it is required for their degree but that it is necessary for them in order to provide competent, professional, and ethical services for people with disabilities” as “Demonstrates genuine motivation to become a competent and ethical rehabilitation counselor”

Combined the terms/phrases “ability to show deep reflection of feelings,” “facilitates client expression of thoughts and feelings,” “demonstrating understanding of the client’s ideas, experiences, and beliefs through reflection of feelings and meanings of client statements,” “reflective listen,” “reflection,” “reflecting feeling,” “reflecting meaning,” “using reflections,” “reflection,” and “accurately reflect client feelings” into two phrases “Reflect feeling of client statements” and “Reflect meaning of client statements”

June 1, 2008

Combine the terms/phrases “confrontation,” “knowing when to use confrontation,” “confront” and “confrontation” to “knowing when to use confrontation”

Split the phrase “Uses supervision, including preparation, participation, and follow through” into three sections “prepares for supervision,” “participates in supervision,” and “follows through with supervision”

Split the phrase “Evaluates relevance, value, and meaning of feedback and implements changes as needed” into two sections “evaluates relevance, value, and meaning of supervisory feedback” and “implements feedback”

Combine the terms/phrases: and “follows through with supervision,” “ability to use supervision to improve their skills,” “how they make use of that feedback,” “implements feedback,” and “an

ability to demonstrate how they have incorporated feedback into their practice" into "Incorporates supervisor feedback into practice"

Combine the terms/phrases: "self-disclosing in a way that facilitates formation of an effective counseling relationship and serves to further client exploration," "appropriate use of self-disclosure," "using self-disclosure appropriately, " and " self disclosure" into "Uses self-disclosure appropriately"

June 2, 2008

Combine the terms/phrases: "receptivity to clinical supervision," "acceptance of feedback," "willingness to improve skills," "willing to incorporate supervisors' feedback into their practice," "openness to feedback," and "ability to take constructive feedback – some students become defensive" into "Non-defensive /receptive to clinical supervision"

Split the phrase "above average verbal and written expression" into two phrases "above average verbal expression" and "above average written expression"

Combine the terms/phrases: "report writing skills," "adequate case reporting skills," "above average written expression," "ability to write at a master's level, some students cannot write case notes," and "preparation of written reports, progress notes, and correspondence, emphasizing clarity, organization, and professional presentation" into "Preparation of written reports and progress notes (accurate, clarity, organization, professional presentation)"

Combine the terms/phrases: "genuineness" and "genuine" into the phrase "genuine"

Interpret the phrase "ability to approach all their clinical learning experiences openly and nonjudgmentally" as two personal characteristics exhibited during a counseling session: open and non-judgmental; and one characteristic during clinical supervision: open (open to supervisor feedback)

Place the phrase "open (open to supervisor feedback)" under the "Non-defensive /receptive to clinical supervision" item

Combine the terms/phrases: "the ability to suspend preconceived notions and judgments of human behavior," non-judgmental," "non-judgmental attitude," and "judgmental" into the term "non-judgmental"

Split the phrase/terms: "an ability to use counseling skills intentionally and to flex when needed" into two phrases "An ability to use counseling skills intentionally" and "Flex counseling skills when needed"

Interpret "flex counseling skills when needed" as "be flexible with counseling skills when necessary"

Split the phrase “open and closed questions” into two sections “open questions” and “closed questions”

Combine the terms/phrases: “open question” and “open ended questions” into “Uses open ended questions”

Combine the terms/phrases: “flexible,” “flexible (mental and emotional),” “adaptability is one of the most important attributes,” and “a trainee needs to be able to adapt and change to make the therapeutic relationship beneficial to the client” to “Flexible/adaptable”

Combine the terms/phrases: “closed questions” and “use close ended questions appropriately” into “Use close ended questions (when appropriate)”

Combine the terms/phrases “empowering,” and “empower the client,” “self-detemination,” and “ability to form empowering relationships with clients” into “Empowers the client”

Combine the terms/phrases: “ethical conduct,” “confidential,” “ethical,” “understands of ethical issues, including, for example, confidentiality, representation of competence and qualifications, loyalties, and informed consent,” “demonstration of ethical behavior - Showing up on site - some students do not realize this is required and some site managers allow this to go on,” and “understands ethics of counseling relationship” into “Understands/practices in ethical manner (i.e. confidentiality, representation of competence/qualifications, dual relationships, informed consent, appropriate boundaries)”

Combine the terms/phrases “showing up on site” and “being on time for practicum/internship” into “

Combine the terms/phrases: “providing client with choices” and “identifies and explores options with client” to “Identify and explore options with client”

Combine the terms/phrases: “minimal encouragers,” “using confirmations,” and “uses affirmations/positive reinforcement” into “Uses positive reinforcement/affirmations”

Split the phrase “requests guidance as needed while demonstrating openness to experimentation and risk taking” into two sections “requests guidance as needed” and “willing to experiment or take risks in session”

June 3, 2008

Combine the terms/phrases: “individualizing treatment,” “planning for interventions and services that will assist the client in his or her goal,” and “being able to treatment plan” into “Plan interventions and services that will assist the client in his or her goal (i.e. individualized treatment planning)”

Split the phrase: “assessing client traits, problems, and needs in a comprehensive and specific manner that emphasizes strengths and deficits in behavioral terms” into two sections “assess

client traits in a comprehensive and specific manner that emphasize strengths and deficits in behavioral terms" and "assess client problems in a comprehensive and specific manner"

Split the phrase: "a trainee should be aware of each client's individual characteristics and problems to be able to guide the therapeutic relationship to fit the client's needs" into two sections "a trainee should be aware of each client's individual characteristics" and "a trainee should be aware of each client's individual problems"
Combine the terms/phrases: "assess client traits in a comprehensive and specific manner that emphasize strengths and deficits in behavioral terms," "a trainee should be aware of each client's individual characteristics," "assess client's strengths and weaknesses" into the phrase "Assess client strengths and weaknesses"

Combine the terms/phrases: "assess client problems in a comprehensive and specific manner," "a trainee should be aware of each client's individual problems," and "indentify client problems/issues" into "Identify client problems"

Combine the terms/phrases: "demonstrating cultural sensitivity," "acceptance of difference," "becoming cultural proficient," and "awareness of cultural differences/influences" into "Aware of cultural differences/influences"

Combine the terms/phrases: "understanding the impact of disability" and "knowledge of disability and its myriad effects" into "Understanding the impact of disability"

Combine the terms/phrases: "structuring session to yield success" and "ability to continue to move session toward some therapeutic outcome" to "Continues to move session toward the therapeutic goal"

Combines the terms/phrases: "avoids using heterosexist, ablest, racist, and sexist language in interactions with other students, supervisors, clients, and other stakeholders in rehabilitation" and "use person first language" into "Uses appropriate language/terminology (e.g. person first language; avoids heterosexist, ablest, racist, and sexist language)"

Combines the terms/phrases: "demonstrates respect for clients and their point of view" and "refrains from imposing personal values" to "Demonstrates respect for client's values/beliefs"

Combine the terms/phrases: "Summarizing process dynamics, themes, activities, and milestones in the counseling relationship," "summarize," and "summarizing" into "Summarize"

Combine the terms/phrases: "provide feedback" and "provide accurate and honest feedback" into "Provide accurate feedback"

Combine the terms/phrases: "ask effective questions" and "know how and when to use questions" into "Ask effective questions"

Combine the term/phrases: "gives an accurate and balanced self-assessment of professional competencies," "development of the ability to self-critique accurately," and "assesses own

strengths and weaknesses" into "Identifies own strengths and weakness related to counseling performance/competency"

Combine the term/phrases: "conceptualize the client's life (i.e. psychosocial, vocational, etc.)" and "conceptualizes client from all aspects" into "Conceptualize the client's life (i.e. psychosocial, vocational, etc.)"

Split the phrase "ability to apply theories and techniques appropriately to the client's situation" into two sections: "ability to apply theory to a client's situation" and "ability to apply techniques based in theory to the client's situation"

Combine the terms/phrases "ability to apply theory to a client's situation" and "working within a theoretical approach" into "Working within a theoretical approach"

Combine the terms/phrases "ability to apply techniques based in theory to the client's situation," "specific counseling techniques based on a chosen theory," and "utilize simple techniques grounded in counseling theory" into "Utilize simple techniques grounded in counseling theory"

Combine the terms/phrases "ability and willingness to research and explore resources (i.e. books, journal articles, videos, training, etc.) that help the practitioner with ideas for techniques and approaches" and "keep up to date on publications" into "Willing to research and explore counseling resources (i.e. journal articles, books, etc.)"

