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Leadership, Competencies, and Clinical Supervision: A Mixed-Methods Study of Clinical Supervision in Recreational Therapy

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LEADERSHIP, COMPETENCIES, AND CLINICAL SUPERVISION:
A MIXED-METHODS STUDY OF
CLINICAL SUPERVISION IN RECREATIONAL THERAPY

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ABSTRACT

Clinical supervision (CS) is important to student interns and novice professionals, as it provides guidance for competency development. However, in recreational therapy (RT), there are few requirements for a CTRS to be qualified to supervise interns. There is also minimal research regarding the effectiveness of current clinical supervisory and leadership practices in RT, or their effect on competency development in interns. Therefore, the purpose of this mixed methods study was to identify the factors of CS that predict competency development among RT interns during their 560-hour internship. Additionally, this study sought to understand the prominent leadership behaviors and competencies among clinical supervisors in RT and how those behaviors and competencies impact competency development in RT interns. Purposive sampling was used to recruit supervisor-intern dyads (N=24). Self-assessment surveys were used to measure relationship quality between each supervisor and intern pair, as well as supervisor competency and intern competency change. Intern competencies at the beginning of the internship were measured retrospectively, followed by a post-internship measure. Interns who completed the quantitative portion of the study were recruited for an individual follow up interview. Semi structured interviews were completed with 10 RT interns via Zoom video conferencing software. Regression analysis was used to determine what factors predict competency development. Results indicate that competency prior to internship and intern's perception of relationship quality are the two strongest predictors of competency development among RT interns. Five themes emerged from the qualitative data. Qualitative reports indicate that supervisor communication

style, demonstrated RT competencies, mentorship, personality, and scaffolded learning approach all contributed to intern competency development. Both quantitative and qualitative results were presented side by side in a joint display table, highlighting these themes as contributors to high-quality relationships or intern competency development. Implications for the RT profession are discussed.

PERSONAL DEDICATION

This dissertation is dedicated to my husband, Matthew. This journey was four years in the making and so much happened along the way. We got married, we both worked two jobs, we went vegan (mostly me), and we came together to take care of our two sick kitties. His unwavering love and support were pivotal to my success, especially during the great quarantine of Spring 2020. He pushed me to keep going every time I waivered in my own faith to do so. I thank him for all the times he cooked dinner, did the laundry, washed the dishes, went grocery shopping, cleaned the cat litter, vacuumed, cleaned the house (including the bathroom), tried to help me understand statistics, packed my lunch, and made me vegan wings on Seitan Sunday.

PROFESSIONAL DEDICATION

This dissertation is also dedicated to the recreational therapy profession. The inspiration for completing this research was the work that others have done before me, and universal desire to provide high-quality internship experiences. My hope is that this study inspires others to continue this important research and collaborate with others to strengthen and streamline our clinical supervision and internship process.

ACKNOWLEDGMENTS

TABLE OF CONTENTS

Table of Contents (Continued)   Page

Table of Contents (Continued)   Page

LIST OF TABLES

Lists of Tables (Continued)

LIST OF FIGURES

Chapter 1

Introduction

Clinical supervision (CS) is a vital component to clinical practice and internships

and is typically provided by an experienced clinician to help students and healthcare

professionals develop the necessary knowledge, skills and abilities related to their scope

of practice (Bernard & Goodyear, 2014b). The leadership behaviors exhibited by a

clinical supervisor can have a positive or a negative impact on the developing

professional(s) they supervise. In recreational therapy (RT), little is known about the

effects of the current clinical supervisory practices, specifically related to intern

competency development. As a result, CS and leadership are two areas that recreational

therapists (RTs) need to explore in much more depth and breadth, as there is significantly

less research completed in these areas, as compared to research on CS and leadership in

other allied health professions (e.g., nursing and social work). The following sections

discuss the background, rationale and design for the current study, as well as the

theoretical and conceptual frameworks.

Background

Previous research on CS found that RTs feel CS education is important, yet

education on CS is provided minimally and inconsistently (Gruver & Austin, 1990; Jones

& Anderson, 2004). Additionally, an expert panel of seasoned RTs identified the

importance of supervisor competencies during the clinical supervisory process (Hutchins,

2005). Based on these studies, what is known about CS in RT is that supervisor

competencies and CS education are deemed important (Hutchins, 2005), but are provided

minimally and inconsistently, or not at all in undergraduate and graduate programs

(Gruver & Austin, 1990; Jones & Anderson, 2004). There has also been no empirical

research in RT that used leadership theory to evaluate competency development in RT

interns. As a result of this void, there is a need for additional research that evaluates the

current status of CS and the factors affecting competency development in RT student

interns. There is also a need for research that evaluates the role of leadership behaviors in

intern competency development.

Theoretical Framework

The prominent theory being used in this study is the Leader-Member Exchange

theory (LMX). The LMX is classified as a relational type of leadership theory (Barling et

al., 2011) that focuses on the behaviors of the follower as well as the leader (Graen &

Uhl-bien, 1995) and how these behaviors impact the development of high or low-quality

relationships (Liden et al., 2016). While this dual focus makes this leadership theory

unique, some leadership researchers feel that the LMX lacks the ability to describe how

these high or low-quality relationships develop between leaders and followers (Nahrgang

& Seo, 2016). To account for this concern, two additional leadership theories were

applied to this study in order to account for the characteristics and behavioral traits of a

clinical supervisor that are not captured by the LMX. These two theories are the

Authentic Leadership theory and Functional Leadership theory.

Authentic Leadership is classified as an ethical/moral type of leadership theory

(Dinh et al., 2014) and essentially describes the need for leaders to be moral, ethical, self-

aware, and authentic (Gardner et al., 2011) in order to have a positive effect on their

followers (Chan et al., 2005). Functional Leadership is a type of theory that describes

what leaders do and the actions they take (i.e., behaviors) when providing leadership

(Barnett & McCormick, 2016). Santos et al (2015) describe Functional Leadership as

monitoring and taking action. The characteristics and behaviors of an authentic and

functional leader have application to RT because clinical supervisors are expected to

behave authentically, as well as monitor their interns and take action when needed. In

order to blend these theories with the LMX theory, the Leadership Making model was

used to develop the conceptual framework for this study, which allowed all three theories

to be incorporated (Graen & Uhl-bien, 1991, 1995).

Conceptual Framework

Graen and Uhl-Bien (1991, 1995) applied the LMX theory to the Leadership

Making model, which consists of three stages, the stranger stage, the acquaintance stage,

and the mature relationship stage. Each stage describes the progression of the dyadic

relationship between leader and follower. The stranger stage is more transactional and

formal, while the acquaintance stage describes the dyad engaging in more dialogue as

they learn the importance of each person's role and the interdependence related to

achieving work related goals. The mature relationship stage is achieved when the dyad's

relationship has become transformational. In this final stage both the leader and the

follower have mutual trust and respect for one another, as well as for their individualized

roles. Applying the Authentic and Functional Leadership theories to the Leadership

Making model allows for an increased understanding of the characteristics and behaviors

of the clinical supervisor during each stage. Each of these stages is described next, as they relate to a RT internship.

