

1992

The Effects of Knowledge of Accrued Clinical Clock Hours on Supervisors' Evaluations of Clinical Competence

Julie Ann Johnston-Palmer

This research is a product of the graduate program in [Communication Disorders and Sciences](#) at Eastern Illinois University. [Find out more](#) about the program.

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The Effects of Knowledge of Accrued Clinical Clock Hours

on Supervisors' Evaluations of Clinical Competence
(TITLE)

BY

Julie Ann Johnston-Palmer

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE OF

Master of Science

IN THE GRADUATE SCHOOL, EASTERN ILLINOIS UNIVERSITY
CHARLESTON, ILLINOIS

1992
YEAR

I HEREBY RECOMMEND THIS THESIS BE ACCEPTED AS FULFILLING
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ABSTRACT

Supervision in speech-language pathology is one facet of the field in which all speech-language pathologists have had to engage. The more that is known about the process of supervision the better future speech-language pathologists can be prepared to interact in a professional setting. Many variables are present in supervision related to the field of speech-language pathology. One variable which has received only minimal attention relates to the effect knowledge about a student clinician's number of accrued clinical clock hours has on the evaluation of the clinician's skills. The assumption is often made that a student clinician with more clinical clock hours will provide more efficacious services than a student clinician with fewer clinical clock hours. It has been found that during interactions with student clinicians, supervisors regularly regard all clinicians in a similar manner, and in evaluations, supervisors do not use the information of the amount of accrued clinical clock hours to determine the effectiveness of clinician's interactions.

The purpose of this study was, then, to determine if knowledge of student clinicians' accrued clinical clock hours influenced supervisors' evaluations of student clinicians. Subjects were 26 university supervisors from six midwestern states. Stimuli were videotapes of a beginning clinician with 19 accrued clinical clock hours

interacting with a client and an advanced clinician with 225 accrued clinical clock hours interacting with a different client. Subjects rated the advanced and beginning clinicians' performances on a nine-point Likert scale using the Cognitive Behavioral System (Leith, 1989).

All data were group analyzed according to one of six treatment conditions by information versus no information and by one order effect versus the second order effect. Response similarities and response differences were calculated by using Analysis of Variance (ANOVA) and Multiple Analysis of Variance (MANOVA) procedures. The data revealed no significant difference in evaluations based on knowledge of accrued clinical clock hours. Implications for future research were reviewed.

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CHAPTER I

INTRODUCTION

Supervision of Communication Disorders and Sciences students has been an integral part of clinical training since the conception of the field (ASHA, 1978). As early as 1937, the concept of supervision was described in the Journal of Speech and Hearing Disorders (Robbins, 1937), and in 1965 Van Riper heralded supervision as "one of the most important functions in the training center" (Van Riper, 1965, p. 75).

Over the years considerable research has emerged regarding the supervisory process. Such research has enabled supervisors and supervisees alike to gain a clearer understanding of supervisory perceptions, objectives and evaluation processes. Relatively recently the variable of the accrued number of supervised clinical clock hours of student clinicians has come to be viewed as a factor which might influence the clinical evaluation process. A study conducted by Andersen (1981) demonstrated that supervisors' evaluations were not influenced by the amount of student accrued clinical clock hours. A second investigator (Anderson, 1988) stated that student clinicians vacillate along a continuum of needs of supervisory styles throughout practicum experiences. This vacillation fluctuates with the student clinicians' levels of clinical maturity. Therefore, it appears necessary that in valid supervisory evaluations,

supervisors should be influenced by students' accrued number of clinical clock hours. With these points noted in the literature, further research is warranted to clarify the influence of student clinicians' accrued number of clinical clock hours on the evaluation process.

Purpose of the Study

The purpose of this investigation was to determine if knowledge of student clinicians' accrued clinical clock hours influenced supervisors' evaluations of the clinicians.

Summary

Points were discovered in the literature regarding the amount of significance student clinicians' number of accrued clinical clock hours should carry in the evaluation process. The intent of this study was to determine if supervisors in speech-language pathology in the university setting were biased in their evaluations of clinicians' performances by knowledge of the amount of prior accrued clinical clock hours of student clinicians.

CHAPTER II

REVIEW OF LITERATURE

Supervision of Communication Disorders and Sciences students has been inherent in the clinical training since the conception of the field (ASHA, 1978). In 1974, the American Speech and Hearing Association (ASHA) officially recognized the relevance by appointing a standing committee to specifically define, address and monitor activities related to the supervisory process. ASHA defined clinical supervision as:

"the tasks and skills of clinical teaching related to the interaction between a clinician and client" (ASHA, 1985, p. 57).

The specific charges of the ASHA Committee on Supervision of Speech-Language Pathology and Audiology (CSSPA) were to:

1. Investigate the perceived status problems in supervision and propose solutions for whatever problems may be identified.
2. Develop role definitions and guidelines for supervisors in various settings.
3. Define qualification standards for supervisors in various settings.
4. Investigate the possibility of determining a supervisor/supervisee ratio at various settings.
5. Develop criteria for evaluation and devise systems

of accountability for supervisors.

6. Develop guidelines for training programs for supervisors in various settings (ASHA, 1978, p. 485).

In May 1982, CSSPA drafted a position statement which defined minimum qualifications for supervisors. Five minimum qualifications were identified: 1) a master's degree or its equivalent in the subject area for which supervision would be provided, 2) the Certificate of Clinical Competence in the subject area for which supervision would be provided, 3) a minimum of two years of full-time professional experience beyond the Clinical Fellowship Year in the subject area to be supervised, 4) six semester credit hours or nine Continuing Education Units (CEUs) in supervision with at least one-half of the credit hours or CEUs being specific to the supervisory process in communication disorders, and 5) fifty hours of involvement with, or observation of a "competent, experienced" supervisor (ASHA, 1982). In an ASHA 1978 document, the committee proposed twelve tasks that comprised the foundation activities of clinical supervisors. These were later revised to include thirteen tasks (Appendix A). Responsibilities of clinical supervisors were also summarized:

A clinical supervisor engages in clinical teaching through observation, conferences, review of records,

and other procedures which are related to the interaction between a clinician and a client and the evaluation or management of communication skills (ASHA, 1978).

Evaluation in the Supervisory Process

Clinical supervisors may evaluate the competence of student clinicians in both verbal and written forms. Verbal evaluation occurs on a frequent basis while written evaluation normally occurs as a result of observation of the clinical session (Farmer & Farmer, 1989). Although several tools are available for use in the written evaluation process, Farmer and Farmer (1989) have urged that in order to be valid, effective evaluation tools should meet certain minimum criteria. They should:

1. Allow for evaluation of both skills and dispositions.
2. Be of sufficient length to cover essential components of competence as defined by and [sic] individual institution.
3. Be relatively easy and efficient to complete.
4. Be formatted logically and attractively and reproduced clearly.
5. Combine qualitative and quantitative grading.
6. Use descriptors or definitions to clarify terminology.
7. Be flexibly designed to be used with a range of

personnel levels.

8. Provide information that would be useful feedback to assist personnel in professional development (Farmer & Farmer, 1989, p. 300).

Although not specifically stated, Farmer and Farmer (1989) have implied in their evaluation criteria that valid evaluations must be influenced by knowledge of the number of clinical clock hours of the clinician being evaluated. Following is a summary of the various types of evaluation mechanisms, systems and scales which are available.