Combine the terms/phrases "open" and "broad minded" into "Open minded"

Combine the terms/phrases "willing to help" and "altruistic" into "Altruistic"

Combine the terms/phrases "calm" and "soothing" into "Calming/soothing"

Combine the terms/phrases: "intuitive" and "perceptive" into "Intuitive/perceptive"

Combine the terms/phrases: "kind" and "thoughtful" into "Kind/thoughtful"

Combine the terms/phrases: "common sense" and "common sensical" into "Common sense"

Combine the terms/phrases" "prudent" and "conscientious" into "Conscientious/prudent"

Combine the terms/phrases: "intelligent" and "wise" into "Intelligent/wise"

Interpret the phrase "limit setting" as "establishes appropriate boundaries with clients"

Include "establishes appropriate boundaries with client" under the "Understands/practices in ethical manner (i.e. confidentiality, representation of competence/qualifications, dual relationships, informed consent)" item to form ""Understands/practices in ethical manner (i.e. confidentiality, representation of competence/qualifications, dual relationships, informed consent, establishes appropriate boundaries)"

Split the phrase “Able to convey an appropriate level of ease when they’re working with clients, colleagues, and supervisors” into two sections “Able to convey an appropriate level of ease with clients” and “Able to convey an appropriate level of ease with colleagues and supervisors”

Combine the phrases “comfortable with client” and “able to convey an appropriate level of ease when they’re working with clients” into “comfortable with client”

Split the phrase “confidence in approaching any interpersonal session with clients, site supervisor, or faculty supervisors” into “Confident in approaching any interpersonal session with clients” and “Confident in approaching any interpersonal session with site or faculty supervisor”

June 4, 2008

Combine the items: “Builds rapport,” “Active listening (e.g. attending to client; listening and responding),” “Orient client to the counseling process,” “Non verbal skills (e.g. eye contact, body position, voice tone, gestures, facial expressions, physical distance, and appropriate touch),” “Seamless delivery of the counseling skills,” “Recognizes how their personal limitations, biases, and beliefs impact the counseling relationship,” “Set clear boundaries with client,” “Educates client regarding referral information,” “Demonstrates respect for client’s values/beliefs,” “Controls own feelings and personal thoughts about clients to increase understanding and to decrease interference in the counselor relationship,” “Maintains awareness of personal feelings, limitations, and experiences during the counseling session,” “Fosters a therapeutic environment,” “An ability to use counseling skills intentionally/purposefully,” “Flexible with counseling skills (when necessary),” “Avoids countertransference,” “Focuses on client rather than themselves in counseling sessions,” “Identifies and meets the client’s needs,” “Establishes a working alliance,” “Continues to move session toward the therapeutic goal,” “Clearly explains limits of confidentiality to client,” “Manages the time of the session appropriately,” “Closes cases appropriately,” “Develops trust,” “Faith in intuitive responses,” “Ability to be objective (lose their subjective thought),” “Keeps client focused,” “Reflects on the counseling session,” “Functions at any level of the helping relationship, from limited to intense,” “Confidence in approaching any interpersonal session with clients,” “Use multiple techniques (i.e. eclectic style),” “Takes good notes during session,” and “Applies structure to the counseling process (e.g. rapport building, exploration, treatment, termination)” into the category/competency domain “General Counseling Process”

Combine the items: “Assess client interests, skills, and aptitudes,” “Knowledge of career development,” “Ability to conceptualize,” “Conceptualize a case within a theoretical frame of reference,” “Diagnose (with some assistance),” “Clear understanding of theory(s),” and “Understanding the impact of disability” into the category/competency domain “Assessment/Conceptualization”

Combine the items: “Observation skills,” “Use and understand solution skills (giving advice, information, and directive),” “Appropriately uses silence,” “Paraphrase client statements,” “Reflect feeling of client statements,” “Reflect meaning of client statements,” “Interpret client statements,” “Assess accuracy of interpretations with the clients,” “Clarify client statements,”

“Appropriate use confrontation,” “Disagreeing as needed, while maintaining a respectful and supportive attitude,” “Uses self-disclosure appropriately,” “Utilize simple techniques grounded in counseling theory,” “Utilize advanced techniques grounded in counseling theory,” “Working within a theoretical approach,” “Interviewing skills,” “Group counseling skills,” “Use open ended questions,” “Use close ended questions (when appropriate),” “Uses confirmations/affirmations,” “Ability to change client’s emotional arousal levels,” “Critical thinking ability,” “Reframes client statements,” “Enhance or help client to increase his or her self-esteem,” “Avoids sympathy,” “Avoids advice,” “Ability to be insightful,” “Summarize,” “Provide accurate feedback,” “Asks effective questions,” “Intervenes in a ways that produce client progress in achieving his or her behavioral and/or emotional goals,” “Assesses client motivation,” “Elicits motivating statements from client,” “Allows client to elaborate,” “Assess client’s self-efficacy,” “Ability to handle client’s strong emotions (e.g. crying),” and “Redirects client (when appropriate)” into the category/competency domain “Process skills”

Combine the items: “Identify goals that reflect the client’s perspective,” “Identify short and long term goals,” “Sets realistic, attainable goals,” “Job development and placement skills,” “Providing client with choices,” “Identify and explore options with client,” “Individualized treatment planning (i.e. plan interventions and services that will assist the client in his or her goal),” “Gather pertinent information from the client and relevant others through assessments, observations, and facilitative questions,” “Assess client strengths and weaknesses,” “Identify client problems,” “Prioritize client problems,” “Conceptualize the client’s life (i.e. psychosocial, vocational, etc.),” “Understanding of and ability to develop accommodation strategies,” “Understanding of family and interpersonal dynamics,” and “Regularly evaluates client progress” into the category/competency domain “Identifying goals/Treatment planning”

Combine the items: “Evaluates relevance, value, and meaning of supervisory feedback,” “Sets personal learning goals,” “Non-defensive /receptive to clinical supervision,” “Prepares for supervision,” “Participates in supervision,” “Incorporates supervisor feedback into practice,” “Demonstrates respect for the expertise of supervisors,” “An understanding of and belief in the importance of supervision,” “An awareness of when to seek supervision,” “Ability to state a disclosure statement,” “Ability to write a disclosure statement,” “Preparation of written reports and progress notes (accuracy, clarity, organization, professional presentation),” “Ability to reflect on one’s practice,” “Requests guidance as needed (during supervision),” “Balance the needs of the faculty supervisor and site supervision,” “Willing to experiment or take risks in session,” “Identifies own strengths and weakness related to counseling performance/competency,” “Willing to research and explore counseling resources (i.e. journal articles, books, etc.),” and “Confident in approaching any interpersonal session with site or faculty supervisor” into the category/competency domain “Supervision”

Combine the items: “Respects other professionals,” “Demonstrates genuine motivation to become a competent and ethical rehabilitation counselor,” “Commitment to social justice,” “Understands/practices in ethical manner (i.e. confidentiality, representation of competence/qualifications, dual relationships, informed consent),” “Understands the challenges to communication with persons with hearing, visual, or cognitive impairments,” “Aware of cultural differences/influences with clients,” “Deals directly and appropriately with conflict rather than avoiding it,” “Ability to recognize when they are responding to supervisors, clients,

students and other professionals in a manner that puts their own needs before those of their clients," "Uses appropriate language/terminology (e.g. person first language; avoids heterosexist, ablest, racist, and sexist language)," "Recognizes limits of competency," "An ability to engage in critical self-reflection rather than focusing solely on the mistakes of others when they participate in clinical training, practicum and internship experiences," "Able to convey an appropriate level of ease with colleagues and supervisors," "Appropriate dress," and "Willingness to change when their own biases and beliefs that interfere with their ability to learn how to function as competent and ethical rehabilitation counselor" into the category/competency domain "Professional Behavior"

Combine the items: "Sets career goals," "Evaluates progress toward own goals," "Develop ability to supervise others," "Above average verbal and written expression," "Willingness to continue to learn and develop professionally," "An ability to articulate why the counseling skills they learn are crucial to all the roles and functions (e.g., vocational rehabilitation counselor, case manager, job developer, vocational evaluator) of rehabilitation counselors," and "Goal oriented" into the category/competency domain "General Professional Development"

Combine the items: "Recognition of the importance of self care," "An awareness of when their own personal issues are interfering with their ability to learn and practice in a professionally and ethically responsible manner," "Manage/work on personal issues that arise during counseling or supervision sessions," "Willingness to seek out professional counseling for themselves when it is needed in order for them to function ethically and professionally," "Emotional stability," and "Manage own mental health disabilities" into the category/competency domain "Self Care"

Combine the items: "Suicide risk assessment," "Manages resources," "Fiscal management," "Time management," and "Crisis management" into the category/competency domain "Other"

Combine the items: "Empathetic / Convey empathy to clients," "Dependable," "Demonstrates unconditional positive regard," "Genuine," "Warm," "Open minded," "Non-judgmental," "Flexible/adaptable," "Non-threatening demeanor," "Patient," "Honest," "Trustful," "Humble," "Altruistic," "Motivating," "Energetic," "Assertive," "Calming/soothing," "Positive," "Attentive," "Humorous," "Respectful," "Caring," "Direct," "Gentle," "Creative," "Intelligent/wise," "Logical," "Experienced," "Confident (but not arrogant)," "Kind/thoughtful," "Mature," "Comfortable with client," "Non-defensive (with clients)," "Common sense," "Reliable," "Conscientious/prudent," "Intuitive/perceptive," "Extroverted," "Introverted," "Thoughtful," "Capable," "Approachable," "Ebullient/happy," "Hard-working," "Moderating/judging," "Timely/opportune," "Just," "Succinct," "Pleasure to work with," "Team player," and "Healthy" into the category/competency domain "Personal Characteristics"

June 5, 2008

Combine the items: "Collaborates with client" and "Establishes a working alliance" into "Establishes a working alliance"

Move the phrase "Recognizes how their personal limitations, biases, and beliefs impact the counseling relationship" into the Professional Behavior Domain.