Through the lens of an RT internship, the stranger phase describes a transactional relationship between the supervisor and the intern. The intern is learning their new role and the supervisor is learning about the intern. What they learn about each other could include the interns preferred instructional style and what motivates them. Essentially, both members of the dyad are learning how to work with one another. What happens at this stage is crucial to the outcome of how the relationship develops (Nahrgang et al., 2009), so it is important for the leader to act authentically by communicating clearly (Ilies et al., 2005), being honest about expectations, and adhering to those expectations (Barnett & McCormick, 2016). As a functional leader, the clinical supervisor will observe the intern for signs of maladaptive behavior or psychosocial distress (Liden et al., 1993) related to their new role or interactions with the leader, or others in the organization. In the acquaintance stage, the dyad continues to learn about one another, but have become more comfortable in their roles and in their communication with one another, as it relates to their interdependency (Graen & Uhl-bien, 1995). The authentic leader continues to behave authentically, but now the intern will start to take notice of whether or not their supervisor behaves authentically toward others (Ilies et al., 2007). As a functional leader, the clinical supervisor will observe the intern completing specific job tasks, and provide feedback and/or intervene when necessary. In the mature relationship stage the dyad has entered into a transformational relationship where the intern and supervisor support one another and benefit equally from that support (Graen & Uhl-bien,

1995). As an authentic and functional leader, the clinical supervisor becomes more of a mentor. The intern trusts the integrity of their supervisor and uses their supervisor's behavior as an example of good practice. Also, the supervisor and intern can now anticipate each other's needs, and take the appropriate actions to be loyal and reliable to one another.

Purpose and Rationale

The purpose of this study is to understand the association between the leadership behaviors and competencies among clinical supervisors, the relationship quality between supervisors and interns, and how those impact competency development among RT interns. What the RT intern learns during their internship will have a significant impact on the type of professional they become, yet there is minimal research in the RT field regarding the status, implementation, and effectiveness of CS during the internship fieldwork experience. Subsequently, there is a need to know what the current clinical supervisory practices are and how these practices may impact the development of competencies among RT interns. The LMX was applied because of its focus on the dyadic relationship between leader and follower. Using the LMX in this study allows for an evaluation of the quality of the relationship between clinical supervisors and RT interns. This in turn could lead to the ability to evaluate its association between the dyad's relationship quality and competency development in RT interns.

Design

An explanatory sequential mixed methods design will be used to collect quantitative data first, followed by collection of in-depth qualitative data to help explain

the relationships between the variables measured during the quantitative phase. In the

first phase of the study, quantitative data on the leadership and RT practice competencies

were collected from clinical supervisors in RT, as well as their interns, from multiple

sites across the United States. A measure of the Leader-Member Exchange (LMX)

theory, called the LMX-7, was used to assess whether the quality of the relationship

between the supervisor and intern dyad have an effect on competency development in RT

interns. Additionally, a competency assessment tool will be used to evaluate potential

impacts of supervisor competencies on the competency development in RT interns. The

second phase of the study included collection of qualitative data through individual

interviews. The interviews were completed as a follow up to the quantitative results to

help explain the leadership and supervisory practices of clinical supervisors and the

impact of those practices on intern competency development.

Research Questions

The overarching mixed-methods research question asks: *what are the prominent*

leadership behaviors and competencies among clinical supervisors in RT and how do

those behaviors and competencies impact the competency development in RT interns?

There are three additional research questions that assist with answering the overarching

mixed methods research question. Research questions 1-2 address the quantitative portion

of the study, while research question 3 addresses the qualitative portion of the study.

RQ1: What is the association between relationship quality and interns perceived

competency development?

RQ2: What is the relationship between an intern's perceived competency

development and the supervisors perceived competency level?

RQ3: What is the experience of RT intern competency development as related to

the student's perception of their supervisor's leadership behaviors and

competency in RT?

Conclusion

This introduction described the rationale, purpose, and proposed methods for the

current study, which evaluated competency development among RT interns and how this

may be impacted by the quality of the relationship between the intern and the supervisor.

Definition of Terms

The following terms will be used in this study. The definitions of the following

terms are provided, in alphabetical order, to clarify their use in this study:

1. *Antecedents*: Actions, behaviors, and personality traits on the part of the supervisor or the intern that impact their relationship (Nahrgang & Seo, 2016).

2. *Authentic Leadership*: "… a process that draws from both positive psychological capacities and a highly developed organizational context to foster greater self-awareness and self-regulated positive behaviors on the part of leaders and associates, producing positive self-development in each." (Avolio, Gardner, & Walumbwa, 2005, p. xxii).

3. *Certified Therapeutic Recreation Specialist (CTRS)*: "…a certified recreational therapist who has demonstrated professional competence by acquiring a specific body of knowledge and passing the NCTRC exam. The CTRS employs a scope of practice that is based upon theoretical constructs and applied methodology, and addresses a wide range of disabling conditions and illnesses" (National Council for Therapeutic Recreation Certification, 2016b).

4. *Clinical supervisor*: A professional who provides supervision and guidance to novice and seasoned professionals, as well as student interns.

5. *Clinical supervision*: Refers to the supervision provided by a CTRS to an RT student during the student's 15-week internship, as well as to novice and seasoned RT professionals.

6. *Competencies*: Refers to the knowledge, skills, and abilities needed to perform a specific job or job tasks.

7. *Functional Leadership*: A type of leadership characterized by the functional behaviors of a leader as it relates to addressing problems that impede the success of the follower(s) (Zaccaro et al., 2001). Their behaviors will vary based on the problem and/or the follower involved.

8. *RT Intern*: A recreational therapy student who is actively completing their 14-week internship.

9. *Leadership Behaviors*: Refer to the actions, decisions, and personality of the leader.

10. *Leader-member exchange (LMX) Theory*: A leadership theory that posits the development of an effective leader-follower relationship is based on the behavior of the leader, as well as the follower (i.e., member).

11. *LMX-7*: A standardized 7-item tool used to measure the quality of the LMX relationship between supervisor and subordinate.

12. *Phenomenology*: A type of qualitative research approach that seeks to explain the lived experience of a group of individuals (Creswell, 2013; Husserl, 1964)

13. *Recreational Therapy (RT)*: "…a systematic process that utilizes recreation and other activity-based interventions to address the assessed needs of individuals with illnesses and/or disabling conditions, as a means to psychological and physical health, recovery and well-being." (ATRA, 2016).

14. *RT Competency Assessment*: Refers to a document created by West, Kinney, and Witman, (2008) that contains a competency self-assessment tool that can be used to evaluate competency status and development in RT practitioners or interns.

15. *Subordinate*: Refers to an intern or a staff member who works under the supervision of their clinical supervisor.

Chapter 2

Literature Review

The purpose of this study was to understand the association between the leadership behaviors and competencies among clinical supervisors, the relationship quality between supervisors and interns, and how those impact competency development among RT interns. This study is relevant because there is limited research in the RT field specifically related to CS, and to date there are no studies that evaluated the supervisor's influence on competency outcomes in RT interns. To understand the impact and importance of effective CS, the focus of this chapter is to a) review the prominent literature regarding clinical supervisory practices among health care professionals; b) highlight the impact that leadership behaviors can have on the relationship between supervisors and subordinates; c) review the status of CS in RT; d) compare current RT internship requirements to other allied health professions; e) and review relevant leadership theories as it relates to the RT internship process.

CS can be provided to a novice or a seasoned professional who is looking for guidance on how to improve skills, increase competencies, or approach a difficult clinical decision (Edwards, 2013). CS also refers to the supervision given to an intern during their fieldwork experience (Hutchins, 2005). This literature review includes research from both purviews; however, the focus of this study was on the supervisory process that occurs between the RT professional (i.e., CTRS; internship supervisor; clinical supervisor) and the RT intern over the course of the internship.

Defining Leadership and Clinical Supervision

Both leadership and CS are concepts and practices that have been defined repeatedly by several authors and researchers. Northouse (2019) offers a simplified definition of leadership, stating that "leadership is a process whereby an individual influences a group of individuals to achieve a common goal." While the topic of leadership is vast and encompasses myriad theories, this definition can easily be applied to any setting, dyad, or group, and offers a basic understanding for the purposes of this introduction.

A widely accepted definition of CS by Bernard and Goodyear (2004) states that CS is:

> An intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients that she, he, or they see, and serving as a gatekeeper for those who are to enter the particular profession (p. 8).