Narrative Evaluative Statements

Narrative evaluative statements are often subjective. Runyan and Seal (1985) have discovered that comments made by supervisors can be expected to vary in range and type. Comment types range in order of frequency from statements concerning using appropriate voice, speech and language, to being skillful in motivating the client to attending to therapy setting and clinical materials. More recently, Runyan (1991) has detailed the advantages and disadvantages of narrative evaluative statements. Advantages include a low amount of effort, a high amount of expediency, an opportunity to identify behaviors that are not appropriate to chart but need to be addressed, and the enjoyment experienced by student clinicians receiving this form of feedback. Some disadvantages are that narrative evaluative statements discourage supervisees from self-analysis and

creative thinking, set the supervisor up as an authority and judge, do not consider accrued clinical clock hours and potentially foster dependence on the part of the supervisee. In addition, a supervisor may have a particularly narrow focus which may influence the evaluations. Although no specific forms for narrative evaluation statements were identified, an example of a narrative evaluation is, "You have modified your intervention strategies from the first of your assignment, and I feel you are showing growth as a clinician!! You are much more natural in your language modeling. Your engagement with _____ is exciting to watch, and I can tell that both of you are interested in the materials and activity".

Interaction Analysis

A second method of evaluation, interaction analysis, is defined as a structured form of recording observations that categorizes behaviors occurring in clinical sessions into common distinguishable sets (Anderson, 1988; Peaper, 1991). The interaction between events can be analyzed and patterns identified. These may then be correlated with certain outcomes (Peaper, 1991).

Much like narrative evaluation statements, several interactional analyses advantages and disadvantages have been recognized (Peaper, 1991). One advantage is that large quantities of information concerning supervisee behaviors may be organized in a theoretical, structured, meaningful

fashion. Still further, progress may be measured against a baseline of clinical behaviors, and such analyses may be based on "previously described categories set forth by each system thus reducing opinion, judgement, inaccuracy, misinterpretation and errors due to poor memory" (Peaper, 1991, p. 2). Once the system is learned, analysis can be accomplished rather quickly and reliably. Interaction analysis systems are also useful for supervisee self-analysis, and finally, both the supervisor and supervisee are able to distinguish individual behaviors for further attention and discussion.

Peaper (1991) similarly determined several disadvantages of interactive analysis systems. First, selected behaviors may reflect author bias or specific theoretical approaches. There may also be an increased potential for subjectivity in selecting one category over another, and behaviors observed may not always fit into one of the pre-determined categories. Still further, interaction analysis systems may not relate to the efficacy of the treatment session nor always account for non-verbal behaviors. Since the focus is on the process of interaction, not on the content, content may be lost. Another disadvantage is that the reliability and validity for most interaction analysis systems have not been well established. Also, the amount of accrued clinical clock hours may or may not be accounted for in interactional

analyses.

A well-known interactive analysis format is The Content and Sequence Analysis of Speech and Hearing Therapy (Boone and Prescott, 1972). The Boone and Prescott (1972) tool was probably among the first to so clearly "dissect" the clinical process (Anderson, 1988). This interactive analysis requires a supervisor to chart each verbal behavior of the clinician and the reaction/response of the client followed by the clinician's response. The interactions are classified into the following categories: explain, describe; model, instruction; good evaluative; bad evaluative; neutral-social; correct response; incorrect response; inappropriate-social; good self-evaluative; and bad self-evaluative. After the interactions of the client and student clinician have been charted, a graph may be drawn to facilitate conceptualization and analysis of the interaction sequence. The format does not regard the experience level of the supervisee or other potentially pertinent background information. Although this format analyzes the type of interactions without regard to content, it is frequently used due to 1) ease of application and 2) the relatively minimal amount of time required to learn use of the system.

The The Analysis of Behavior of Clinicians (ABC) System (Schubert, 1978) is another interactive analysis tool. This system is a timed system in that the supervisor charts

behaviors at three second intervals or when a behavior changes within a three second interval. The following eight supervisee-related categories are charted: (1) observing and modifying lesson appropriately; (2) instruction and demonstration; (3) auditory and/or visual stimulation; (4) auditory and/or visual positive reinforcement of client's correct response; (5) punishment; (6) auditory and/or visual positive reinforcement of client's incorrect response; (7) clinician relating irrelevant information and/or asking irrelevant questions; (8) and using authority or demonstrating disapproval. In addition to supervisee behaviors, four categories are available for observing the client: client responds correctly; client responds incorrectly; client relating irrelevant information and/or asking irrelevant questions; and client is silent. This tool, like the Content and Sequence Analysis of Speech and Hearing Therapy (Boone and Prescott, 1972), is easy to apply but is limited in scope. Its use may be taxing on the supervisor due to the need to monitor behaviors in three second intervals. The categories used for evaluation are judged to be clinically appropriate but do not address interpersonal aspects.

The Multidimensional Clinical Process Scoring System (Diedrich, 1969) and (Johnson, 1970), a third interaction analysis tool, contains forty categories which may be used to evaluate supervisee behavior. Although great preparation

was undertaken to obtain a concise yet thorough tool, the primary disadvantage specific to this tool is that its excessive length makes it impractical.

A fourth interactive analysis tool is the Conover Verbal Analysis System (Conover, 1979). Categories for analysis of supervisee performance include authority, information, model, stimulate, reward, punishment and social. Client analyses occur along the categories of question, correct response, incorrect response and social. The Conover System is similar to the Content and Sequence Analysis of Speech and Hearing Therapy (Boone and Prescott, 1972) in the classification of categories and in the manner of recording. No reliability nor validity information has yet been provided for this system, and the system is noted to have a narrow focus of specific behaviors (Anderson, 1988).

Rating Scales

In addition to narrative evaluative statements and interactional analyses, a third mechanism for supervisory evaluation is that which is conducted through application of one of several rating scales. A rating scale is defined by Farmer & Farmer (1989) as "groups of symbols used to indicate relationships". Rating scales are used to observe specific behaviors, skills or events which have been identified as important to the clinical experience (Farmer, 1991). The Wisconsin Procedure for Appraisal of Clinical Competence (W-PACC) (Shriberg, et al., 1975) is a two part

rating scale containing an interpersonal scale of 10 items and a professional-technical scale of 28 items. Supervisee ratings vary depending upon factors such as hours of experience, number of clients, experience with the disorder area or management approach, and the supervisor's judgement of the student clinician's academic preparation. Each of the 38 items is ranked from one to ten on a Likert type scale (Shriberg, et al., 1975). A percentage score is obtained from the rankings which is ultimately used to calculate a grade for the supervisee. The W-PACC is a tool which accounts for experience, background information of the supervisee and academic preparation (Shriberg, et al., 1975).

The Pennsylvania State University Practicum Evaluation Form (Klevans and Volz, 1974), also a rating type evaluation instrument, was established to reduce evaluation time and procedures and to increase the clarity of evaluation parameters. The tool encompasses four broad areas which include 25 specific clinical skills. These broad areas are diagnosis and reporting, developing and planning therapy, interacting with clients, and personal and professional qualities. Generally, using the Practicum Evaluation Form, the supervisor evaluates a student clinician across all listed clinical skills and charts progress made throughout a semester. A graphic representation is available so that progress may be readily apparent. While the Pennsylvania State tool, or adaptations of it, are frequently used in

practice, no statistical support for this system is available. Many of the clinical skills included are subjective in nature and judged without regard to accrued number of clinical clock hours (Klevans and Volz, 1974).