Move the items: “Assesses client motivation” and “Assess client’s self-efficacy” from Process Skills to Assessment/Conceptualization

Move item: “Intervenes in a ways that produce client progress in achieving his or her behavioral and/or emotional goals” from Process Skills to Identifying goals/Treatment planning

Move the items: “Gather pertinent information from the client and relevant others through assessments, observations, and facilitative questions” “Assess client strengths and weaknesses” “Identify client problems” “Prioritize client problems” “Conceptualize the client’s life (i.e. psychosocial, vocational, etc.)” and “Understanding of family and interpersonal dynamics” from Identifying goals/Treatment planning to Assessment/Conceptualization

Combine the terms/phrases: “Ability to state a disclosure statement” and “Ability to write a disclosure statement” into one statement “Ability to state and write a disclosure statement”

Move the phrases: “Ability to state and write a disclosure statement” and “Willing to research and explore counseling resources (i.e. journal articles, books, etc.)” from Supervision to General Professional Development

Move the phrases: “Recognizes limits of competency” and “An ability to engage in critical self-reflection rather than focusing solely on the mistakes of others when they participate in clinical training, practicum and internship experiences” from Professional Behavior to General Professional Development

Move the phrase: “Goal oriented” from General Professional Development to Personal Characteristics

Combine the terms: “Dependable” and “Reliable” into “Dependable/reliable”

Combine the terms: “Non-threatening demeanor” and “Approachable” into “Approachable/Non-threatening demeanor”

Combine the terms: “Kind,” “Thoughtful,” and “Kind/thoughtful” into the phrase “Kind/thoughtful/caring”

APPENDIX F
ROUND 2 EMAIL TO REHABILITATION COUNSELING EDUCATORS

Dr. XXXXX,

Thank you for participating in round 1 of our clinical supervision Delphi study. The data has been analyzed and we have identified 184 items representing 10 theoretical competency domains. Per the Delphi format, we ask that you complete the second round of questioning whereby you rate the "usefulness" of each item on a five point Likert scale. In order to remain consistent with the purpose of this study, please read the instructions page before rating the items.

In addition, we know that your time is valuable and we really appreciate your contribution to this project. However, because we are on a limited time schedule we would really appreciate if you could complete the second round by FRIDAY, JUNE 20th. Educators who pilot tested this round completed it in approximately 30 minutes.

Survey Link: https://www.surveymonkey.com/s.aspx?sm=ShzVwIjPeW1wOgt9VkLo_2bg_3d_3d

If you have any questions, please contact Michael Moorhouse at mmoorhou@phhp.ufl.edu or 352-273-6491.

Thank you,

Michael Moorhouse

Rehabilitation Science Doctoral Student

University of Florida

Department of Behavioral Science & Community Health

APPENDIX G
DELPHI ROUND 2 SURVEY

PLEASE READ THE FOLLOWING INSTRUCTIONS BEFORE COMPLETING ROUND 2

The purpose of this research study is to identify and draw consensus on a comprehensive set of skills, behaviors, and personal attributes which are **"USEFUL"** for clinical supervision evaluation.

Specifically for this study, we define a **"USEFUL"** item as any item that is representative of some aspect of rehabilitation counseling performance and could potentially help the supervisor evaluate the trainee. You will rate each item on a 5 point Likert scale ranging from "strongly disagree" to "strongly agree."

We are emphasizing that you are rating the item based on whether you believe the item **COULD** be used by clinical supervisors to evalaute a trainee. For example, you may believe that students who are in their first practicum or working at a particular site should not be required to "conceptualize a client within a theoretical framework." However, you recognize that if the trainee did demonstrate this ability, the supervisor **COULD** use this information to evaluate the trainee's clinical ability. Therefore, in this instance, you would agree that the item is **"USEFUL"** for clinical supervision evaluation.

In addition to rating the items, there will be a section on the survey for any comments you may have regarding the items. These comments may be included in the final round of the Delphi to help participants reevaluate their ratings.

*** 1. Please rate whether you agree each item is "useful" for clinical supervision evaluation.**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Builds rapport	◯	◯	◯	◯	◯
Develops trust	◯	◯	◯	◯	◯
Active listening (e.g. attending to client; listening and responding)	◯	◯	◯	◯	◯
Non verbal skills (e.g. eye contact, body position, voice tone, gestures, facial expressions, physical distance, and appropriate touch)	◯	◯	◯	◯	◯
Orient client to the counseling process	◯	◯	◯	◯	◯
Set clear boundaries with client	◯	◯	◯	◯	◯
Clearly explains limits of confidentiality to client	◯	◯	◯	◯	◯
Demonstrates respect for client's values/beliefs	◯	◯	◯	◯	◯
Fosters a therapeutic environment	◯	◯	◯	◯	◯
Establishes a working alliance	◯	◯	◯	◯	◯
Seamless delivery of the counseling skills	◯	◯	◯	◯	◯
An ability to use counseling skills intentionally/purposefully	◯	◯	◯	◯	◯
Flexible with counseling skills (when necessary)	◯	◯	◯	◯	◯
Use multiple techniques (i.e. eclectic style)	◯	◯	◯	◯	◯
Avoids countertransference	◯	◯	◯	◯	◯
Identifies and meets the client's needs	◯	◯	◯	◯	◯
Applies structure to the counseling process (e.g. rapport building, exploration, treatment, termination)	◯	◯	◯	◯	◯
Continues to move session toward the therapeutic goal	◯	◯	◯	◯	◯
Manages the time of the session appropriately	◯	◯	◯	◯	◯
Maintains awareness of personal feelings, limitations, and experiences during the counseling session	◯	◯	◯	◯	◯
Controls own feelings and personal thoughts about clients to increase understanding and to decrease interference during the counseling session	◯	◯	◯	◯	◯
Has faith in intuitive responses	◯	◯	◯	◯	◯
Ability to be objective (lose their subjective thought)	◯	◯	◯	◯	◯

Keeps client focused	◯	◯	◯	◯	◯
Focuses on client rather than themselves in counseling sessions	◯	◯	◯	◯	◯
Functions at any level of the helping relationship, from limited to intense	◯	◯	◯	◯	◯
Confident in approaching any interpersonal session with clients	◯	◯	◯	◯	◯
Takes good notes during session	◯	◯	◯	◯	◯
Educates client regarding referral information	◯	◯	◯	◯	◯
Closes cases appropriately	◯	◯	◯	◯	◯
Reflects on the counseling session	◯	◯	◯	◯	◯

Comments

*** 2. Please rate whether you agree each item is "useful" for clinical supervision evaluation.**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Observation skills	◯	◯	◯	◯	◯
Use and understand solution skills (giving advice, information, and directive)	◯	◯	◯	◯	◯
Paraphrase client statements	◯	◯	◯	◯	◯
Reflect feeling of client statements	◯	◯	◯	◯	◯
Reflect meaning of client statements	◯	◯	◯	◯	◯
Use open ended questions	◯	◯	◯	◯	◯
Use close ended questions (when appropriate)	◯	◯	◯	◯	◯
Reframes client statements	◯	◯	◯	◯	◯
Interpret client statements	◯	◯	◯	◯	◯
Assess accuracy of interpretations with the clients	◯	◯	◯	◯	◯
Clarify client statements	◯	◯	◯	◯	◯
Allows client to elaborate	◯	◯	◯	◯	◯
Uses confirmations/affirmations	◯	◯	◯	◯	◯
Asks effective questions	◯	◯	◯	◯	◯
Redirects client (when appropriate)	◯	◯	◯	◯	◯
Summarize	◯	◯	◯	◯	◯
Provide accurate feedback	◯	◯	◯	◯	◯
Appropriately uses silence	◯	◯	◯	◯	◯
Appropriate use confrontation	◯	◯	◯	◯	◯
Ability to be insightful	◯	◯	◯	◯	◯
Elicits motivating statements from client	◯	◯	◯	◯	◯
Uses self-disclosure appropriately	◯	◯	◯	◯	◯
Ability to handle client's strong emotions (e.g. crying)	◯	◯	◯	◯	◯
Disagreeing as needed, while maintaining a respectful and supportive attitude	◯	◯	◯	◯	◯
Utilize simple techniques grounded in counseling theory	◯	◯	◯	◯	◯
Utilize advanced techniques grounded in counseling theory	◯	◯	◯	◯	◯
Working within a theoretical approach	◯	◯	◯	◯	◯
Interviewing skills	◯	◯	◯	◯	◯
Group counseling skills	◯	◯	◯	◯	◯
Critical thinking ability	◯	◯	◯	◯	◯
Ability to change client's emotional arousal levels	◯	◯	◯	◯	◯
Enhance or help client to increase his or her self-esteem	◯	◯	◯	◯	◯
Avoids sympathy	◯	◯	◯	◯	◯
Avoids advice	◯	◯	◯	◯	◯