Milne (2007) offers an empirical definition, which states that CS is:

> "the formal provision by senior/qualified health practitioners of an intensive relationship-based education and training that is case-focused and which supports, directs and guides the work of colleagues (supervisees); quality control; maintaining and facilitating the supervisees' competence and capability; and helping supervisees' to work effectively." (p. 440).

In creating this definition, Milne was outwardly critical of the Bernard and Goodyear definition, stating that it is not precise or specific enough to be used in empirical research. Of particular note, the Milne definition includes the dimensions of the dyadic relationship, as well as the competence of the subordinate, which are the two key aspects being examined in this study. For this reason, Milne's definition was used for this study.

Recreational Therapy

Recreational Therapy (RT) is also referred to as Therapeutic Recreation (TR) and is defined by the American Therapeutic Recreation Association (ATRA) as "a systematic process that utilizes recreation and other activity-based interventions to address the assessed needs of individuals with illnesses and/or disabling conditions, as a means to psychological and physical health, recovery and well-being" (ATRA, 2016). RT is considered an allied health profession by the Committee on Accreditation of Allied Health Education Programs (CAAHEP, 2017), and the professionals who work in the field are called Recreational Therapists, or RTs.

The National Council for Therapeutic Recreation Certification (NCTRC), established in 1981, is responsible for setting the minimum standards for RT education and continuing education (i.e., professional development), and is the only international credentialing body for RTs (NCTRC, 2016a). In order to practice as a recreational therapist using the CTRS credentials, one must first obtain at least a bachelor's degree that meets the minimum course requirements set by NCTRC, successfully complete a 14 week (560-hour) internship, and then pass the NCTRC certification exam (NCTRC,

2018). Specific NCTRC course requirements are discussed later in this chapter. As of

2016, there were 16,000+ CTRSs who were active, inactive, or eligible for re-entry

(NCTRC, 2016a).

RTs work as a member of the treatment team to provide services to clients with

"illnesses and/or disabling conditions" (ATRA, 2016) typically alongside other allied

health professions such as Physical Therapy (PT), Occupational Therapy (OT), and

Speech Therapy (ST). Based on the most recent job analysis by NCTRC (2017b), the

majority of RTs work in behavioral or mental health care settings (37%), geriatric care

(30.4%), physical rehabilitation (20.4%), and in programs that provide services to people

with developmental disabilities (11.7%). Among these populations served, the top five

service settings are hospitals (32%), skilled nursing facilities (17.1%),

residential/transitional care facilities (10.3%), outpatient/day treatment programs (9.7%),

and adaptive recreation programs (7.3%). The top four levels of service (i.e., types of

services) provided by an RT includes long-term care (25.8%), acute care (23.5%),

rehabilitation (20.8%), and community (15.5%). Additionally, the top three age groups

receiving services from an RT are adults/older adults (34.4%), adults (23.1%) and older

adults (17.3%). RTs also work with children/adolescents, but the percentage is much

smaller, at 8.1%. This report indicates that a recreational therapist is most likely to work

with adults or older adults, in a hospital or nursing home, while providing long-term care,

acute care, or rehabilitation services. The following sections discuss competency

measures in RT, the status of CS in RT, and research in the RT field.

Competency Measures in Recreational Therapy

The ability to measure competency in a field is important in determining an individual's readiness to enter the field as an entry level practitioner. In RT, the only standardized measure of competence is the national certification exam, through NCTRC. The NCTRC exam assesses whether or not a RT professional possesses the minimum level of competency required to enter the field as a credential practitioner (NCTRC, 2016b). There are two other competency measures that were developed specifically to measure competency in RT. Both of them are discussed below.

Another competency measure in RT can be found in the ATRA *Standards for the Practice of Recreational Therapy* (ATRA-SOP), which contains a Competency Assessment worksheet that consists of twenty items and has two evaluation options, which are, "C*annot perform independently; needs remediation and supervision*" and "*Performs independently*". Each of the 20 items is assessed using one of six different methods, which include; self-assessment, skills demonstration/test, performance observation, written test, course performance, and certification. This tool was developed by the ATRA-SOP committee members, at that time, and was field tested prior to publication (West et al., 2013). Per instructions in the ATRA-SOP manual this Competency Assessment should be used with new RT employees to establish a baseline level of their knowledge as part of a probationary review, and for each subsequent annual performance review. The intention is to identify areas where the employee excels and areas where they may be lacking knowledge, skill, or competency. If need be, the ATRA-SOP Competency Assessment can be used to assess progress for employees who receive disciplinary action (West et al., 2013).

A third competency measure in RT is called the Guidelines for Competency Assessment and Curriculum Planning for Recreational Therapy Practice (West et al., 2008). This publication contains a total of 16 sections that each focus on a different area of competency. The first seven sections are; Foundations of Professional Practice, Individualized Patient/Client Assessment; Individualized Patient/Client Assessment; Planning Treatment/Programs; Implementing Treatment/Programs; Modalities and Facilitation Techniques (Modalities and Facilitation Techniques/Theories; Evaluating Treatment/Programs; and Managing Recreational Therapy Practice. There are an additional nine sections of support content, which are; Functional Aspects of the Human Body; Human Growth and Development; Psychology, Cognitive/Educational Psychology, and Abnormal Psychology; Counseling, Group Dynamics and Leadership; First Aid and Safety; Disabling Conditions; Pharmacology; Understanding Health Care Services and Systems; and Recreation and Leisure.

Both of the previously mentioned competency measures are ATRA publications. While they are not as widely used, or as standardized as the NCTRC exam, they were not developed for the same purpose. The NCTRC exam determines whether or not an individual possesses the minimum level of competency to practice RT with the CTRS credentials. The ATRA-SOP Competency Assessment and the Guidelines for Competency Assessment and Curriculum Planning for Recreational Therapy Practice were developed to be used as either a self-assessment measure (by students and practitioners) or as a means for supervisors to evaluate their staff members who hold the CTRS credential.

Clinical Supervision in Recreational Therapy

In 1990, Gruver and Austin brought attention to the need for the field of RT to include CS as part of the educational curriculum, as other allied health professions were making CS a "critical component of clinical practice" (p. 19). They further identified that one of the benefits to CS is quality assurance, as it relates to client goals and organizational outcomes.

While two definitions of CS have already been provided, the following definition speaks specifically to CS in RT. Jones and Anderson (2004) defined CS in RT as "a dynamic, enabling, and ongoing process that is interpersonally focused and professional, in which Therapeutic Recreation specialists who are skilled and knowledgeable facilitate another's therapeutic competence in order to maintain or enhance effective practice" (p. 329-330, adapted from Gruver & Austin, 1990).

The key components in this definition speak to the clinical supervisor being knowledgeable and skillful (i.e., possessing competencies) and capable of facilitating competency development in another (i.e., supervision), through effective interpersonal practices (i.e., leadership). This definition indicates that a clinical supervisor must be skilled and knowledgeable in both the practice of RT and the practice of CS. Curriculum requirements from the Commission on Accreditation of Recreational Therapy Education (CARTE) list "skill in providing CS and education to staff and students" (CARTE, 2010, p. 39). Additionally, CS is listed as a job task by NCTRC, but is not included as an educational requirement (NCTRC, 2018), and there is not a standard qualification process to prepare the recreational therapist to become an effective clinical supervisor.

As of 2011, CS was being provided to only 37% of RTs actively working in the

field (Witman et al., 2011, as cited in Austin, 2013). While this is an older figure, it is the

most recent data available. Such a small percentage of RTs receiving CS is cause for

concern, considering the medical fragility of some of the clients/participants who receive

RT services. There is an obligation, as therapists and educators, to ensure that students

and practitioners are properly prepared. However, a barrier, and a common theme among

RTs is that they are the only recreational therapist at their site, and/or are expected to

provide CS to others without having been trained themselves (Jones & Anderson, 2004).