Although most rating scales have weak validity and reliability (Farmer, 1991), one scale, the Cognitive Behavior System (CBS) (Leith, 1989), is recognized as one which has demonstrated both reliability and validity. The CBS was established through a theoretical foundation of Meichenbaum (1977). The CBS allows for the rating of a supervisee across four broad areas: planning, interactions, clinical management, and procedures. Each skill is assigned two "grades". The first grade is determined on the basis of the amount of guidance required to complete the skill at an acceptable level of competency, and the second determined by the quality of the performance. The "grades" are adjusted depending on the amount of accrued number of clinical clock hours brought to the clinical assignment. Experience levels are well described within a "key to clinical competency" list which specifically states the tasks a student should be able to perform and how well (Leith, 1989). The CBS allows for evaluation of both skills and dispositions and its length covers essential components of competence. Descriptors are included to define each element, and the tool allows flexible application to different experience levels. Finally, the qualitative and

quantitative feedback provide useful information to the supervisee.

While three methods of written evaluation are widely used in the evaluation of speech-language pathology and audiology students (Anderson, 1988; Farmer & Farmer, 1989), each supervisor seems to have preferences for adopting these mechanisms of evaluation. Both the degree of subjectivity and objectivity of any chosen method of evaluation ultimately dictates the form that evaluation of a supervisee's skills will take.

Variables Affecting Supervisory Evaluation

An attempt should be made to recognize and understand the impact or influence of variables on the evaluation of supervisees who are engaged in clinical training programs. Some variables include prior clinical evaluations, grade point average (GPA), total number of clinical clock hours and the potential for these three to interact to bias evaluation (Andersen, 1981). An assumption made by Andersen (1981) has been that there is probably no valid way to control bias. Therefore, supervisors must be aware of bias and attempt to examine reliable, observable data in evaluating supervisees (Andersen, 1981).

Andersen (1981) further indicated that knowledge of prior clinical supervisory evaluations does bias a supervisor's present evaluation. Supervisors tend to rank supervisees who have had prior positive clinical evaluations

higher while ranking lower those supervisees with negative (less than desirable) prior clinical evaluations. Similarly, prior knowledge of the supervisee's grade point average (GPA) has been noted to influence evaluations. Supervisors tended to rank the supervisees higher who have a 3.5 GPA as opposed to supervisees with a 2.5 GPA. A consistent assumption appears to be that prior knowledge regarding academic and clinical performance alters the supervisor's responses during the evaluation process.

The extent to which knowledge of supervisee number of accrued clinical clock hours influences expectations during evaluation is less clear. This finding is of particular interest because it is inconsistent with the basic assumption that different styles of supervisory interaction are needed as the experience of the student increases (Anderson, 1988). Shapiro (1987) has stated that roles and responsibilities of the participants in the supervisory interaction should and do change on the basis of experience and skill level. Still further, the ASHA (1985) Task Number 9 (Appendix A) specifically suggests that evaluation of clinical performance should vary in accordance with the supervisee's experience level.

Conclusions

A review of the evaluations available for the supervisory process presented a dilemma regarding the lack of attention given to the student's number of accrued

clinical clock hours. Observations of the supervisory process suggest that a bias exists when evaluating student clinicians in regard to the accrued number of clinical clock hours. This observation combined with the literature regarding the importance of knowledge of the student's accrued number of clinical clock hours led the investigator to pose the following question: Does prior knowledge of a student clinician's accrued clinical clock hours bias the evaluation of clinical performance?

CHAPTER III

METHODS

Subjects

Twenty-six supervisors of speech-language pathology students from Kentucky, Illinois, North Dakota, Missouri, Tennessee and Indiana participated in this study. All supervisors held a Certificate of Clinical Competence in Speech-Language Pathology from the American Speech-Language-Hearing-Association (ASHA). The clinical supervisors (subjects) had at least one year of experience as university supervisors. Twenty-four of the subjects were female; two were male. This ratio is directly proportional to the 1992 OMNIBUS (ASHA, 1992) survey regarding gender of the speech-language pathology population consisting of 95% females and 5% males.

Eight subjects were randomly assigned to each of two of the three experimental conditions. The third experimental condition contained ten subjects. Group I was comprised of eight females with an average of 9.5 years of supervisory experience. Group II consisted of six females and two males with an average of 12.5 years of supervisory experience, and Group III, ten females, had an average of 8.5 years of supervisory experience. Further demographic information regarding subjects' years of supervisory experience, participation in supervision training and educational level is listed in Table 1.

Table 1

Subject Demographic Information

<u>Subject No.</u>	<u>Experience</u>	<u>Sup. Train.</u>	<u>Ed. Level</u>
04	03	Y	MS
09	14	Y	MS
11	03	N	PhD
12	07	Y	MS
14	01	N	MS
32	06	Y	MS
33	14	Y	MS
34	01	N	PhD
36	07	N	MS
37	02	Y	MS
38	13	Y	PhD
39	04	N	PhD
40	02	N	MS
41	29	Y	MS
44	18	Y	MS
45	11	Y	MS
46	04	N	MS
47	11	Y	PhD
48	28	N	PhD
62	28	Y	PhD
64	25	Y	PhD
65	07	Y	PhD
66	09	Y	MS
67	20	Y	PhD
68	01	N	MS
70	01	N	MS

Videotape Preparation

The videotape prepared for use in this study was recorded on standard VHS tapes and consisted of three segments: (a) a 3:45 minute segment of directions to the subjects, (b) a 9 minute segment of a beginning clinician's treatment session with a client and (c) a 9 minute segment of an advanced clinician's treatment session with a client. Script of the 3:45 minute segment of directions to the subjects is located in Appendix B. The beginning clinician had accrued 19 supervised clinical clock hours, while the advanced clinician had 225 supervised clinical clock hours. The clinical hour differentiation categories for the terms "beginning" and "advanced" were adopted from the Wisconsin Procedure for Appraisal of Clinical Competence (W-PACC) (Shriberg, 1975).

During the videotape preparation of the beginning clinician, the dyad participants were seated a comfortable distance from each other (approximately two - three feet) at a table in a large room in which therapy materials were present. Portable video recording equipment was positioned in the therapy room in a lateral, frontal position to the participants. The videotape preparation of the advanced clinician segment occurred as the dyad participants were seated a comfortable distance from each other on the floor. The recording equipment was positioned in the same lateral, frontal position to the participants as in the beginning

clinician videotape segment. Both videotape preparations occurred in the same clinical room at the Speech-Language-Hearing Clinic at Eastern Illinois University.

Clinician/Client Dyads

Permission to videotape for research purposes was obtained from the student clinicians, guardians of clients, and supervisors. (Appendices C, D and E). The client interacting with the beginning clinician was a four year old female diagnosed with Down syndrome with subsequent phonological and language disorders. She had received treatment with a different clinician at Eastern Illinois University for one semester previous to the taping utilized for the present study. The beginning clinician and client had been engaged in clinical activities for one hour sessions four times a week for three weeks prior to the taping of the segment used in the current study.

The client interacting with the advanced clinician was a six year old male who had a severe articulation deficit and language processing disorder. The client had participated in treatment with different clinicians at Eastern Illinois University for two semesters previous to the taping utilized for the present study. The advanced clinician and client had been engaged in clinical activities for one hour sessions four times a week for five weeks prior to the segment used in the current study. Video segments for both the beginning and advanced clinicians were

collected from actual therapy sessions. Appendix F and G contain lesson plans for the two treatment sessions.