Comments

*** 3. Please rate whether you agree each item is "useful" for clinical supervision evaluation.**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Gather pertinent information from the client and relevant others through assessments, observations, and facilitative questions	◯	◯	◯	◯	◯
Assess client self-efficacy	◯	◯	◯	◯	◯
Assess client motivation	◯	◯	◯	◯	◯
Assess client strengths and weaknesses	◯	◯	◯	◯	◯
General ability to conceptualize	◯	◯	◯	◯	◯
Conceptualize a case within a theoretical frame of reference	◯	◯	◯	◯	◯
Conceptualize a client's life (i.e. psychosocial, vocational, etc.)	◯	◯	◯	◯	◯
Identify client problems	◯	◯	◯	◯	◯
Prioritize client problems	◯	◯	◯	◯	◯
Diagnose (with some assistance)	◯	◯	◯	◯	◯
Clear understanding of theory(s)	◯	◯	◯	◯	◯
Knowledge of career development	◯	◯	◯	◯	◯
Understanding of family and interpersonal dynamics	◯	◯	◯	◯	◯
Understanding the impact of disability	◯	◯	◯	◯	◯

Comments

*** 4. Please rate whether you agree each item is "useful" for clinical supervision evaluation.**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Identify goals that reflect the client's perspective	◯	◯	◯	◯	◯
Identify short and long term goals	◯	◯	◯	◯	◯
Sets realistic, attainable goals	◯	◯	◯	◯	◯
Identify and explore options with client	◯	◯	◯	◯	◯
Providing client with choices	◯	◯	◯	◯	◯
Intervenes in a ways that produce client progress in achieving his or her behavioral and/or emotional goals.	◯	◯	◯	◯	◯
Individualized treatment planning (i.e. plan interventions and services that will assist the client in his or her goal)	◯	◯	◯	◯	◯
Understanding of and ability to develop accommodation strategies	◯	◯	◯	◯	◯
Job development and placement skills	◯	◯	◯	◯	◯
Regularly evaluates client progress	◯	◯	◯	◯	◯

Comments

*** 5. Please rate whether you agree each item is "useful" for clinical supervision evaluation.**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
An understanding of and belief in the importance of supervision	◯	◯	◯	◯	◯
Demonstrates respect for the expertise of supervisor	◯	◯	◯	◯	◯
Confident in approaching any interpersonal session with site or faculty supervisor	◯	◯	◯	◯	◯
Non-defensive / receptive to clinical supervision	◯	◯	◯	◯	◯
Prepares for supervision	◯	◯	◯	◯	◯
Participates in supervision	◯	◯	◯	◯	◯
Evaluates relevance, value, and meaning of supervisory feedback	◯	◯	◯	◯	◯
Incorporates supervisor feedback into practice	◯	◯	◯	◯	◯
An awareness of when to seek supervision	◯	◯	◯	◯	◯
Requests guidance as needed (during supervision)	◯	◯	◯	◯	◯
Preparation of written reports and progress notes (accuracy, clarity, organization, professional presentation)	◯	◯	◯	◯	◯
Identifies own strengths and weakness related to counseling performance/competency	◯	◯	◯	◯	◯
Ability to reflect on one's practice	◯	◯	◯	◯	◯
Manage/work on personal issues that arise during counseling or supervision sessions	◯	◯	◯	◯	◯
Balance the needs of the faculty supervisor and site supervision	◯	◯	◯	◯	◯
Willing to research and explore counseling resources (i.e. journal articles, books, etc.)	◯	◯	◯	◯	◯
Completes supervision tapes/reports on time	◯	◯	◯	◯	◯
Sets personal learning goals	◯	◯	◯	◯	◯

Comments

*** 6. Please indicate how much you agree that the item is "useful" for clinical supervision evaluation.**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Respects other professionals	◯	◯	◯	◯	◯
Demonstrates genuine motivation to become a competent and ethical rehabilitation counselor	◯	◯	◯	◯	◯
Commitment to social justice	◯	◯	◯	◯	◯
Understands/practices in ethical manner (i.e. confidentiality, representation of competence/qualifications, dual relationships, informed consent)	◯	◯	◯	◯	◯
Understands the challenges to communication with persons with hearing, visual, or cognitive impairments	◯	◯	◯	◯	◯
Aware of client's cultural differences/influences	◯	◯	◯	◯	◯
Deals directly and appropriately with conflict rather than avoiding it.	◯	◯	◯	◯	◯
Ability to recognize when they are responding to supervisors, clients, students and other professionals in a manner that puts their own needs before those of their clients	◯	◯	◯	◯	◯
Uses appropriate language/terminology (e.g. person first language; avoids heterosexist, ablest, racist, and sexist language)	◯	◯	◯	◯	◯
Able to convey an appropriate level of ease with colleagues and supervisors	◯	◯	◯	◯	◯
Appropriate dress	◯	◯	◯	◯	◯
Recognizes how their personal limitations, biases, and beliefs impact the counseling relationship	◯	◯	◯	◯	◯
Willingness to change when their own biases and beliefs that interfere with their ability to learn how to function as competent and ethical rehabilitation counselor	◯	◯	◯	◯	◯

Comments

*** 7. Please indicate how much you agree that the item is "useful" for clinical supervision evaluation.**

	Strongly Disagree	Diagree	Neutral	Agree	Strongly Agree
Sets career goals	◯	◯	◯	◯	◯
Evaluates progress toward own goals	◯	◯	◯	◯	◯
Develop ability to supervise others	◯	◯	◯	◯	◯
Above average verbal and written expression	◯	◯	◯	◯	◯
Willingness to continue to learn and develop professionally	◯	◯	◯	◯	◯
An ability to articulate why the counseling skills they learn are crucial to all the roles and functions (e.g., vocational rehabilitation counselor, case manager, job developer, vocational evaluator) of rehabilitation counselors	◯	◯	◯	◯	◯
Willing to experiment or take risks in counseling session	◯	◯	◯	◯	◯
Recognizes limits of competency	◯	◯	◯	◯	◯
An ability to engage in critical self-reflection rather than focusing solely on the mistakes of others when they participate in clinical training, practicum and internship experiences	◯	◯	◯	◯	◯
Ability to write and state a disclosure statement	◯	◯	◯	◯	◯

Comments

*** 8. Please indicate how much you agree that the item is "useful" for clinical supervision evaluation.**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Recognition of the importance of self care	◯	◯	◯	◯	◯
An awareness of when their own personal issues are interfering with their ability to learn and practice in a professionally and ethically responsible manner	◯	◯	◯	◯	◯
Willingness to seek out professional counseling for themselves when it is needed in order for them to function ethically and professionally	◯	◯	◯	◯	◯
Demonstrates emotional stability	◯	◯	◯	◯	◯
Manages own mental health disabilities	◯	◯	◯	◯	◯

Comments

*** 9. Please indicate how much you agree that the item is "useful" for clinical supervision evaluation.**

	Strongly Disagree	Agree	Neutral	Agree	Strongly Agree
Empathetic / Convey empathy to clients	◯	◯	◯	◯	◯
Dependable / reliable	◯	◯	◯	◯	◯
Demonstrates unconditional positive regard	◯	◯	◯	◯	◯
Genuine	◯	◯	◯	◯	◯
Warm	◯	◯	◯	◯	◯
Open minded	◯	◯	◯	◯	◯
Non-judgmental	◯	◯	◯	◯	◯
Flexible/adaptable	◯	◯	◯	◯	◯
Approachable / Non-threatening	◯	◯	◯	◯	◯
Patient	◯	◯	◯	◯	◯
Honest	◯	◯	◯	◯	◯
Trustful	◯	◯	◯	◯	◯
Humble	◯	◯	◯	◯	◯
Altruistic	◯	◯	◯	◯	◯
Motivating	◯	◯	◯	◯	◯
Energetic	◯	◯	◯	◯	◯
Assertive	◯	◯	◯	◯	◯
Calming/soothing	◯	◯	◯	◯	◯
Positive	◯	◯	◯	◯	◯
Attentive	◯	◯	◯	◯	◯
Humorous	◯	◯	◯	◯	◯
Respectful	◯	◯	◯	◯	◯
Direct	◯	◯	◯	◯	◯
Creative	◯	◯	◯	◯	◯
Intelligent/wise	◯	◯	◯	◯	◯
Logical	◯	◯	◯	◯	◯
Experienced	◯	◯	◯	◯	◯
Confident (but not arrogant)	◯	◯	◯	◯	◯
Kind / thoughtful / caring	◯	◯	◯	◯	◯
Mature	◯	◯	◯	◯	◯
Comfortable with client	◯	◯	◯	◯	◯
Non-defensive	◯	◯	◯	◯	◯
Displays common sense	◯	◯	◯	◯	◯
Conscientious/prudent	◯	◯	◯	◯	◯
Intuitive/perceptive	◯	◯	◯	◯	◯
Extroverted	◯	◯	◯	◯	◯
Introverted	◯	◯	◯	◯	◯
Capable	◯	◯	◯	◯	◯