Professionals who are the only recreational therapist in the facility are at an additional

disadvantage when seeking CS because they may not have anyone to turn to for help, or

if they do, it is someone who may not understand the role of RT. However, the leadership

and CS skills they experienced during their own internship may transfer in the

development of their own supervisory approach as well.

Internship Requirements

After completing required coursework, the student must successfully complete a

14-week (560-hour) internship under a qualified CTRS (NCTRC, 2018). In order to

qualify as an internship supervisor through NCTRC the supervisor must have valid and

current CTRS credentials for at least one year, be employed at least 30 hours (full time),

with 50% or more of their time allotted to providing direct RT services (NCTRC, 2017b).

Other than these practice requirements, there are no explicitly stated supervisory

requirements. The concern here is that the type of or amount of training of the clinical

supervisor can affect the quality of CS (Kuo et al., 2016), and despite the existence of

several CS models that could serve as a guide or framework for any clinical supervisor (Bernard & Goodyear, 2004), most professionals do not reference these models, as they tend to rely on the CS techniques used by their supervisor when they were interns (Edwards, 2013). Such inconsistent approaches to CS will inevitably lead to varied internship experiences for RT students.

Relevant Research in RT Clinical Supervision

While little is known about what leadership approaches are being used to aid in the growth and development of RT interns and practitioners, some researchers have sought to identify the current state of, and competencies associated with, CS in RT (Gruver & Austin, 1990; Hutchins, 2005; Jones & Anderson, 2004). Due to limited research on CS in RT, the only four existing research studies on this topic are discussed in detail in the following sections.

Supervisor Competencies. The concern for clinical competencies and readiness on the part of the clinical supervisor was studied by Hutchins (2005), which is the most recent study on CS in RT. Hutchins used an expert panel of 22 RT practitioners to identify the competencies in which clinical supervisors need to be proficient in order to be effective clinical instructors. Each study participant was asked to complete a 42-item survey that Hutchins developed based on a review of the available literature in CS at the time of the study. The survey consisted of 36 competencies and a list of six professional resources. The 36 competencies were divided into five categories, which included professional practice (11 items), teaching (6 items), counseling (6 items), supervision (7 items), and personal attributes (6 items). These categories were followed by a list of six

professional resources, specific to RT. The six professional resources included; the

NCTRC certification, *membership in a professional organization*, the *ATRA Code of*

Ethics, the *ATRA Standards of Practice*, the *NCTRC Field Placement Standards*, and the

ATRA Guidelines for Internship. See table 2.1 for a full list of categories. Study

participants were asked to use a five-point Likert scale to rate the level of importance of

each item. Response options for each item included; *not important*, *slightly important*,

moderately important, *significantly important* and *extremely important*. The survey also

included three additional open-ended questions that asked the study participants to; 1)

add to the list of competencies; 2) list competencies that they feel should be addressed in

undergraduate curriculum; and 3) list competencies they feel should be addressed as part

of a continuing education program.

      Prior to survey implementation, Hutchins conducted two pilot tests to determine

face validity of the instrument prior to using it for data collection. The first pilot test

consisted of two RTs and two educators. Based on the feedback from the first pilot test,

changes were made to the survey and the instructions for completing the survey.

Following these changes, a second pilot test was conducted that was comprised of two

educators in RT. Minor formatting edits were suggested as a result of the second pilot

test, so it was deemed appropriate at this time to move forward with data collection. The

survey was sent to 22 RT practitioners who were considered experts in the field. While

all 22 returned a completed survey, only 21 were able to be used secondary to one person

not signing the consent to publish. Results from each competency domain were

calculated separately. Table 2.1 lists each of the 36 competencies, as well as the rating

that was most often received from the 21 experts that completed the survey. Each of the

36 competencies listed in Table 2.1 were rated as *moderately*, *significantly*, or *extremely*

important by the professionals in the Hutchins (2005) study, and none were rated as

slightly or *not important*. In fact, 22/36 of the competencies listed were most often rated

as *extremely important* and are displayed in Table 2.1.

Table 2.1

Competency Ratings for Effective Clinical Supervision in Recreational Therapy

Professional Practice: Knowledge, Skills, and Abilities Required of an RT	**Rating**
Knowledge of major theories related to TR	Moderately Important
Knowledge of basic sciences that support TR	Moderately Important
Knowledge of current TR research findings	Moderately Important
Utilizes various assessment methods	Extremely Important
Interprets client information to design Tx	Extremely Important
Designs Tx plan in collaborative manner	Extremely Important
Implements interventions to meet client needs	Extremely Important
Applies knowledge of disabilities in Tx	Extremely Important
Systematically evaluates clients	Extremely Important
Systematically evaluates programs	Extremely Important
Demonstrates ethical behavior	Extremely Important

Teaching: Instruction from CS	**Rating**
Knowledgeable about learning styles	Moderately Important
Knowledgeable about reference materials	Moderately Important
Designs sequential educational activities	Moderately Important
Utilizes a variety of educational strategies	Extremely Important
Develops students' critical thinking skills	Extremely Important

Supervision: Of the Student by the CS	**Rating**
Demonstrates effective organization skills	Moderately Important
Collaborates with student and facility	Moderately Important
Communicates effectively with university	Moderately Important
Communication effectively with student	Extremely Important
Monitors internship outcomes	Extremely Important
Provides specific and direct feedback to student	Extremely Important
Initiates action to resolve conflicts	Extremely Important

Counseling: Guidance Provided by CS	Rating
Facilitates student exploration of feelings	Moderately Important
Engages student in active listening	Moderately Important
Provides effective mentoring	Moderately Important
Facilitates case analysis and problem-solving	Moderately Important
Involves student in self-reflection and evaluation	Extremely Important
Demonstrates genuineness, empathy, and caring	Extremely Important

Personal Attributes: Supervisor Attitude Toward the Profession	Rating
Awareness of professional capabilities	Extremely Important
Demonstrates a positive attitude	Extremely Important
Demonstrates emotional maturity	Extremely Important
Demonstrates effective interpersonal skills	Extremely Important
Demonstrates ability to work with diversity	Extremely Important
Evidence of continued professional development	Extremely Important

Professional Resources (in RT)	Rating
NCTRC Certification as a CTRS	Extremely Important
ATRA Code of Ethics	Extremely Important
ATRA Standards of Practice	Extremely Important
NCTRC Field Placement Standards	Extremely Important
ATRA Guidelines for Internship	Significantly Important
Professional Membership	Significantly Important

Note. TR= Therapeutic Recreation, Tx= Therapy; CS= Clinical Supervisor

Results from the open-ended portion of the surveys yielded an additional 17

competencies. These included; knowledge in the areas of health care delivery systems,

accreditation standards and risk management; having specific skills in strategic planning,

time management and disciplinary techniques; and the ability to define student roles and

expectations, delegate supervision of the student intern to other staff while also

maintaining a primary supervisory role, and coaching the intern. Subsequently, a total of

54 competencies were identified as being important to the clinical supervisory process.

These competencies were identified through a review of the existing literature and

through surveying a panel of experts in the field of RT. Competencies in the supervision

category that were rated as *extremely important* addressed the provision of specific and direct feedback to the student, effective communication, initiating conflict resolution, and monitoring internship outcomes. These competencies are all relevant to the provision of effective CS and have implications for the current study. A second study evaluated the status of CS in RT and is discussed in the next section.