The two student clinicians, both females of similar age, were selected by categorization according to the number of accrued clinical clock hours as determined by the W-PACC, matches in grade point average (GPA), and previous supervisory evaluation. These criteria were selected based upon results of an Andersen (1981) study which revealed that knowledge of GPA and previous supervisory evaluations biased evaluations of student clinicians' clinical competence, but knowledge of accrued clinical clock hours did not. The primary difference between the two clinicians was that of previous accrued number of clinical clock hours, with the beginning clinician having 19 hours of supervised clinical practicum training and the advanced clinician having 225. The majority of the hours accrued for both clinicians was in the areas of speech and language. Three speech-language pathologists viewed the videotaped segments of the beginning and advanced clinicians without knowledge of the clinicians' accrued number of clinical clock hours and judged the clinicians to be functioning at a beginning and advanced level, respectively. The second criteria by which the two student clinicians were matched was that of GPA. The beginning clinician had a major GPA of 4.0 on a 4.0 scale while the advanced clinician's major GPA was 3.74. The third criteria by which the two were matched was that of

previous supervisory evaluation, both having been evaluated by the same supervisor at an "A" level.

Procedures

Each of the twenty-six subjects responded to a letter which invited participation in the study (Appendix H) and completed a biographical information sheet (Appendix I). A "name-to-number" sheet was also included for establishing a subject identification number for each supervisor (Appendix J). Documentation of their eligibility to engage in the study across dimensions of years of clinical experience and verification of clinical competence was obtained. After subjects were identified, a letter was sent to each university with directions for completing the investigation and for returning the materials to the investigator (Appendix K).

Group I was given no information concerning the clinicians' accrued clinical clock hours. Group II was informed that both the beginning and advanced clinicians were at a beginning level of clinical training. Group III was informed that both the beginning and advanced clinicians were at an advanced level of clinical training. Order effects were controlled in that half of the subjects in each treatment condition first viewed the beginning clinician dyad, whereas the other half first viewed the advanced clinician dyad. Table 2 contains the research design.

Table 2

Research Design

<u>Info. Condition</u>		<u>Group I</u>	<u>Group II</u>
None	n=08	BA	AB
Beginning (B)	n=08	BA	AB
Advanced (A)	n=10	BA	AB

All subjects in all groups individually viewed the same segments of the beginning and advanced clinicians' treatment sessions. They were told they would rate videotaped treatment sessions to determine if supervisors in different university settings were consistent in their evaluations of student clinician behaviors.

Prior to viewing the videotaped segments, each subject in each treatment condition was provided with the evaluation instrument, the procedures section of the Cognitive Behavioral System (Leith, 1989). Appendices L, M, N, O, P and Q contain the instrument with the three different treatments available to subjects, while Appendix R contains the permission to use the CBS section from the authors. The subjects then viewed a 3:45 minute instructional segment on videotape (Appendix B). The evaluation tool, CBS, contained thirteen items which were to be rated on a nine-point Likert scale with one representing the lowest score and nine representing the highest. (Appendix S contains behavioral descriptions of the 13 items.) After viewing the first videotaped segment of either the beginning or the advanced clinician dyad, each subject was required to complete a CBS evaluation. Subsequently, subjects viewed and rated the remaining clinician dyad. Completed ratings were returned via postal service delivery to the investigator for analyses.

Statistical Procedure

An Analysis of Variance (ANOVA) and a Multiple Analysis of Variance were conducted to determine the main effects and interaction effects of the independent variables: (a) the order of presentation of clinician dyads, and (b) the knowledge of number of accrued clinical clock hours on the three groups of data. The dependent variable was the CBS ratings.

CHAPTER IV

RESULTS

The purpose of this study was to determine if knowledge of student clinicians' accrued clinical clock hours influenced supervisors' evaluations of the clinicians. Twenty-six speech-language pathologists employed as supervisors in university settings served as subjects and supplied evaluations of videotaped clinician/client interactions. These subjects represent 70% of the subjects who had committed participation in the study.

The mean and standard deviation for each of the 13 items on the CBS (Appendix L) for evaluation of the advanced and beginning clinicians are displayed in Table 3. The scoring scale ranged from one to nine with one representing the lowest and nine representing the highest score. Table 3 data was manipulated with median replacement for any missing data, which totalled 1.7%.

Insert Table 3 about here

Table 3

Means and Standard Deviations of 26 CBS Scores (Leith, et al., 1989) for the Advanced and Beginning Clinicians

<u>Item No.</u>	<u>Mean</u>	<u>Std. Dev.</u>
<u>Advanced</u>		
01	*5.19	2.33
02	6.38	2.33
03	5.15	2.26
04	5.19	2.40
05	6.50	2.28
06	5.31	2.20
07	5.62	1.96
08	6.23	2.25
09	4.15	2.24
10	5.46	2.83
11	5.00	2.45
12	2.04	2.11
13	5.73	2.68
<u>Beginning</u>		
01	3.54	2.45
02	4.85	2.51
03	5.08	1.92
04	4.00	2.08
05	3.69	2.17
06	4.77	2.23
07	5.00	2.06
08	5.27	2.20
09	4.00	2.35
10	3.23	2.27
11	3.46	1.88
12	1.65	1.38
13	4.54	2.34

* Maximal mean = 9.0.

Information Effect

An Analysis of Variance (ANOVA) procedure was computed to determine if knowledge of accrued clinical clock hours of student clinicians influenced supervisors' evaluations of the clinicians. The results indicated that there was not a significant influence on the evaluations relative to knowledge of accrued clinical clock hours for either the advanced or the beginning clinician (Table 4). Repeated measures ANOVAs (Table 5) were utilized to further examine differences in the ratings for the advanced and beginning clinicians. Total evaluation scores for the advanced clinician's performance were statistically higher than total evaluation scores of the beginning clinician's performance. In other words, the advanced clinician was consistently rated more clinically effective than the beginning clinician despite what information was provided.

Insert Tables 4 and 5 about here

Table 4

ANOVA for Information Effect (Advanced and Beginning Clinicians)

<u>Main Effects</u>	<u>df</u>	<u>F</u>	<u>Sig. of F</u>
<u>Advanced</u>			
INFO	2	.215	*.808
<u>Beginning</u>			
INFO	2	.763	.479

* Significance level = .05 level of confidence.

Table 5

Degrees of freedom, F and Significance of F for Clinician Evaluation (Advanced vs. Beginning)

<u>Source of Variation</u>	<u>df</u>	<u>F</u>	<u>Sig. of F</u>
Clinician	20	6.52	*.019

* Significance level = .02 level of confidence.

Order Effect

An order effect was accounted for within groups so that half of the subjects in each treatment condition first viewed the beginning clinician dyad, while the other half viewed the advanced clinician dyad first. The results of an ANOVA indicated a marginal significance regarding the order of presentation of the stimuli when the information condition was that both clinicians were advanced. No significance was discovered for an order effect when the information condition was that both clinicians were at a beginning level (Table 6).