Ebullient/happy	◯	◯	◯	◯	◯
Hard-working	◯	◯	◯	◯	◯
Moderating/judging	◯	◯	◯	◯	◯
Timely/opportune	◯	◯	◯	◯	◯
Just	◯	◯	◯	◯	◯
Succinct	◯	◯	◯	◯	◯
Pleasure to work with	◯	◯	◯	◯	◯
Team player	◯	◯	◯	◯	◯
Healthy	◯	◯	◯	◯	◯
Goal oriented	◯	◯	◯	◯	◯

Comments

*** 10. Please indicate how much you agree that the item is "useful" for clinical supervision evaluation.**

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Suicide risk assessment	◯	◯	◯	◯	◯
Manages resources	◯	◯	◯	◯	◯
Fiscal management	◯	◯	◯	◯	◯
Crisis management	◯	◯	◯	◯	◯

Comments

APPENDIX H
ROUND 2 FRIENDLY REMINDER EMAIL

Dr. XXXXX,

This is a reminder email regarding your participation in the University of Florida clinical supervision Delphi study. As previously mentioned, the data from Round 1 has been analyzed and we have identified 184 items representing 10 theoretical competency domains. Per the Delphi format, we ask that you complete the second round of questioning whereby you rate the "usefulness" of each item on a five point Likert scale. In order to remain consistent with the purpose of this study, please read the instructions page before rating the items.

We know that your time is valuable and we really appreciate your contribution to this project. However, because we are on a limited time schedule we would really appreciate if you could complete the second round by FRIDAY, JUNE 20th. Educators who pilot tested this round completed it in approximately 30 minutes.

Survey Link: https://www.surveymonkey.com/s.aspx?sm=SHzVwIjPeW1wOgt9VkLo_2bg_3d_3d

If you have any questions, please contact Michael Moorhouse at mmoorhou@phhp.ufl.edu or 352-273-6491.

Thank you,
Michael Moorhouse

APPENDIX I
ROUND 3 EMAIL TO REHABILITATION COUNSELING EDUCATORS

Dr. XXXXX

Thank you for completing the first and second rounds of the clinical supervision Delphi study. The third and final round is now ready for your participation. Similar to round 2, this round is considerably quicker than round 1 and should take between 15-20 minutes to finish. Because we are on a limited time schedule and this round takes considerably less time, we would really appreciate if you could complete this final round by FRIDAY, JULY 4th.

The goal of the third round is to achieve consensus regarding whether or not each item is "useful" for clinical supervision evaluation. Therefore, your participation in this round is highly valuable.

You will now have the opportunity to review the group statistical data as well as your previous ratings. Based on this information, please decide whether or not you would like to keep or change your responses. Unlike the previous round you will not be expected to re-rate each item, only those items you wish to change. Again we want to express our extreme gratitude to you for participating in this study.

To begin the final round of this study, please click on the following link.

https://www.surveymonkey.com/s.aspx?sm=FHfex8ctiiWdtz9s2E1Kfw_3d_3d

Please contact Michael Moorhouse at (352) 273-6491 with any questions regarding this study.

APPENDIX J
DELPHI ROUND 3 SURVEY

1. Instructions

Thank you for completing the second round of the Delphi study.

For the final round, we ask that you compare your initial item ratings to the group statistical data (i.e. items means and standard deviations; comments) and simply re-rate only those items you want to change. For your convenience, your initial item ratings and group statistical data can be found in bold directly beneath each item. Keep in mind that unlike the previous round, you only rate the items you wish to change. For example, the item "avoids countertransference" appears below. If after examining the item data you choose to change your rating from "Agree(4)" to "Strongly Agree(5)," then you would select the "Strongly Agree (5)" circle. However, if you examine the data and choose to keep your item rating as "Agree (4)," then simply select nothing and move on to the next item.

In addition to group statistical data, participant comments can be found in two areas. Comments which are related to a specific item are located directly beneath your item/group ratings and general comments can be found in the upper part of the page before the first item.

It is important to reiterate that you are rating items based on whether you believe the item COULD be "useful" for clinical supervision evaluation. A "useful" item is one that is representative of some aspect of rehabilitation counseling performance and potentially helps the supervisor evaluate the trainee.

>NOTE: Please enter your name at the completion of the survey even if you do not change any items.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
avoids countertransference (YOUR RATING: 4; GROUP MEAN: 4.33, SD: .77)	○	○	○	○	○

2. Please re-rate whether you agree each item is "useful" for clinical supervision evaluation.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
Builds rapport (YOUR RATING: 5; GROUP MEAN: 4.83, SD: .38)	○	○	○	○	○
Develops trust (YOUR RATING: 5; GROUP MEAN: 4.61, SD: .61)	○	○	○	○	○
Active listening (e.g. attending to client; listening and responding) (YOUR RATING: 5; GROUP MEAN: 4.94, SD: .24)	○	○	○	○	○
Non verbal skills (e.g. eye contact, body position, voice tone, gestures, facial expressions, physical distance, and appropriate touch) (YOUR RATING: 5; GROUP MEAN: 4.78, SD: .59)	○	○	○	○	○
Orient client to the counseling process (YOUR RATING: 4; GROUP MEAN: 4.56, SD: .51)	○	○	○	○	○
Set clear boundaries with client (YOUR RATING: 4; GROUP MEAN: 4.61, SD: .50)	○	○	○	○	○
Clearly explains limits of confidentiality to client (YOUR RATING: 4; GROUP MEAN: 4.83, SD: .38)	○	○	○	○	○
Demonstrates respect for client's values/beliefs (YOUR RATING: 4; GROUP MEAN: 4.83, SD: .38)	○	○	○	○	○
Fosters a therapeutic environment (YOUR RATING: 3; GROUP MEAN: 4.56, SD: .70)	○	○	○	○	○
Establishes a working alliance (YOUR RATING: 3; GROUP MEAN: 4.50, SD: .79)	○	○	○	○	○
Seamless delivery of the counseling skills (YOUR RATING: 3; GROUP MEAN: 3.94, SD: .73)	○	○	○	○	○
An ability to use counseling skills intentionally/purposefully (YOUR RATING: 4; GROUP MEAN: 4.50, SD: .62)	○	○	○	○	○
Flexible with counseling skills (when necessary) (YOUR RATING: 5; GROUP MEAN: 4.33, SD: .49)	○	○	○	○	○
Use multiple techniques (i.e. eclectic style) (YOUR RATING: 5; GROUP MEAN: 3.89, SD: .76)	○	○	○	○	○
Avoids countertransference (YOUR RATING: 4; GROUP MEAN: 4.33, SD: .77)	○	○	○	○	○
Identifies and meets the client's needs (YOUR RATING: 5; GROUP MEAN: 4.56, SD: .51)	○	○	○	○	○
Applies structure to the counseling process (e.g. rapport building, exploration, treatment, termination) (YOUR RATING: 4; GROUP MEAN: 4.39, SD: .50)	○	○	○	○	○
Continues to move session toward the therapeutic goal (YOUR RATING: 4; GROUP MEAN: 4.61, SD: .50)	○	○	○	○	○

Manages the time of the session appropriately (YOUR RATING:3; GROUP MEAN:4.28, SD:.75)	○	○	○	○	○
Maintains awareness of personal feelings, limitations, and experiences during the counseling session (YOUR RATING:3; GROUP MEAN:4.44, SD:.78)	○	○	○	○	○
Controls own feelings and personal thoughts about clients to increase understanding and to decrease interference during the counseling session (YOUR RATING:4; GROUP MEAN:4.56, SD:.51)	○	○	○	○	○
Has faith in intuitive responses (YOUR RATING:3; GROUP MEAN:3.33, SD:.84)	○	○	○	○	○
Ability to be objective (lose their subjective thought) (YOUR RATING:4; GROUP MEAN:3.94, SD:.87)	○	○	○	○	○
Keeps client focused (YOUR RATING:4; GROUP MEAN:4.28, SD:.46)	○	○	○	○	○
Focuses on client rather than themselves in counseling sessions (YOUR RATING:5; GROUP MEAN:4.78, SD:.43)	○	○	○	○	○
Functions at any level of the helping relationship, from limited to intense (YOUR RATING:3; GROUP MEAN:3.89, SD:.68)	○	○	○	○	○
Confident in approaching any interpersonal session with clients (YOUR RATING:4; GROUP MEAN:3.78, SD:.65)	○	○	○	○	○
Takes good notes during session (YOUR RATING:3; GROUP MEAN:3.44, SD:1.04)	○	○	○	○	○
Educates client regarding referral information (YOUR RATING:3; GROUP MEAN:3.94, SD:.66)	○	○	○	○	○
Closes cases appropriately (YOUR RATING:3; GROUP MEAN:3.94, SD:.80)	○	○	○	○	○
Reflects on the counseling session (YOUR RATING:3; GROUP MEAN:4.22, SD:.65)	○	○	○	○	○