The Status of Clinical Supervision in RT. Jones and Anderson (2004) evaluated the status of CS being provided to clinicians (as opposed to interns) in RT by conducting a survey study that was comprised of 44 closed and open-ended questions. Questions on the survey were developed by the researchers with the intent to gather information on several variables, including demographic information; the type and frequency of CS each respondent either received or provided to others; what type of CS training respondents received; and what the perceived needs are for CS in RT. Surveys were initially mailed to 500 active RTs, and after one reminder postcard, 236 surveys were returned. This study revealed that 24.6% of respondents (58/236) were currently receiving CS and 18.6% (44/236) had never received CS at all. The remaining respondents (130/236) had received CS in the past but were no longer receiving supervision. Of those receiving supervision at the time of the study and those who had received supervision in the past, 41% were receiving it from an RT, 20.3% were receiving it from a non-RT within their agency, and 13.1% were receiving CS from an RT within their agency who was their peer and not their supervisor.

Results from this study provided meaningful insights into the frequency of CS among RTs, who they were receiving CS from, and the amount of CS training their

supervisors had received. This study also revealed that respondents with a Master's or a

Doctoral degree were more likely to have received some type of education or training in

CS than those with a Bachelor's degrees only. In total, 52.1% of the RTs in their study

reported that they had not received any type of training yet were expected to supervise

interns or provide supervision to established practitioners. Interestingly, those who had

received training in CS (49.1% of the respondents) received it from a workshop or

conference (49.1%), a full course at a university (22.8%), or through single lectures

within a course (19.5%). Based on these results, only half of the people providing CS had

received training to do so, and the type of training they received varied from a single

lecture, to a conference session, to a full course in CS. The inconsistencies revealed in the

provision of CS training could account for the inconsistencies seen in the provision of CS

to RTs. Furthermore, while this study evaluated the provision of CS to practitioners, and

not interns, the findings indicate that some of the current internship supervisors do not

have any education or training in how to provide CS. The next section discusses the

benefits of mentoring in RT.

The Benefits of Mentoring. In 2003, Bedini and Anderson published a study that

evaluated the benefits of mentoring among active CTRSs. The purpose of the study was

to evaluate job satisfaction, intent to leave, and the rate of mentorship among the

respondents. Using a stratified random sample technique, 1000 active CTRSs, in all

levels of management, were selected from the NCTRC database of ~16,000, at that time.

Resulting in a total of 800 women and 200 men who received the questionnaire via mail.

The questionnaire used in the study was designed by the researchers to include specific

questions pulled from four previously validated measurement tools. Each of these addressed the areas of organizational commitment, job satisfaction, organizational citizenship, and intent to leave current employment. Results indicated that respondents in middle management positions were more likely to be mentored, at a rate of 64.2%. Second to this was entry level positions, at 24.9%, followed by executive level management, at 10.9%. Respondents who were not being mentored were more likely to have intent to leave their current job and had lower rates of job satisfaction. While this study looked at active RTs, it has implications for RT interns, as an intern who does not receive proper mentorship may experience increased self-doubt and question their ability to work as an independent and competent professional in RT. The next section discusses the results of a study that evaluated the status of CS education in RT programs.

Clinical Supervision in RT Education. While Jones and Anderson (2004) found that RTs are more likely to receive clinical supervisory education and training as a master's or doctoral student, Gruver and Austin (1990) found that, among undergraduate and graduate educators, the majority (79% and 92%, respectively) viewed CS to be important, but only half actually included it within their curriculum. In their study, Gruver and Austin developed two survey tools, one for undergraduate RT programs and one for graduate RT programs. After pilot testing the surveys with faculty and graduate students in RT, the surveys were mailed to 90 curriculum coordinators of RT programs at educational institutions. Since some programs offered both undergraduate and graduate degrees there were a total of 122 returned surveys (67 undergraduate and 55 graduate).

Responses from the undergraduate programs revealed that 53/67 respondents felt that CS education was important, however, only ~50% (34/67) of the RT programs reported actually providing education on CS. The manner in which CS education was provide varied from it being a single lecture, part of a unit in a course (the most common), or a combination of this provided in more than one course. The method of instruction also varied, but the most common were guest lecturers and the provision of written materials. Responses from the graduate survey revealed that ~52% (19/36) of the graduate RT programs provided education on CS. Of those 19 graduate programs, 11 provided CS education within a unit in a single course, six provided it as a single lecture, and three used a combination of both. The most common instructional methods for graduate programs were also guest lecturers and the provision of written materials. While the provision of CS was not consistent among RT educational institutions, the majority of RT programs offered one unit on CS and the most common method of instruction (i.e., guest lectures and written materials) was also consistent for the majority of those programs. Further research is needed to evaluate the effectiveness of these two common instructional styles.

The common themes among these studies are that CS is viewed as important among RTs but is not consistently taught in the classroom or implemented in the field. The study by Hutchins (2005) indicates that the clinical supervisors need to achieve specific competencies in order to provide effective and meaningful CS. Results from the Jones and Anderson (2004) study indicate that practitioners want CS in order to be more skilled at advancing the profession, for general professional development, and to develop

skills for outreach, advocacy, and public relations. Variables that impacted the provision

of CS included, poor quality of CS, lack of proper resources secondary to a limited

budget, lack of time, and a lack of administrative support (Jones & Anderson, 2004).

Additionally, 50% of Jones and Anderson's study participants were the only CTRS at

their facility. Being the only CTRS on site creates a problem for an inexperienced and

untrained clinical supervisor, as this limits their ability to seek council should they

experience a problematic situation with their intern. This also limits the intern's exposure

to the diverse treatment approaches used by different CTRSs, potentially limiting their

development as a skilled practitioner. Another interesting finding is that approximately

half of the institutions that responded to the Gruver and Austin (1990) survey reported

that they included any kind of CS education or training within their RT curriculum and

approximately half of the RTs surveyed in the Jones and Anderson (2004) study had

received CS education or training. These findings imply that what happens at the

education level could be impacting what happens in practice. Additionally, the finding

from the Jones and Anderson (2004) study where CTRSs who had been practicing

between 11-15 years received CS more than CTRSs with less experience in the field (i.e.,

0-10 years) is concerning considering the suggestion from (Austin et al., 2016) that

novice CTRSs are in greater need of CS than those with more experience.

 Overall, the research that exists reveals that education for CS is viewed as

important (Hutchins, 2005), yet is provided to only half of clinicians (Jones & Anderson,

2004), and the type of education and/or training in CS varies depending on the institution

(Gruver & Austin, 1990).

Best Practice Standards in Recreational Therapy

Currently there are no requirements for CS education in RT curriculum, and the only current practice requirements in RT related to CS are established by NCTRC and CARTE. ATRA is the professional organization for the RT field, but ATRA does not have CS requirements or guidelines.

ATRA was created in 1984 and serves as the membership organization for RTs. The best practice standards via ATRA are published through the document *ATRA Standards for the Practice of Recreational Therapy and Self-Assessment Guide*, also referred to as the ATRA-SOP (West et al., 2013). ATRA first adopted professional standards in 1991 and has made several revisions since then in order to maintain compliance with the accreditation and regulatory agencies that govern healthcare organizations (ATRA, n.d.). The ATRA-SOP is comprised of 12 practice standards, a self-assessment guide based on these standards, as well as a Management Audit, a Documentation Audit, an Outcomes Audit, a Competency Assessment, and a Clinical Performance Appraisal (West et al., 2013), which are all tools that practitioners can use to measure compliance and promote accountability. The 12 standards pertain to Assessment; Treatment Planning; Plan Implementation; Re-Assessment and Evaluation; Discharge/Transition Planning; Prevention, Safety Planning and Risk Management; Ethical Conduct; Written Plan of Operation; Staff Qualifications and Competency Assessment; Quality Improvement; Resource Management; Program Evaluation and Research. The guidelines written in each of these 12 standards are expected to be incorporated into RT curriculum and implemented in practice by CTRSs.