Insert Table 6 about here

Table 6

ANOVA (df, Mean Square, F and Sig. of F) of Order Effect of 26 CBS Evaluations (Leith, et al., 1989) (Information Condition= both clinicians at an advanced and beginning level)

<u>Source of Variation</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>Sig. of F</u>
<u>Advanced</u>				
Order	1	2165.686	4.1	*.056
<u>Beginning</u>				
Order	1	474.510	.868	.363

* Significance level = .05 level of confidence.

Post Hoc Analyses

A post hoc analysis was completed using ANOVA procedures to determine if biographical variables of the subjects contributed significantly to the study's results. The post hoc ANOVAs were conducted on the subject group variables of educational level, previous academic training in supervision and years of supervisory experience.

The ANOVA regarding the educational level of the subjects resulted in an insignificant difference in the evaluations of subjects according to education level of a Master of Science degree (M.S. or the equivalent) or a Doctorate of Philosophy (Ph.D. or the equivalent). In other words, there was no main effect for education level. When evaluating the advanced clinician, the Ph.D. subjects tended to evaluate the clinician lower than did the M.S. subjects, although not significantly lower. The ANOVAs for main effects by educational level are located in Table 7 while totals of evaluations for the advanced and beginning clinicians are located in Table 8. As evidenced in Table 8, the Ph.D. level subjects tended to rate the beginning clinician higher than did the M.S. level subjects, a finding which is opposite of that for the advanced clinician evaluations.

Insert Tables 7 and 8 about here

Table 7

ANOVA for Education Level (Advanced and Beginning Clinicians)

<u>Main Effects</u>	<u>df</u>	<u>F</u>	<u>Sig. of F</u>
<u>Advanced</u>			
Educational Level	1	.226	*.640
<u>Beginning</u>			
Educational Level	1	1.802	.195

* Significance level = .05 level of confidence.

Table 8

Totals of CBS Evaluations (Leith, et al., 1989) by Subject Degree Level for the Advanced and Beginning Clinicians

<u>Degree Level</u>	<u>N</u>	<u>Total Score</u>	<u>Mean Score</u>
<u>Advanced</u>			
M.S.	16	70.88	*4.5
Ph.D.	10	63.30	6.5
<u>Beginning</u>			
M.S.	16	50.19	3.0
Ph.D.	10	57.70	5.5

* Rounded to the nearest 0.5 with a maximal mean = 9.0.

The second variable tested for a main effect by a post hoc ANOVA was that of previous academic training in supervision. The data was analyzed in two groups with a positive or negative response regarding prior participation in supervisory academic training. No significant differences were found in the evaluation of the beginning or advanced clinician relative to previous training in clinical supervision. In other words, whether subjects had or had not received specific training on the process of clinical supervision their ratings of the clinicians were not affected. Table 9 displays these data.

Insert Table 9 about here

Table 9

ANOVA for Subject Academic Training in Supervision (Advanced and Beginning Clinicians)

<u>Main Effects</u>	<u>df</u>	<u>F</u>	<u>Sig. of F</u>
<u>Advanced</u>			
Previous Training	1	.527	*.476
<u>Beginning</u>			
Previous Training	1	.894	.356

* Significance level = .05 level of confidence.

The third variable, years of supervisory experience, was also analyzed using an ANOVA procedure. Two groups, one with 7 years or less of supervisory experience and one with 9 years or more of supervisory experience, were studied to determine what influence years of experience had on evaluation of student clinicians. No significant main effect was revealed for the demographic variable of years of supervisory experience. Table 10 displays the 26 total evaluation scores for the beginning and advanced clinicians, while Table 11 reports ANOVA results for the advanced and beginning clinicians relative to years of supervisory experience.

Insert Tables 10 and 11 here

Table 10

Total CBS Scores (Leith, et al., 1989) for the Advanced and Beginning Clinician by Subject Group of Supervisory Experience Level

<u>Amount of Exp.</u>	<u>N</u>	<u>Adv. Clin.</u>	<u>Begin. Clin.</u>
Seven years or less	14	72.21	59.86
Nine years or more	12	63.00	45.17

Table 11

Sum of squares, degrees of freedom, F and Sig. of F for Evaluations of Advanced and Beginning Clinicians by Supervisory Experience Level

<u>Source of Variation</u>	<u>SS</u>	<u>df</u>	<u>F</u>	<u>Sig. of F</u>
<u>Advanced</u>				
Experience in Years	483.7	1	.738	*.400
<u>Beginning</u>				
Experience in Years	965.6	1	1.956	.177

* Significance level = .05 level of confidence.

CHAPTER V
DISCUSSION

The purpose of the present investigation was to determine if knowledge of student clinicians' accrued clinical clock hours influenced supervisors' evaluations of the clinicians. Supervisors of speech-language pathology in university settings served as subjects. The results of the study indicate that accrued clinical clock hours was not a crucial factor in the evaluation of student clinicians' practicum experiences in this study. The present study is in agreement with Andersen's (1981) findings concerning the insignificance of the knowledge of the level of accrued clinical clock hours.

Data revealed that supervisors in a university setting did not utilize the information variable of knowledge of clinician accrued clinical clock hours when evaluating the effectiveness of that clinician's therapeutic interactions. A number of variables which may have contributed to this result will be discussed.

Implications of Research

This research found that supervisors in the university setting consistently evaluated the advanced clinician more favorably than the beginning clinician. This implies that supervisors intuitively evaluate clinical skills in a similar manner. Regardless of educational level, years of supervisory experience or participation in formal training in supervision, supervisors could distinguish between an advanced and a

beginning clinician. It would appear, then, that supervisors have a shared set of expectations of skills for clinicians with some uniformity of definition of characteristics which comprise therapeutic maturity. It is important to note that the data implies a consistency of evaluations across different university settings. The strength of this consistency, significant beyond the .02 level of confidence, might suggest that with such uniformity results might be generalizable to supervisors in other settings. If the N were enlarged beyond the modest number of 26 in this study, the tendency would be for the significance to grow even stronger. This increased N would thus strengthen the generalizability of the results.

Again, this "shared set of characteristics" for the definition of clinician behavior becomes an issue in terms of speculating why the advanced clinician was always rated higher than the beginning. Could the similarities of evaluations be due to each supervisor holding a Certificate of Clinical Competence (CCC) or to each supervisor having had similar coursework? Could it be that each supervisor's own clinical practicum allowed them evaluation insight? Whatever the influencing factors, it did not appear that the variables of level of education, formal supervisory training or years of supervisory experience had impact. These results are particularly enlightening when one reviews ASHA's stance on supervision. In May 1982, ASHA cited minimum qualifications for supervisors, which included earning a master's degree and

CCC, being employed two years beyond the clinical fellowship year, obtaining six to nine continuing education units per year in supervision and participating in fifty hours of collaboration with a "competent, experienced" supervisor (ASHA, 1982). From the current study's results, the necessity of some of these minimum qualifications cited in the ASHA article are debatable. Whether the qualifications were adhered to or not, the supervisors had similar ratings of the clinicians. A review of the minimum qualifications would be an appropriate next action to see if revisions are in order.

Even though the advanced clinician was identified as being significantly more clinically advanced than the beginning clinician, an interesting influence to contemplate is that of clinician academic level. With the current trend toward moving practicum assignments to the graduate level, one might surmise that a new set of supervision evaluation standards may emerge. Would the results of this investigation have been different had both clinicians shared similar academic backgrounds (graduate level) but significantly different backgrounds relative to accrued number of clinical clock hours (one being beginning and the other advanced)?