3. Please re-rate whether you agree each item is "useful" for clinical supervision evaluation.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
Observation skills (YOUR RATING: 5; GROUP MEAN: 4.65, SD: .80)	○	○	○	○	○
Use and understand solution skills (giving advice, information, and directive) (YOUR RATING: 4; GROUP MEAN: 4.08, SD: .69)	○	○	○	○	○
Paraphrase client statements (YOUR RATING: 4; GROUP MEAN: 4.44, SD: .62)	○	○	○	○	○
Reflect feeling of client statements (YOUR RATING: 4; GROUP MEAN: 4.56, SD: .81)	○	○	○	○	○
Reflect meaning of client statements (YOUR RATING: 4; GROUP MEAN: 4.39, SD: .98)	○	○	○	○	○
Use open ended questions (YOUR RATING: 4; GROUP MEAN: 4.65, SD: .80)	○	○	○	○	○
Use close ended questions (when appropriate) (YOUR RATING: 4; GROUP MEAN: 4.17, SD: .71)	○	○	○	○	○
Reframes client statements (YOUR RATING: 4; GROUP MEAN: 4.33, SD: .89)	○	○	○	○	○
Interpret client statements (YOUR RATING: 4; GROUP MEAN: 4.28, SD: .67)	○	○	○	○	○
Assess accuracy of interpretations with the clients (YOUR RATING: 5; GROUP MEAN: 4.56, SD: .81)	○	○	○	○	○
Clarify client statements (YOUR RATING: 4; GROUP MEAN: 4.50, SD: .81)	○	○	○	○	○
Allows client to elaborate (YOUR RATING: 4; GROUP MEAN: 4.50, SD: .81)	○	○	○	○	○
Uses confirmations/affirmations (YOUR RATING: 3; GROUP MEAN: 4.39, SD: .61)	○	○	○	○	○
Asks effective questions (YOUR RATING: 5; GROUP MEAN: 4.56, SD: .62)	○	○	○	○	○
Redirects client (when appropriate) (YOUR RATING: 4; GROUP MEAN: 4.39, SD: .50)	○	○	○	○	○
Summarize (YOUR RATING: 4; GROUP MEAN: 4.50, SD: .81)	○	○	○	○	○
Provide accurate feedback (YOUR RATING: 4; GROUP MEAN: 4.56, SD: .81)	○	○	○	○	○
Appropriately uses silence (YOUR RATING: 4; GROUP MEAN: 4.39, SD: .50)	○	○	○	○	○
Appropriate use confrontation (YOUR RATING: 4; GROUP MEAN: 4.44, SD: .62)	○	○	○	○	○

Ability to be insightful (YOUR RATING: 4; GROUP MEAN: 4.28, SD: .89)	○	○	○	○	○
Elicits motivating statements from client (YOUR RATING: 4; GROUP MEAN: 4.00, SD: .69)	○	○	○	○	○
Uses self-disclosure appropriately (YOUR RATING: 4; GROUP MEAN: 4.22, SD: .73)	○	○	○	○	○
Ability to handle client's strong emotions (e.g. crying) (YOUR RATING: 5; GROUP MEAN: 4.50, SD: .51)	○	○	○	○	○
Disagreeing as needed, while maintaining a respectful and supportive attitude (YOUR RATING: 5; GROUP MEAN: 4.28, SD: .75)	○	○	○	○	○
Utilize simple techniques grounded in counseling theory (YOUR RATING: 4; GROUP MEAN: 4.44, SD: .70)	○	○	○	○	○
Utilize advanced techniques grounded in counseling theory (YOUR RATING: 4; GROUP MEAN: 4.22, SD: .65)	○	○	○	○	○
Working within a theoretical approach (YOUR RATING: 3; GROUP MEAN: 3.83, SD: .86)	○	○	○	○	○
Interviewing skills (YOUR RATING: 5; GROUP MEAN: 4.72, SD: .46)	○	○	○	○	○
Group counseling skills (YOUR RATING: 5; GROUP MEAN: 4.06, SD: .80)	○	○	○	○	○
Critical thinking ability (YOUR RATING: 5; GROUP MEAN: 4.50, SD: .51)	○	○	○	○	○
Ability to change client's emotional arousal levels (YOUR RATING: 4; GROUP MEAN: 3.56, SD: .92)	○	○	○	○	○
Enhance or help client to increase his or her self-esteem (YOUR RATING: 4; GROUP MEAN: 3.83, SD: .86)	○	○	○	○	○
Avoids sympathy (YOUR RATING: 3; GROUP MEAN: 3.67, SD: .77)	○	○	○	○	○
Avoids advice (YOUR RATING: 3; GROUP MEAN: 4.00, SD: .91)	○	○	○	○	○

4. Please re-rate whether you agree each items is "useful" for clinical supervision evaluation.

GENERAL COMMENT:Something in the back of my mind bugs me about using items that reflect more of the career or vocational orientation in the supervision context. While I agree that they are important and may be useful, I think the importance of these is relative and depends highly on the focus of the practicum course, the philosophy and mission of the porgram, and the students' career objectives. Of course it would be terrific if students could experience the range of skills required of rehab counseling at any given practicum site; but not all sites or students have that option. I think it would be inappropraite for a student to be required to demonstrate these skills in supervision with no opportunity to practice career development/assessment activites at his/her practicum site.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Gather pertinent information from the client and relevant others through assessments, observations, and facilitative questions **(YOUR RATING: 5; GROUP MEAN:4.62, SD:.49)**	◯	◯	◯	◯	◯
Assess client interests, skills, and aptitudes **(YOUR RATING: 5; GROUP MEAN:4.17, SD:.86)**	◯	◯	◯	◯	◯
Assess client self-efficacy **(YOUR RATING: 5; GROUP MEAN:4.56, SD:.51)**	◯	◯	◯	◯	◯
Assess client motivation **(YOUR RATING: 5; GROUP MEAN:4.50, SD:.51)**	◯	◯	◯	◯	◯
Assess client strengths and weaknesses **(YOUR RATING: 5; GROUP MEAN:4.61, SD:.50)**	◯	◯	◯	◯	◯
General ability to conceptualize **(YOUR RATING: 5; GROUP MEAN:4.39, SD:.61)**	◯	◯	◯	◯	◯
Conceptualize a case within a theoretical frame of reference **(YOUR RATING: 5; GROUP MEAN:4.06, SD:.87)**	◯	◯	◯	◯	◯
Conceptualize a client's life (i.e. psychosocial, vocational, etc.) **(YOUR RATING: 5; GROUP MEAN:4.44, SD:.51)**	◯	◯	◯	◯	◯
Identify client problems **(YOUR RATING: 5; GROUP MEAN:4.78, SD:.43)**	◯	◯	◯	◯	◯
Prioritize client problems **(YOUR RATING: 5; GROUP MEAN:4.50, SD:.71)**	◯	◯	◯	◯	◯
Diagnose (with some assistance) **(YOUR RATING: 5; GROUP MEAN:3.56, SD:1.15)**	◯	◯	◯	◯	◯
Clear understanding of theory(s) **(YOUR RATING: 5; GROUP MEAN:4.28, SD:.69)**	◯	◯	◯	◯	◯
Knowledge of career development **(YOUR RATING: 5; GROUP MEAN:4.00, SD:.77)**	◯	◯	◯	◯	◯

Understanding of family and interpersonal dynamics (YOUR RATING: 5; GROUP MEAN: 4.39, SD: .80) COMMENT: Understanding of family dynamics and family therapy skills is highly important and often completely over looked in rehab counseling.	○	○	○	○	○
Understanding the impact of disability (YOUR RATING: 5; GROUP MEAN: 4.56, SD: .78)	○	○	○	○	○

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5. Please re-rate whether you agree each item is "useful" for clinical supervision evaluation.