NCTRC was created in 1981 and serves as the credentialing organization for Recreational Therapists (NCTRC, 2016a). NCTRC sets the industry standards for RT curriculum and internship requirements for professionals wishing to obtain the CTRS credential. In order to be eligible for the NCTRC exam RT students must complete the minimum required coursework, followed by a 14-week (consecutive, 560 hour) internship. Required NCTRC coursework includes a minimum of five, three credit, core RT courses, as well as courses in Anatomy and Physiology, Abnormal Psychology, and Human Growth and Development. Suggested, but not required, coursework includes Assessment, the TR Process, and Advancement of the Profession. (NCTRC, 2018).

CARTE was established in 2010 as an accrediting body for RT education (CARTE, 2010). Prior to the creation of CARTE, the Council on Accreditation of Parks, Recreation, Tourism and Related Professions (COAPRT) was the only accrediting body for majors and focus areas in RT and TR (Council on Accreditation of Parks Recreation and Tourism, 2013). Requirements for CARTE accreditation require that the program has appropriate goals, adequate resources, qualified faculty, and a curriculum designed to meet the program's goals and learning outcomes (CAAHEP, 2017). RT programs seeking CARTE accreditation must meet curriculum requirements in the following areas: Foundations of Professional Practice in RT, Individualized Patient/Client Assessment, Planning Treatments/Programs, Implementing Treatment Programs, Evaluating Treatment/Programs, Managing Recreational Therapy Practice, and Support Content/Competencies (CAAHEP, 2017). CARTE accreditation remains optional, as it is not a practice or educational requirement by ATRA or NCTRC.

As there is some overlap among these professional agencies, the standards

contained in each can impact the quality of CS provided to RT students through their

curriculum standards (i.e., NCTRC), practice standards (i.e., ATRA), and regulations

(i.e., CARTE). It should be noted that guidelines for CS are not included in the ATRA-

SOP or the NCTRC certification guidelines for internship. While NCTRC does list the

provision of CS as a management job task, and CARTE references CS as a management

knowledge area for students to be exposed to, there are currently no specific guidelines,

competency standards, or tools for measuring competency development in CS education

or providing CS in practice. This shortcoming has been noted by other CTRSs who each

made their own recommendations for how to improve the status of CS in RT (Austin,

2004, 2013; Austin et al., 2016; Hutchins, 2005; Jones & Harvey, 2007; Murray &

Shank, 1994). Those recommendations are discussed in the next section.

Recommendations

Several recommendations were made as a result of the research on CS in RT. As

can be seen in Table 2.2, there is consistency among professionals in the field that CS

needs more attention, as it is an important and necessary piece of professional

preparation. All of the investigators agreed that additional research is needed to identify

the benefits of CS, as well as the current status of CS in the field today. The last research

study published on this topic (in RT) was nearly 15 years ago (in 2005). The most recent

edition of *Professional Issues in Therapeutic Recreation: On Competence and Outcomes*

(Norma J. Stumbo et al., 2017) discusses what is termed "fieldwork education" through a

cognitive model called the Integrative Learning Framework (ILF), however the focus of

this chapter seems to be more on the teaching role of CS, and less on a counselor or

mentor role (i.e., leadership).

Table 2.2

Recommendations for Clinical Supervision in Recreational Therapy

Author(s)/Year	Type of publication	Recommendations
Gruver & Austin (1990)	Research	• Instructional strategies for CS education should include case studies, role playing, and guest speakers. • Model CS practices after the successes of other professions.
Murray & Shank (1994)	Review	• Seek CS guidance from co-workers • Develop a standard of practice for CS
Bedini & Anderson (2003)	Research	• Mentor education should be taught at the bachelor's level • Mentoring programs should be set up by the facility with a focus on cultural diversity and goodness of fit
Austin (2004)	Book Chapter	• CS should be kept separate from administrative supervision • The clinical supervisor should acquire training (from their place of employment, a professional organization, or through continuing education) prior to supervising others • CS should be provided to practitioners at all stages of professional development
Jones & Anderson (2004)	Research	• CS should be provided at all stages of professional development • CS in RT should be recognized as a competency

		• Training on CS should be a part of RT curriculum, job tasks, required by NCTRC for certification, and for educational accreditation
Hutchins (2005)	Research	• Develop and implement internship supervisor standards • Develop an additional training and set of competencies for clinical supervisors
Jones & Harvey (2007)	Review	• RTs should seek training before providing CS • CS standards should be created by ATRA and accrediting bodies
Austin (2013)	Opinion	• Peer to peer CS should be encouraged
Austin, McCormick, & Van Puymbroeck (2016)	Book Chapter	• CS should be separate from management • Clinicians at all levels will benefit from CS. • Novice RTs should always be provided with CS

Note. Studies are listed chronologically. CS = Clinical Supervision, RT = Recreational Therapy, ATRA = American Therapeutic Recreation Association, CARTE = Committee on the Accreditation of Recreational Therapy Education.

Internships and Supervision in Other Allied Health Professions

The internship and/or CS guidelines/requirements among allied health professions varies greatly from one another, including the requirements for entry level practice. For example, OT, PT, and ST all require a master's or a doctorate level entry degree, with Social Work (SW) entry level requirements varying by state. With the varied requirements in entry level practice, the internship requirements for each of these

professions is also different. However, with the exception of RT, the two commonalities

shared among these professions is that, 1) graduates must obtain their degree from an

accredited program in order to sit for their licensure or certification exam, and 2)

practitioners in each of the professions are required to obtain a license to practice within

their state. A breakdown of the individual internship requirements is depicted in Table

2.3 and discussed below. Each of these allied health professions were chosen for

comparison in this review because they are common disciplines that a CTRS would work

with in a practice setting.

Entry level practice for RT requires a bachelor's degree. The internship and

supervisor requirements are established by the National Council for Therapeutic

Recreation Certification (NCTRC) and the Committee on Accreditation for Recreational

Therapy Certification (CARTE). To qualify to sit for the NCTRC exam, students are

required to complete a 14 week 560-hour internship under a qualified CTRS (NCTRC,

2017c). In order to qualify as an internship supervisor, the recreational therapist must

have their CTRS credentials for at least one year, be employed at least 30 hours (full

time), with 50% or more of their time allotted to providing direct RT services (NCTRC,

2017b). CARTE requirements are similar to NCTRC, in that they require the CTRS to

have their credentials for at least one year and one year of experience providing direct RT

services (CAAHEP, 2017).

The field education requirements for SW are set by the Council on Social Work

Education (CSWE). Students seeking a bachelor's degree in SW (BSW) require 400

hours of field education and can be supervised by a field instructor with a BSW or a

master's in SW (MSW). Students seeking an MSW require 900 hours of field education

and can be supervised only by a field instructor with an MSW. In both cases, where a

BSW or an MSW is being sought, the field instructor must have two years of practice

experience after obtaining their degree. It is preferred that the field instructor has a SW

degree from a CSWE accredited university (CSWE, 2015). Additional supervision

requirements for a licensed social worker (LSW) varies by state. However, this additional

supervision occurs after the student has completed their internship and obtained their SW

degree.

ST requires a master's degree for entry level practice. The fieldwork supervision

requirements are established by the American Speech-Language-Hearing Association

(ASHA). ST students must complete a 400-hour clinical experience while enrolled in the

graduate program, followed by 36 weeks, or 1,260 hours, of full-time (35 hours per

week) professional experience during their clinical fellowship. Students may choose to

complete the hours on a part time basis; however, all hours must be completed within 48

months. Both the clinical experience hours and the clinical fellowship hours must be

supervised by a licensed speech-language pathology (SLP) who holds the Certificate of

Clinical Competence (CCC), has at least nine months of full-time work with the CCC

credential (or the part-time hours equivalent), and at least two professional development

hours in clinical instruction/supervision (ASHA, 2020).