The marginal significance of the data in relation to order effect implies that scheduling of supervisory observations is potentially influencing on clinical evaluations. In other words, evaluation of one clinician may impact on the evaluation of a subsequent clinician. Often

supervisors will engage in back-to-back observations. Therefore, careful scheduling controls may assure objectivity during evaluations of multiple student clinicians.

Limitations of Research

Some limitations were discovered when analyzing the study's stimuli, evaluation tool and subject number. Regarding the stimuli, three subjects who had received the "BA" treatment reported that the videotapes were of less than desirable quality. The videotaped stimuli might have been judged more reliably if the tapes had been of studio quality. Tapes utilized in the study were recorded with a portable recorder and subsequently dubbed from a first generation videotape to second generation tapes. Another potential limitation of the stimuli was the utilization of one client without a diagnosed syndrome and one with a diagnosed syndrome. Although the subjects were to be evaluating the clinician, subjects may have been affected by the client's appearance and behavior. Literature is available which indicates that attitudes are different about persons with obvious dysmorphia related to a syndrome than for persons with no dysmorphic appearance (Graffi & Minnes, 1988).

An additional possible limitation of the study's stimuli relates to the type of therapeutic approach used in the videotaped treatment sessions. Although both clients were receiving treatment for phonology and language deficits, the beginning clinician's session differed from that of the

advanced clinician's session. The beginning clinician's therapy focused on modelling and language skills, whereas the advanced clinician's session focused on eliciting responses and phonology. There were no research controls for techniques used and this lack of control may have influenced the subjects' evaluations.

Regarding the evaluation tool, reliability measures have been established which indicated that this was an appropriate tool for the use in this study. However the CBS did not provide a space in which to record "did not observe". The nine minute videotaped segments used as stimuli may not have captured all CBS behaviors.

Still further, the study format did not provide for a comprehension control of the written information accompanying the stimuli. There was no assurance that the clinicians' identification information had been read.

Twenty-six subjects participated in the current study. The small number of subjects per treatment condition may have affected study outcome. With a larger number of subjects, the possibility of finding more significant differences or agreements is increased (Shearer, 1982). With only twenty-six subjects in the total subject pool, no more than five subjects were in any of the six treatment cells. The power of statistics available for use during the analysis was limited.

Implications for Further Research

Literature on supervision in speech-language pathology

consistently indicates a need for further supervisory research. Several areas to be researched have surfaced from the present study's results.

1. Future investigations of the variable of accrued clinical clock hours should be conducted that account for:
 - a) studio quality taping capacity,
 - b) a range of clinicians representative of diversity in age, gender and ethnicity in speech-language pathology training programs,
 - c) a range of supervisors/subjects representative of diversity in age, gender, ethnicity, and years of supervisory experience in speech-language pathology training programs,
 - d) a larger number of subjects,
 - e) a specific allocation of a character or number to represent a behavior that was not observed, and
 - f) a comprehension check to assure that the identification information has been read.
2. Determine the influence that client characteristics have on judgments of clinician performance.
3. Determine the effect of providing the information to be measured through a written modality only versus a multi-media modality (i.e., videotape, written information and audio recordings).
4. Determine the significance of on-site training to the

task of the study versus the viewing of video recorded training to the task of the study.

5. Determine the influence of manipulating an interaction of the two variables (GPA and previous supervisory evaluations) with the accrued clinical clock hours variable as in the Andersen 1981 study.
6. Determine minimum supervisory qualifications necessary to result in clinician evaluation agreement.
7. Determine the influence of academic training on evaluation of advanced and beginning level clinicians.

Summary and Conclusions

The purpose of this investigation was to determine if knowledge concerning accrued clinical clock hours of a student clinician influenced supervisors' evaluations. ANOVAs and MANOVAs were conducted. Results indicated that, under the conditions present in this investigation, knowledge of accrued clinical clock hours was not a significant variable in evaluations of student clinicians. The evaluations of the advanced clinician were significantly higher than those of the beginning, regardless of the informational variable or supervisory demographic variable. Therefore, it appears that university supervisors are perceptive in identifying critical clinical performance differences between a beginning and an advanced clinician.

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Appendices

Tasks of Effective Supervision

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

(ASHA, 1985, pp. 57-60)

Appendix B

Script of Instructions to Subjects

Hello. My name is Julie Ann Johnston-Palmer, the primary investigator for this study. Thank you for participating in this investigation which will involve viewing two videotaped segments of clinician/client dyads. Each segment is approximately 9 minutes in length. As mentioned in the letter of invitation to participate in this study, the purpose of this research is to determine if supervisors in the university setting are consistent in their evaluations of client and student clinician therapy sessions. As is true in most research, I strongly encourage you to not share any aspect of this investigation with anyone. This suggestion is made in an attempt to ensure the integrity of the research.

At this point I would ask you to check the front of your envelope and the videotape provided to you by your university coordinator to see that the identifying letters match. You will be assigned either tape A or tape B. Now remove all materials from your envelope. Review the evaluation instrument, the Cognitive Behavioral System, known as the CBS, that was developed by Leith in 1989. This is page one of your materials. You will find 13 criteria for use in evaluating the two videotaped segments. If you need further definition of any of the 13 criteria, please refer to the "Behavioral Description of Terms" sheets on

Appendix B (cont.)

pages 2, 3 and 4. You will find information about each of the two clinicians at the top of each evaluation instrument. I would ask you to now pause the VCR while you review the CBS. Pause now.

Please view the first nine minute videotaped segment of a clinician interacting with a client. Please keep in mind the 13 criteria by which you will be evaluating the clinical interaction. Watch the segment in its entirety only one time. After you have observed the first 9 minute segment, please pause the VCR and evaluate the clinical treatment session by completing the CBS. Following completion of the evaluation, place the completed evaluation sheet in the provided envelope and secure the second evaluation sheet which is numbered page 5.

You will then view the second segment with a second clinician interacting with a different client. Again please keep in mind the criteria by which you will be evaluating the clinical interaction as you view the tape. View it in its entirety one time. After viewing the second segment, please stop the VCR, complete the CBS, and return this second evaluation sheet and the "Behavioral Description of Terms" sheets to the envelope. Please rewind the tape and return it to your university coordinator. Thank you again for your participation.

Student Clinician Permission Sheet

I, _____, agree to perform a 10 -15 minute language session with _____ who is a client at the Eastern Illinois University (EIU) Speech-Language-Hearing Clinic. The supervisor will be _____. The session will be videotaped and will be evaluated by 30 Speech-Language Pathologists who are employed as supervisors. This evaluation is part of a master's thesis project. The purpose of the thesis is to determine the effects of bias on the information concerning the evaluation of student clinician experience during the supervisory process. To control for extraneous variables, the investigator may have access to my practicum file and academic records to secure other clinicians with previous clinical records and grade point average comparable to mine. I understand that the information will remain confidential with access only by the principle investigator. I also understand that a decision to withdraw from the study will be honored at any time, and that this decision will in no way affect my practicum grade or evaluations. If questions or concerns arise, please call collect _____ between 6:30 p.m. and 9:00 p.m., from June 1 - June 12, 1992 and ask for _____. Thank you for your time.