GENERAL COMMENT: Many things depend on the circumstance of the client

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
Identify goals that reflect the client's perspective (YOUR RATING: 5; GROUP MEAN: 4.61, SD: .80)	○	○	○	○	○
Identify short and long term goals (YOUR RATING: 4; GROUP MEAN: 4.44, SD: .81)	○	○	○	○	○
Sets realistic, attainable goals (YOUR RATING: 5; GROUP MEAN: 4.67, SD: .49)	○	○	○	○	○
Identify and explore options with client (YOUR RATING: 4; GROUP MEAN: 4.50, SD: .81)	○	○	○	○	○
Providing client with choices (YOUR RATING: 4; GROUP MEAN: 4.56, SD: .81)	○	○	○	○	○
Intervenes in a ways that produce client progress in achieving his or her behavioral and/or emotional goals. (YOUR RATING: 4; GROUP MEAN: 4.44, SD: .62)	○	○	○	○	○
Individualized treatment planning (i.e. plan interventions and services that will assist the client in his or her goal) (YOUR RATING: 5; GROUP MEAN: 4.78, SD: .46)	○	○	○	○	○
Understanding of and ability to develop accommodation strategies (YOUR RATING: 5; GROUP MEAN: 4.44, SD: .62)	○	○	○	○	○
Job development and placement skills (YOUR RATING: 5; GROUP MEAN: 3.83, SD: .99) COMMENT:Again, if job development and placement are part of the practicum experience, then it's appropriate to require the student demonstrate them in supervision. If they are not, then the student should not be penalized for not having the opportunity to demonstrate them.	○	○	○	○	○
Regularly evaluates client progress (YOUR RATING: 5; GROUP MEAN: 4.61, SD: .80)	○	○	○	○	○

6. Please re-rate whether you agree each item is "useful" for clinical supervision evaluation.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
An understanding of and belief in the importance of supervision (YOUR RATING:4; GROUP MEAN:4.36; SD:.70)	○	○	○	○	○
Demonstrates respect for the expertise of supervisor (YOUR RATING:3; GROUP MEAN:4.11; SD:.90)	○	○	○	○	○
Confident in approaching any interpersonal session with site or faculty supervisor (YOUR RATING:4; GROUP MEAN:3.83; SD:.92)	○	○	○	○	○
Non-defensive / receptive to clinical supervision (YOUR RATING:4; GROUP MEAN:4.67; SD:.59)	○	○	○	○	○
Prepares for supervision (YOUR RATING:4; GROUP MEAN:4.56; SD:.62)	○	○	○	○	○
Participates in supervision (YOUR RATING:4; GROUP MEAN:4.67; SD:.49)	○	○	○	○	○
Evaluates relevance, value, and meaning of supervisory feedback (YOUR RATING:4; GROUP MEAN:4.56; SD:.62)	○	○	○	○	○
Incorporates supervisor feedback into practice (YOUR RATING:4; GROUP MEAN:4.44; SD:.62)	○	○	○	○	○
An awareness of when to seek supervision (YOUR RATING:4; GROUP MEAN:4.56; SD:.62)	○	○	○	○	○
Requests guidance as needed (during supervision) (YOUR RATING:4; GROUP MEAN:4.44; SD:.62)	○	○	○	○	○
Preparation of written reports and progress notes(accuracy, clarity, organization, professional presentation) (YOUR RATING:3; GROUP MEAN:4.33; SD:.77)	○	○	○	○	○
Identifies own strengths and weakness related to counseling performance/competency (YOUR RATING:4; GROUP MEAN:4.56; SD:.51)	○	○	○	○	○
Ability to reflect on one's practice (YOUR RATING:4; GROUP MEAN:4.61; SD:.50)	○	○	○	○	○
Manage/work on personal issues that arise during counseling or supervision sessions (YOUR RATING:4; GROUP MEAN:4.28; SD:.75)	○	○	○	○	○
Balance the needs of the faculty supervisor and site supervision (YOUR RATING:2; GROUP MEAN:3.56; SD:1.10) COMMENT: I don't feel that a student should be put in the position of having to balance the needs of the site supervisor and the faculty supervisor. The two professionals in the situation should not be creating situations in which this is an issue.	○	○	○	○	○
Willing to research and explore counseling resources (i.e. journal articles, books, etc.) (YOUR RATING:4; GROUP MEAN:4.22; SD:.73)	○	○	○	○	○

Completes supervision tapes/reports on time (YOUR RATING: 4; GROUP MEAN: 4.44, SD: .62)	○	○	○	○	○
Sets personal learning goals (YOUR RATING: 4; GROUP MEAN: 4.39, SD: .61)	○	○	○	○	○

7. Please re-rate whether you agree each item is "useful" for clinical supervision evaluation.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
Respects other professionals (YOUR RATING:4; GROUP MEAN:4.64, SD:.62)	○	○	○	○	○
Demonstrates genuine motivation to become a competent and ethical rehabilitation counselor (YOUR RATING:4; GROUP MEAN:4.56, SD:.51)	○	○	○	○	○
Commitment to social justice (YOUR RATING:3; GROUP MEAN:3.89, SD:.76)	○	○	○	○	○
Understands/practices in ethical manner (i.e. confidentiality, representation of competence/qualifications, dual relationships, informed consent) (YOUR RATING:4; GROUP MEAN:4.83, SD:.38)	○	○	○	○	○
Understands the challenges to communication with persons with hearing, visual, or cognitive impairments (YOUR RATING:5; GROUP MEAN:4.56, SD:.51)	○	○	○	○	○
Aware of client's cultural differences/influences (YOUR RATING:5; GROUP MEAN:4.56, SD:.62)	○	○	○	○	○
Deals directly and appropriately with conflict rather than avoiding it (YOUR RATING:4; GROUP MEAN:4.39, SD:.50)	○	○	○	○	○
Ability to recognize when they are responding to supervisors, clients, students and other professionals in a manner that puts their own needs before those of their clients (YOUR RATING:4; GROUP MEAN:4.28, SD:.67)	○	○	○	○	○
Uses appropriate language/terminology (e.g. person first language; avoids heterosexist, ableist, racist, and sexist language) (YOUR RATING:4; GROUP MEAN:4.56, SD:.62)	○	○	○	○	○
Able to convey an appropriate level of ease with colleagues and supervisors (YOUR RATING:4; GROUP MEAN:3.72, SD:.57)	○	○	○	○	○
Appropriate dress (YOUR RATING:4; GROUP MEAN:4.22, SD:.65)	○	○	○	○	○
Recognizes how their personal limitations, biases, and beliefs impact the counseling relationship (YOUR RATING:4; GROUP MEAN:4.56, SD:.62)	○	○	○	○	○
Willingness to change when their own biases and beliefs that interfere with their ability to learn how to function as competent and ethical rehabilitation counselor (YOUR RATING:4; GROUP MEAN:4.50, SD:.71) COMMENT: Although it may be useful to have a student be willing to change when their own biases and beliefs interfere with their ability to learn...etc., how is it possible to evaluate a student in these terms. It may not be conveyed as bluntly as "Patty, you are receiving a B in this course because you're not willing to change and do things the right way," that's what the student is going to hear and the pedagogy is likely rendered ineffective. IMHO, it's up to the faculty supervisor to provide guidance and do some motivational work with the student who presents this issue.	○	○	○	○	○

8. Please re-rate whether you agree each item is "useful" for clinical supervision evaluation.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
Sets career goals (YOUR RATING: 4; GROUP MEAN: 3.61, SD: .78)	○	○	○	○	○
Evaluates progress toward own goals (YOUR RATING: 4; GROUP MEAN: 3.89, SD: .83)	○	○	○	○	○
Develop ability to supervise others (YOUR RATING: 3; GROUP MEAN: 3.56, SD: .86)	○	○	○	○	○
Above average verbal and written expression (YOUR RATING: 4; GROUP MEAN: 4.06, SD: .77)	○	○	○	○	○
Willingness to continue to learn and develop professionally (YOUR RATING: 4; GROUP MEAN: 4.61, SD: .61)	○	○	○	○	○
An ability to articulate why the counseling skills they learn are crucial to all the roles and functions (e.g., vocational rehabilitation counselor, case manager, job developer, vocational evaluator) of rehabilitation counselors (YOUR RATING: 3; GROUP MEAN: 4.17, SD: .92)	○	○	○	○	○
Willing to experiment or take risks in counseling session (YOUR RATING: 3; GROUP MEAN: 4.06, SD: .77)	○	○	○	○	○
Recognizes limits of competency (YOUR RATING: 3; GROUP MEAN: 4.56, SD: .70)	○	○	○	○	○
An ability to engage in critical self-reflection rather than focusing solely on the mistakes of others when they participate in clinical training, practicum and internship experiences (YOUR RATING: 4; GROUP MEAN: 4.56, SD: .71) COMMENT: An ability to engage in critical self-reflection rather than focusing solely on the mistakes of others when they participate in clinical training, practicum and internship experiences Regarding the above item, although I think this may be important, I would rather rate only the first phrase. This is a maturity issue and can be addressed in supervision as guidance and motivational work.	○	○	○	○	○
Ability to write and state a disclosure statement (YOUR RATING: 4; GROUP MEAN: 4.06, SD: .77)	○	○	○	○	○

9. Please re-rate whether you agree each item is "useful" for clinical supervision evaluation.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
Recognition of the importance of self care (YOUR RATING:4; GROUP MEAN:4.17, SD:.62) COMMENT: Recognition of the importance of self care An awareness of when their own personal issues are interfering with their ability to learn and practice in a professionally and ethically responsible manner regarding the above statements. Awareness or recognition is one thing; demonstrating awareness of what to do about it and subsequently following through is another, and I believe the more important "behavior" to evaluate.	○	○	○	○	○
An awareness of when their own personal issues are interfering with their ability to learn and practice in a professionally and ethically responsible manner (YOUR RATING:4; GROUP MEAN:4.56, SD:.70)	○	○	○	○	○
Willingness to seek out professional counseling for themselves when it is needed in order for them to function ethically and professionally (YOUR RATING:4; GROUP MEAN:4.44, SD:.70)	○	○	○	○	○
Demonstrates emotional stability (YOUR RATING:5; GROUP MEAN:4.39, SD:1.04)	○	○	○	○	○
Manages own mental health disabilities (YOUR RATING:5; GROUP MEAN:4.33, SD:1.14) COMMENT: The self care statements are very important. In particular, the manages own mental health disabilities. I know this is overlooked in some institutions.	○	○	○	○	○

10. Please re-rate whether you agree each item is "useful" for clinical supervision evaluation.

GENERAL COMMENT: I don't know what many of these words mean. I know what I mean by them, but I don't know what others may mean by them. The shades of meaning of many of these words are too variable for me to interpret-and therefore they are not useful (to me).