Clinical education requirements in PT are established by the Commission on

Accreditation in Physical Therapy Education (CAPTE). Entry level practice for PT is at

the doctorate level. Students exiting a PT program will have a Doctor of Physical

Therapy (DPT). The length of their internship may vary by institution, but the minimum

requirement for contact hours is 30 weeks for a PT (CAPTE, 2017b)and 520-720 hours

for PT Assistant (PTAs) students (CAPTE, 2017a) Clinical instructors (i.e., internship

supervisors) are required to be a licensed DPT with one year of full-time experience

following licensure (CAPTE, 2017b). Additionally, APTA offers an optional 16-hour

clinical instructor training course certificate called the *Credentialed Clinical Instructor,*

as part of a continuing education opportunity (McCallum et al., 2016), however, this

course is voluntary and focuses on developing clinical competencies over CS education.

      The fieldwork requirements in OT are determined by the Accreditation Council

for Occupational Therapy Education (ACOTE) and the American Occupational Therapy

Association (AOTA). OT students are required to complete a Level I and a Level II

fieldwork requirement. The hours requirement for level I vary by institution. OT students

in level II fieldwork must complete at least 960-hours. OT assistants (OTAs) must

complete 640-hours (AOTA, 2018). Fieldwork requirements differ depending on whether

the site employs a licensed occupational therapist. For sites that employ an OT, the OT is

required to have an OT license and one year of practice experience. For sites that do not

employ an OT the student may be supervised by a professional who has knowledge of

OT. At these sites, additional supervision must be provided by a licensed OT, from

another site, for at least eight hours per week. This type of supervision requires the

supervisor to have at least three years of experience practicing with their OT licensure

(AOTA, 2013).

It is worth noting that the focus of the clinical instructor training programs for PT and ST are focused on the supervisor's clinical competencies specific to the field, instead of CS practices and models. However, as it relates to professional competencies and CS training, ST is the only profession with an established requirement in both areas. The CCC credential is specific to ST. It signifies an SLPs excellence in professional knowledge, skills, and abilities. The two-hour requirement for clinical instruction/supervision education is unique to ST as well. All other allied health professions strongly recommend CS education/training, but it is not required. However, faculty within these university programs reserve the right to judge whether a site or a particular supervisor meets their learning standards. In RT, CARTE requires the university to provide an orientation to all their clinical instructors (i.e., internship supervisors) (CAAHEP, 2017), however there are no universal guidelines for the content of the orientation.

Table 2.3

Internship Guidelines of Allied Health Professions

Profession	Degree/Internship length	Supervisor Requirements	Governing Body
Recreational Therapy	BS, 14 weeks (560 hours)	• Current CTRS credentials, for at least one year • Employed full time (30+ hours) (NCTRC only) • Spends at least 50% of work time providing direct RT services (NCTRC only) • One year of providing direct RT services (CARTE only)	NCTRC [a] & CARTE-CAAHEP [b]

Social Work	BSW, 400 MSW, 900 LSW, varies by state	• BSW can supervise a BSW student • MSW can supervise a BSW or MSW student • Two years of practice experience	CSWE [c]
Speech Therapy	MS, 400 clinical practicum hours 1,260 hours or 36 weeks of full-time professional experience (35 hours/week, or part time equivalent) for the clinical fellowship	• SLP licensure • Certificate of Clinical Competence • 9 months of full-time work in ST following establishment of SLP-CCC (or the part time hours equivalent) • 2 professional development hours in clinical instruction/supervision	ASHA [d]
Physical Therapy	Doctoral, minimum 30 weeks full time	• PT licensure • DPT from accredited university • One-year full time clinical experience post licensure • Credentialed Clinical Instructor (optional)	APTA [e]
Physical Therapy Assistant	BS, 520-720 hours	• PT/PTA licensure	APTA [f]
Occupational Therapy	MS or Doctorate, Level I, hours vary by institution Level II, 24 weeks (960 hours)	• Any professional with an understanding of OT • For sites with an OT: OT licensure with one year of practice experience • For "roll-emerging" sites: three years of practice experience and knowledge of OT	AOTA [g] & ACOTE

		• Optional supervisor education programs	
Occupational Therapy Assistant	Associate or BS, 16 weeks (640 hours)	• OT or OTA licensure with one year of practice experience • OTA has subsequent supervision from licensed OT	AOTA & ACOTE

Note. BSW = Bachelor's in social work; MSW = Master's in Social Work; LSW = Licensed Social Worker; MS = Master of Science; CTRS = Certified Therapeutic Recreation Specialist.

[a]National Council for Therapeutic Recreation Certification (2018). [b]Committee on the Accreditation of Recreational Therapy Education through Commision on Accreditation of Allied Health Eeducation Programs, 2017. [c]Council on Social Work Education (2012). American Physical Therapy Association (2017b). [d]American Speech-Language-Hearing Association (2016) [e]American Physical Therapy Association (2017a). [f]American Occupational Therapy Association (2018).

Factors Effecting the Clinical Supervisory Relationship

Despite the availability of CS models (Edwards, 2013), each supervisor-subordinate dyad will experience variables that influence their relationship. These can include, age and/or generational gaps (Venne & Coleman, 2010), gender (Eagly & Johannesen-Schmidt, 2001), years in practice, budget/funding, workload/availability of supervisor or subordinate (Jones & Anderson, 2004), and perceived or actual power differential (Venne & Coleman, 2010). Following a review of the literature on Millennial learners, Venne and Coleman (2010) hypothesized that Millennials possess characteristics different than that of previous generations and that those who supervise

them will have to adjust their approach in managing them. Eagly and Johannesen-

Schmidt (2001) conducted a review of the available research and concluded that men and

women have different approaches to leadership. Additionally, whether in a position of

organizational leadership or peer leadership, women tend to be more democratic in their

approach than men. While they related these conclusions back to the power differential

historically experienced between men and women, this also has implications for CS in

RT, as the field is predominantly female (NCTRC, 2017b). The difference in leadership

approaches between male and female clinical supervisors may have an impact on the

supervisor-intern working relationship. And finally, responses from Jones and Anderson

(2004) revealed that a practitioner's ability to provide effective CS and be available to

their supervisees was based on their workload, as well as support from their

administration to provide additional budgeting for proper CS structure. Due to the

countless influences, it is important for clinical supervisors to consider their leadership

behaviors and individual approach to leadership, and the impact that has on their interns

and supervisees.

The Role of Leadership in Clinical Supervision

CS is important to the delivery of training and development of accountability in

young professionals (Bernard & Goodyear, 2014b). It is a dynamic process where the

goals of learning and clinical skill development, on the part of the student intern, must

also benefit the clients they work with (Edwards, 2013). Essentially, the interns learning

objectives cannot take precedence over the client's goals toward recovery. This is an

important ethical and educational balance, and leadership can play a key role in this

process. The benefits of implementing leadership philosophies into the clinical

supervisory process have been demonstrated by multiple researchers (Bono et al., 2007;

Eagly & Johannesen-Schmidt, 2001; Huang et al., 2016; Severinsson & Hallberg, 1996;

Sosik & Godshalk, 2000), indicating that leadership can be an important element to the

RT internship process.

Leadership Defined

Leadership can be difficult to define, as there is an abundance of leadership

theories that can be applied in a multitude of settings and professions (e.g., business,

management, psychology, healthcare, etc.) (Dinh et al., 2014). Additionally, RTs work in

a variety of service settings (i.e., hospital, community, skilled nursing facility, residential

facility, etc.) (NCTRC, 2017b), making it difficult to select one leadership theory to

apply to all service settings. Subsequently, three leadership theories were selected for this

study with consideration of the knowledge, skills, and abilities required to be a CTRS, as

well as their two main roles of practitioner and supervisor. The three theories chosen for

this study are the Leader-Member Exchange (LMX), Authentic Leadership, and

Functional Leadership. The LMX considers the relationship between supervisor and

intern from the perspective of both parties, while the Authentic Leadership theory focuses

on the traits of the supervisor, and the Functional Leadership theory focuses on the

actions of the supervisor. Each theory was chosen to aid in the understanding of the

intern-supervisor relationship as they progress through the internship process and are

discussed in detail in the following sections.