Investigator

Thesis Chairperson

Clinician

Appendix D

Guardian of Client Permission Sheet

I agree to allow my son/ daughter _____
to participate in a 10 - 15 minute videotaped language
session with his/ her clinician at the Eastern Illinois
University (EIU) Speech-Language-Hearing Clinic. The
videotape will be evaluated by 30 Speech-Language
Pathologists who are employed as supervisors. This
evaluation is part of a master's thesis project. The
purpose of the thesis is to determine whether or not
introducing information concerning the clinician's level of
clinical experience affects the evaluation of the clinical
session. The treatment your child receives at EIU will not
be influenced by your choice to participate or not to
participate, and a decision to withdraw from the study will
be honored at any time. If you have any questions or
concerns, please call _____ collect at _____ between
6:30 p.m. and 9:00 p.m., from June 1 - June 12, 1992. Thank
you for your time.

Investigator

Thesis Chairperson

Parent/Guardian

Witness

Supervisor

Clinician

Appendix E

Supervisor Permission Sheet

I am _____ an ASHA certified, licensed Speech-Language Pathologist who will agree to supervise a 10 -15 minute language session performed by _____ who is a clinician at the Eastern Illinois University (EIU) Speech-Language-Hearing Clinic. The session will be videotaped and will be evaluated by 30 Speech-Language Pathologists who are employed as supervisors. This evaluation is part of a master's thesis project. The purpose of the thesis is to determine the effects of bias on the information concerning the evaluation of student clinician experience during the supervisory process. I understand that a decision to withdraw from the study will be honored at any time. If questions or concerns arise, I will call collect between 6:30 p.m. and 9:00 p.m., from June 1 - June 12, 1992 and ask for _____.

Thank you for your time.

 Investigator

 Thesis Chairperson

 Supervisor

Appendix F

Beginning Clinician Treatment Session Lesson Plan

Objective One: To display and understanding of the basic concepts on and in with 85% accuracy.

Objective Two: To produce on and in 10 times during an activity.

Objective Three: To produce copula is 5 times during an activity.

Objective Four: To answer who, what and where questions when talking about immediately observable objects and pictures with 85% accuracy.

Objective Five: To produce don't 5 times during an activity.

Objective Six: To be less resistant to a casual touch.

Objective Seven: To produce /f/ with 75% accuracy.

METHODS:

Clinician will provide a book of /f/ sounds along with an art activity of making a fireman and a frog while incorporating objectives 1,2,3,4,5,6 and 7.

Appendix G

Advanced Clinician Treatment Session Lesson Plan

Objective One: The client will produce /g/ in the initial position with 60% accuracy.

Objective Two: The client will receptively identify the spatial concepts top, bottom, in front and behind with 70 - 80% accuracy.

Objective Three: The client will expressively identify the spatial concepts top, bottom, in front and behind with 70 - 80% accuracy.

METHODS:

Clinician will provide blocks and a game board to incorporate objectives 1,2 and 3.

Appendix H

Invitation To Participate In The Study

September 1, 1992

Dear :

I am writing to request an hour of time of each of the supervisors at your university to participate in gathering data for a master's thesis in supervision in Speech-Language Pathology. The thesis is being coordinated through Eastern Illinois University, and data collection will begin in the middle of the fall semester, 1992. The purpose of this study is to determine if supervisors in the university setting are consistent in their evaluations of client and student clinician therapy sessions.

After viewing a short videotaped directional segment, each supervisor will be asked to use a 13 item assessment tool to individually evaluate two student clinicians' performances during two, 10 minute videotaped treatment sessions.

Please share this letter with your fellow supervisors, complete the name-to-number sheet, and then ask each supervisor to complete a biographical information sheet (which is coordinated with the name-to-number sheet). Please return these information sheets to me in the postage paid envelope by 1992. Your willingness to participate is of vital importance to the completion of this work and will directly contribute to our knowledge base concerning the supervisory process.

Please direct any questions to the investigator, via a collect call to .

Thank you for your participation.

Sincerely,

Charlotte A. Wasson, M.S. CCC/SLP-L
Assistant Professor and Thesis Chairperson

Julie Ann Johnston-Palmer, B.A.

Supervisor Professional Biographical Information Form

Number _____

Please complete all survey items. Indicate your response by circling the appropriate letter or writing your answer.

1. How many years of experience do you have as a university supervisor?
a. 1 - 2 b. 3 - 5 c. 6 - 10 d. Over 10
2. How many student clinicians do you typically supervise?
a. 1 - 5 b. 6 - 10 c. 11 - 15 d. 16 - 20 e. Over 20
3. What is your gender?
a. Female b. Male
4. What is your highest academic degree?
a. M.S. (M.A., M.Ed.) b. Ph.D. (Ed.D.)
5. Have you received any training in supervision? (e.g. continuing education or university courses)
a. Yes b. No If yes, briefly describe. _____
6. Are you employed full or part time?
a. Full time b. 3/4 time c. 1/2 time d. 1/4 time
7. What percentage of your employment time do you spend supervising?
a. 100% b. 75% c. 50% d. 25% e. Less than 25%
8. What level clinician do you supervise most often?
a. Beginning level, less than 20 hours of experience
b. Intermediate level, at least 30-40 hours of experience
c. Advanced level, at least 90-100 hours of experience
d. Transition level, at least 150-200 hours of experience
9. Which disorder groups do you primarily supervise?
a. Speech b. Language c. Hearing
10. Which age group is your primary responsibility to supervise?
a. Infants/Toddlers b. School Age c. Adults

Appendix J

Name to Number Sheet

Complete and return, please.

Supervisor Name	Number on Bio. Sheet
A.	#
B.	#
C.	#
D.	#

If you have additional supervisors who are willing to participate, please advise me so that I may provide the necessary extra forms. Thank you.

Appendix K

Letter to Coordinate Completion of Study and Return of
Materials

Date

Name
Street
Place

Dear :

As you may recall, you received a letter, a name-to-number sheet, and several biographical information sheets a few weeks ago which related to my master's thesis investigation. The purpose of this study is to determine if supervisors in the university setting are consistent in their evaluations of clients' and student clinicians' interactions.

Thank you for the willingness of you and your colleagues to participate in this investigation. Enclosed you will find packets of materials for each subject's completion of the study. Each packet includes explicit instructions, evaluation tools, and definitions of terms. Also enclosed with this letter are video stimuli tapes A and/or B. Please match subjects to the appropriate tape by ensuring that the identifying letter on the subject's packet matches the tape letter A or B that the subject is to view. Each subject should complete the study individually and return the tape and material packet to you, the coordinator.

After all of the subjects at your university have completed the study, please return materials (the videotapes and completed documents in the packets) to the investigator via the enclosed postage-paid envelope by October 16, 1992.

Again, I appreciate your willingness to contribute to the field of knowledge on supervision in speech-language pathology. We look forward to receiving your information.

Charlotte A. Wasson, M.S. CCC/SLP-L
Assistant Professor and Thesis Chairperson

Julie Ann Johnston-Palmer, B.A.
Primary Investigator

CBS Evaluation Instrument

After viewing a clinical interaction only one time, please evaluate the session based on the following criteria from a one to nine (1 to 9) scale. Circle the rating applicable to each criteria. Nine is the highest score, and one is the lowest. Please do not discuss your reaction or judgement with any other participant.

The clinician in this videotape segment has a GPA of approximately 4.0 on a 4.0 scale and has achieved a grade of "A" on a previous practicum assignment.