	Strongly Disagree (1)	Agree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
Empathetic / Convey empathy to clients (YOUR RATING: 5; GROUP MEAN: 4.89, SD: .32)	○	○	○	○	○
Dependable / reliable (YOUR RATING: 5; GROUP MEAN: 4.94, SD: .24)	○	○	○	○	○
Demonstrates unconditional positive regard (YOUR RATING: 5; GROUP MEAN: 4.50, SD: .71)	○	○	○	○	○
Genuine (YOUR RATING: 5; GROUP MEAN: 4.89, SD: .32)	○	○	○	○	○
Warm (YOUR RATING: 4; GROUP MEAN: 4.61, SD: .80)	○	○	○	○	○
Open minded (YOUR RATING: 5; GROUP MEAN: 4.72, SD: .46)	○	○	○	○	○
Non-judgmental (YOUR RATING: 5; GROUP MEAN: 4.78, SD: .43)	○	○	○	○	○
Flexible/adaptable (YOUR RATING: 5; GROUP MEAN: 4.67, SD: .49)	○	○	○	○	○
Approachable / Non-threatening (YOUR RATING: 5; GROUP MEAN: 4.83, SD: .38)	○	○	○	○	○
Patient (YOUR RATING: 4; GROUP MEAN: 4.39, SD: .61)	○	○	○	○	○
Honest (YOUR RATING: 5; GROUP MEAN: 4.44, SD: .86)	○	○	○	○	○
Truthful (YOUR RATING: 5; GROUP MEAN: 4.61, SD: .78)	○	○	○	○	○
Humble (YOUR RATING: 3; GROUP MEAN: 3.67, SD: .77)	○	○	○	○	○
Altruistic (YOUR RATING: 3; GROUP MEAN: 3.94, SD: .94)	○	○	○	○	○
Motivating (YOUR RATING: 3; GROUP MEAN: 4.17, SD: .79)	○	○	○	○	○
Energetic (YOUR RATING: 3; GROUP MEAN: 3.72, SD: .89)	○	○	○	○	○

Assertive (YOUR RATING: 3; GROUP MEAN: 3.83, SD: .86)	○	○	○	○	○
Calming/soothing (YOUR RATING: 3; GROUP MEAN: 3.78, SD: .88)	○	○	○	○	○
Positive (YOUR RATING: 4; GROUP MEAN: 4.17, SD: .79)	○	○	○	○	○
Attentive (YOUR RATING: 4; GROUP MEAN: 4.61, SD: .61)	○	○	○	○	○
Humorous (YOUR RATING: 4; GROUP MEAN: 3.61, SD: .78)	○	○	○	○	○
Respectful (YOUR RATING: 4; GROUP MEAN: 4.72, SD: .46)	○	○	○	○	○
Direct (YOUR RATING: 3; GROUP MEAN: 3.67, SD: .91)	○	○	○	○	○
Creative (YOUR RATING: 3; GROUP MEAN: 4.00, SD: .69)	○	○	○	○	○
Intelligent/wise (YOUR RATING: 3; GROUP MEAN: 3.67, SD: .91)	○	○	○	○	○
Logical (YOUR RATING: 3; GROUP MEAN: 3.83, SD: .92)	○	○	○	○	○
Experienced (YOUR RATING: 3; GROUP MEAN: 3.44, SD: .78)	○	○	○	○	○
Confident (but not arrogant) (YOUR RATING: 4; GROUP MEAN: 4.11, SD: .68)	○	○	○	○	○
Kind / thoughtful / caring (YOUR RATING: 4; GROUP MEAN: 4.33, SD: .81)	○	○	○	○	○
Mature (YOUR RATING: 4; GROUP MEAN: 4.28, SD: .83)	○	○	○	○	○
Comfortable with client (YOUR RATING: 4; GROUP MEAN: 4.28, SD: .67)	○	○	○	○	○
Non-defensive (YOUR RATING: 4; GROUP MEAN: 4.50, SD: .62)	○	○	○	○	○
Displays common sense (YOUR RATING: 4; GROUP MEAN: 4.28, SD: .89)	○	○	○	○	○
Conscientious/prudent (YOUR RATING: 4; GROUP MEAN: 4.17, SD: .86)	○	○	○	○	○
Intuitive/perceptive (YOUR RATING: 4; GROUP MEAN: 4.00, SD: .84)	○	○	○	○	○
Extroverted (YOUR RATING: 3; GROUP MEAN: 2.78, SD: .94)	○	○	○	○	○
Introverted (YOUR RATING: 3; GROUP MEAN: 3.67, SD: .97)	○	○	○	○	○
Capable (YOUR RATING: 4; GROUP MEAN: 4.11, SD: 1.02)	○	○	○	○	○

Ebullient/happy (YOUR RATING:3; GROUP MEAN:3.00, SD:.87)	○	○	○	○	○
Hard-working (YOUR RATING:3; GROUP MEAN:4.06, SD:.87)	○	○	○	○	○
Moderating/judging (YOUR RATING:3; GROUP MEAN:3.17, SD:1.10)	○	○	○	○	○
Timely/opportune (YOUR RATING:4; GROUP MEAN:3.83, SD:.86)	○	○	○	○	○
Just (YOUR RATING:4; GROUP MEAN:4.00, SD:.91)	○	○	○	○	○
Succinct (YOUR RATING:3; GROUP MEAN:3.56, SD:.78)	○	○	○	○	○
Pleasure to work with (YOUR RATING:3; GROUP MEAN:3.56, SD:1.20)	○	○	○	○	○
Team player (YOUR RATING:3; GROUP MEAN:3.72, SD:.96)	○	○	○	○	○
Healthy (YOUR RATING:3; GROUP MEAN:3.61, SD:1.09)	○	○	○	○	○
Goal oriented (YOUR RATING:3; GROUP MEAN:4.06, SD:.87)	○	○	○	○	○

11. Please re-rate whether you agree each item is "useful" for clinical supervision evaluation.

	Strongly Disagree (1)	Disagree (2)	Neutral (3)	Agree (4)	Strongly Agree (5)
Suicide risk assessment (YOUR RATING: 5; GROUP MEAN: 4.67, SD: .89)	○	○	○	○	○
Manages resources (YOUR RATING: 5; GROUP MEAN: 4.39, SD: .70)	○	○	○	○	○
Fiscal management (YOUR RATING: 5; GROUP MEAN: 4.06, SD: .87)	○	○	○	○	○
Crisis management (YOUR RATING: 5; GROUP MEAN: 4.61, SD: .80)	○	○	○	○	○

12. Thank you for completing this Delphi study. Your contribution is very much appreciated

In order for us to keep track with your final submission, please include your name in the box below.

APPENDIX K
ROUND 3 FRIENDLY REMINDER EMAIL

Dr. XXXXX

This is a reminder email regarding your participation in the University of Florida clinical supervision Delphi study. Thank you for completing the first and second rounds of the clinical supervision Delphi study. The third and final round is now ready for your participation. Similar to round 2, this round is considerably quicker than round 1 and should take between 15-20 minutes to finish. Because we are on a limited time schedule and this round takes considerably less time, we would really appreciate if you could complete this final round by FRIDAY, JULY 4th.

The goal of the third round is to achieve consensus regarding whether or not each item is "useful" for clinical supervision evaluation. Therefore, your participation in this round is highly valuable.

You will now have the opportunity to review the group statistical data as well as your previous ratings. Based on this information, please decide whether or not you would like to keep or change your responses. Unlike the previous round you will not be expected to re-rate each item, only those items you wish to change. Again we want to express our extreme gratitude to you for participating in this study.

To begin the final round of this study, please click on the following link.

https://www.surveymonkey.com/s.aspx?sm=FHfex8ctiiWdtz9s2E1Kfw_3d_3d

Please contact Michael Moorhouse at (352) 273-6491 with any questions regarding this study.

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