-
- | | |
|---|-------------------|
| 1 Goals clear to client or significant other. | 1 2 3 4 5 6 7 8 9 |
| 2 Goal-oriented therapy. | 1 2 3 4 5 6 7 8 9 |
| 3 Use of materials and activities. | 1 2 3 4 5 6 7 8 9 |
| 4 Effectiveness of instructional techniques. | 1 2 3 4 5 6 7 8 9 |
| 5 Evaluating responses. | 1 2 3 4 5 6 7 8 9 |
| 6 Time efficiency of procedure. | 1 2 3 4 5 6 7 8 9 |
| 7 Clinical flexibility. | 1 2 3 4 5 6 7 8 9 |
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| 10 Client self-evaluation. | 1 2 3 4 5 6 7 8 9 |
| 11 Client/significant other talking or response time. | 1 2 3 4 5 6 7 8 9 |
| 12 Behavioral data collection. | 1 2 3 4 5 6 7 8 9 |
| 13 Session goals remain in focus. | 1 2 3 4 5 6 7 8 9 |

Years of supervisory experience in the university setting. _____

Have you ever used this tool before?

Yes

No

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The clinician in this videotape segment has a GPA of approximately 4.0 on a 4.0 scale and has achieved a grade of "A" on a previous practicum assignment, and has 19 accrued clinical clock hours.

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The clinician in this videotape segment has a GPA of approximately 4.0 on a 4.0 scale and has achieved a grade of "A" on a previous practicum assignment, and has 225 accrued clinical clock hours.

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-

Speech-Language Pathology



THE UNIVERSITY OF
CENTRAL ARKANSAS

P.O. BOX 4985
CONWAY, ARKANSAS 72032
(501) 450-3176

July 21, 1992

Julie Ann Johnston
501 W. Arcadia Ave.
Dawson Springs, KY 42408

Dear Julie,

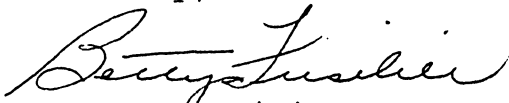
I apologize for not writing you sooner. My summer schedule has really been hectic! I hope this information reaches you in time.

Bill Leith indicated that you were interested in receiving information on the reliability study we did on the Cognitive Behavioral Supervision System. I'm enclosing a copy of the paper Elaine McNiece and I presented at ASHA on the initial study. He also indicated that you were interested in using the system in a thesis project. You certainly have our permission to use the system, or any of the components of the system in your project.

If you need any additional information or if you would like to discuss the system with me, please feel free to contact me by telephone or by letter. I will be glad to help in any way I can. I'm enclosing my card that gives my office as well as home telephone number.

We would really be interested in seeing the results of your project. Please let us know how things go. I'm looking forward to hearing from you. Good luck!

Sincerely,


Betty B. Fusilier

William R. Leith, Ph. D.

798 Westchester Rd.
Grosse Pointe Park, MI
48230
Tele: (313) 823-1098

Date: June 5, 1992

Julie Ann Johnston
501 W. Arcadia Ave.
Dawson Springs, KY 42408

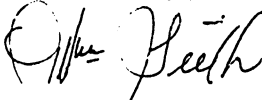
Dear Julie:

I received your letter of June 1st requesting permission to use specific parts of the book, "Handbook of Supervision: A Cognitive Behavioral Approach." We all thank you for your kind comments regarding our book. Please feel free to use the sections of the book you requested for your research.

I have forwarded your letter to Betty Fusilier and Elaine McNiece and they will provide you with the reliability information. If you want to correspond with them they can be reached at: University of Central Arkansas, POB U1745, Conway, Arkansas, 72032.

Good luck with your research!

Sincerely,



William R. Leith

Behavioral Description Of CBS Items

1. **Goals clear to client/significant other:** presents instructions so that the client and his significant other understand the goals of the session and the behaviors needed to be performed to meet those goals.
2. **Goal-oriented therapy:** therapy consistently focuses on clinical goal. Procedures used are congruent with and compliment therapy goals and objectives.
3. **Use of materials and activities:** uses materials effectively and efficiently in eliciting and practicing goal-related behaviors.
4. **Effectiveness of instructional techniques:** uses appropriate methods and strategies to elicit target behaviors or to transmit information. Therapy and conference is both effective and efficient.
5. **Evaluating responses:** the ability to discriminate error behavior from target behavior consistently and correctly. Carefully and accurately interprets responses of significant other during conferences.
6. **Time efficiency of procedure:** appropriate pacing of therapy procedures. Therapy or conference time is efficient. Interactions are not too fast and rushed or too slow and dragging. Appropriate amount of time is spent on each activity, with smooth transitions between activities.

7. **Clinical flexibility:** monitoring and adjusting to client's or significant other's changing needs and performance. Recognizes change in behavior that warrants modification of program.
8. **Use of modeling, information, guidance, feedback:** consistently uses modeling, information, guidance, and feedback appropriate for the significant other or for the age, disorder, and cognitive level of client, in the clinical interactions.
9. **Use of reward and penalty:** determines an appropriate reward/penalty system for the client and clinical setting. Uses that system consistently with ongoing verification of its effectiveness.
10. **Client self-evaluation:** consistently models, cues or stimulates client to self-evaluate and/or self-correct depending on client's ability.
11. **Client/significant other talking/response time:** structures therapy so that activities elicit the maximum number of goal-related behavioral responses from the client with clinician's talking time held to a minimum. As client behaviors are elicited, adequate response time is allowed. Significant other allowed sufficient time to participate in conference.
12. **Behavioral data collection:** determines and implements recording system. Consistently checks the correctness and frequency of occurrence of the target behavior. Makes adjustments in therapy based on these data. Progress notes indicate good qualitative and quantitative charting of behavioral responses.

13. **Session goals remain in focus:** successfully maintains focus on all daily goals throughout the session so that reward/penalty is continual and consistent. Conference remains focused on relating pertinent information to the significant other.

(Leith, 1989, pp. 98-99)

Appendix T

Letter of appreciation for participation

November 10, 1992

Dear :

Thank you for your participation in my thesis project entitled: The Effects of Knowledge of Accrued Clinical Clock Hours on Supervisors' Evaluations of Clinical Competence. Without each supervisor's willingness to participate, this project would not have been possible. I extend my appreciation to each one of you.

Each supervisor was assigned to one of six treatments. The treatments were coded by order of the tape segments and the information provided regarding the accrued clinical clock hours of the student clinicians.

Treatment 1=	AB	No information
Treatment 2=	AB	19 hours
Treatment 3=	AB	225 hours
Treatment 4=	BA	No information
Treatment 5=	BA	19 hours
Treatment 6=	BA	225 hours

LEGEND:

AB- the beginning clinician was observed first followed by the advanced clinician.

BA- the advanced clinician was observed first followed by the beginning clinician.

No information- regarding the amount of accrued clinical clock hours.

19 hours- the supervisors were informed that both clinicians had 19 accrued clinical clock hours.

225 hours- the supervisors were informed that both clinicians had 225 accrued clinical clock hours.

The results of the investigation indicated that the supervisors who participated were not influenced by the information provided regarding the clinicians' accrued clinical clock hours. The advanced clinician was rated significantly higher in all evaluations. Still further, the order effect was marginally significant in the evaluations of the student clinicians.

Charlotte A. Wasson, M.S. CCC/SLP-L
Assistant Professor and Thesis Chairperson

Julie Ann Johnston-Palmer, B.A.
Primary Investigator