The rationale for choosing these specific theories is twofold. First, the LMX theory describes the quality of the relationship between a leader and a follower (Bauer & Erdogan, 2016b), which has applications to the relationship development experienced by the supervisor-intern dyad during RT internships. For example, the supervisor is expected to serve as a leader and a mentor to their intern throughout the internship process. In the LMX theory the behaviors of the follower (i.e., intern) are also considered because research has shown that follower behaviors also impact the outcome of the dyads relationship (Schyns, 2016). Students completing their RT internship enter into this fieldwork experience with varying degrees of maturity among them, creating an additional variable that can impact the relationship between the supervisor and intern. Additionally, the LMX theory was studied 112 times between the years 2000-2012 (Dinh et al., 2014), indicating its popularity, as well as providing ample research outlining its applications. Second, the Authentic and Functional Leadership theories were chosen for their ability to lend insight into the effect of the supervisor's personality traits and sense of ethics (Authentic leadership), as well as their behaviors toward supervising interns (Functional leadership). These latter two theories were chosen due to criticisms that the LMX theory falls short in explaining what personality traits lead to the development of positive relationships between supervisors and subordinates, nor its practical applications in changing behavior (Barling et al., 2011). Additionally, Porter-O'Grady and Malloch (2018), advise against choosing only one leadership theory for supervisors and managers to apply, as the needs of each follower vary. Therefore, viewing the LMX theory through

the lens of the Authentic Leadership and Functional Leadership theories allows for a

flexible framework to be developed.

Leader-Member Exchange

The LMX is classified as a relational theory (Barling et al., 2011), with focus on

the dyadic relationship between the supervisor and the subordinate. Originally termed

Vertical Dyad Linkage (VDL) theory (Bauer & Erdogan, 2016a; Dansereau et al, 1975),

LMX has evolved over the years to become a separate theory from its origins as VDL

(Graen & Uhl-Bien, 1995). While VDL focuses on the superiority of the leader in the

hierarchy, the LMX focuses on the impact that both the leader and the follower have on

the quality of the relationship (Liden et al., 2016). Additionally, the LMX theory states

that leaders interact or behave differently with different followers (Martin et al, 2016),

which essentially forms different types of relationships with different followers.

Graen and Uhl-Bien (1991, 1995) characterize the LMX theory by the

development of high and low-quality relationships between leaders and followers. Uhl-

Bien and Maslyn (2003) found that high quality relationships developed as a result of

mutual interest, perceived organizational support, and altruism, while low-quality

relationships would develop when the dyad's interactions are devoid of these things. This

unique approach describes the relationship as more of a partnership by focusing on the

roles of both the supervisor and the subordinate, rather than focusing on leader behaviors

only. While this makes the LMX theory unique, it has been criticized for falling short in

its description of how the relationships are developed (Barling et al., 2011; Martin et al.,

2016; Nahrgang & Seo, 2016). To assist in better understanding how relationships

develop under the LMX theory, Graen and Uhl-Bien (1991, 1995) use their model of

Leadership Making, which consists of three stages of relationship development. These

stages are labeled *stranger, acquaintance,* and *maturity*. At the *stranger* stage, the

relationship is more transactional, formal, and contractual. For the RT supervisor-intern

dyad, this stage of the relationship may consist of the intern completing orientations and

responding to directives from their supervisor, with little to no conversation occurring

outside of the supervisor providing instructions. Dyads enter the *acquaintance* stage once

they begin engaging in dialogue with each other that supports the interdependence of

each other's roles (i.e., exchanging information, support, or favors). For the RT

supervisor-intern dyad, this stage of the relationship occurs once the intern and/or the

supervisor has proven themselves to be knowledgeable and reliable. They develop a

sense of trust for one another and can begin to anticipate each other's needs. A *mature*

relationship or "mature partnership" is achieved when the dyad is making even exchanges

with a sense of mutual respect, trust, and loyalty. At this stage the relationship would be

more transformational. For the RT supervisor-intern dyad this stage of the relationship

resembles that of colleagues who are respectful and trustful of one another, and work

together to help clients achieve their goals, as well as working together to achieve the

goals of the organization.

Additional attempts to conceptualize the development of relationships within the

LMX theory include pairing it with other theories, such as role theory or social exchange

theory (Graen, 1976). Other researchers have studied leadership dyads to identify what

specific leader and follower behaviors lead to high or low-quality relationships.

Essentially, high-quality relationships can develop when the leader is trustworthy, and

when the employee is task oriented and produces quality work. For example, the

supervisor's behaviors can affect the extent to which their subordinates are loyal and how

much their subordinates trust them, as well as the likability of their subordinates based on

their attitude and job performance (i.e., the social aspects of work relationships)

(Dulebohn et al., 2012; Nahrgang & Seo, 2016). These traits and behaviors have been

described as antecedents to the development of high or low-quality relationships.

Additional antecedents have been identified in LMX research and are discussed in the

next section.

   Antecedents. Because of its versatility, the LMX theory can be applied to

multiple settings and organizations (Northouse, 2007). However, LMX has been

criticized over the years for its inability to consider the nature of relationship dyads

through identification of distinct leader-follower traits (Barling et al., 2011). This means

that little is known about what personality characteristics lead to high or low-quality

relationships (i.e., antecedents) (Schyns, 2016). Some antecedents could include the

opinion that the subordinate has about their leader (and vice versa) before even meeting

or working with the other, based on reputation alone (Liden & Maslyn, 1998). This could

involve either member of the dyad developing either a high amount of respect or a low

amount of respect for the other, even prior to formal introductions between the two. In

this case, the type of professional reputation of the leader or the follower could have a

significant impact on the development of a high-quality relationship.

Despite its criticism for failing to identify how relationships are developed,

Nahrgang et al (2009) found evidence that the predictability of relationship development

lies in the initial interactions between the leader and the follower. Specifically, high-

quality relationships were made when the leaders initially viewed their followers as

extraverted, and when followers viewed their leader as agreeable. In addition to the initial

impressions of one another, high-quality LMX relationships have been related to

expectations, similarities, liking, and trust of one another (Liden et al., 1993; Nahrgang &

Seo, 2016). Similarities, specifically, between the leader and the follower have shown to

have the greatest impact during the initial stages of the relationship (Nahrgang & Seo,

2016). Additionally, performance, effort, leadership behaviors (Nahrgang & Seo, 2016),

the extent of leader delegation (Bauer & Green, 1996), and member competence

(Gerstner & Day, 1997) can also influence the LMX relationship. Also, interpersonal

interactions, as opposed to organizational influence, seems to be more predictive of

relationship development (Ilies et al., 2007).

A meta-analytic study by Martin et al., (2016) sought to fill the gap in research on

LMX and work performance. Their argument was that previous LMX meta-analyses

focused only on job performance (e.g., performance ratings by supervisor) and did not

consider other dimensions of performance (i.e., task, citizenship, and counterproductive).

They used the three dimensional model by Rotundo and Sackett (2002) to evaluate 146

data samples of *task performance*, 97 data samples of *citizenship performance* and 19

data samples of *counterproductive performance*. The most notable findings were that

trust in the leader accounted for the highest amount of variance in the development of

high-quality relationships, with motivation, empowerment, and job satisfaction also

emerging as strong mediators for the development of a high-quality LMX relationship.

These findings indicate that high-quality LMX relationships are affected by multiple

factors. Specifically, trust in the leader is based on the leader's traits and behaviors,

motivation and empowerment are based on characteristics of the follower and

interactions with their leader, while job satisfaction can be based on any of the factors

previously mentioned, with the addition of perceived organizational support.

　　　　LMX has implications for the supervisor-intern dyad in RT because the ability to

elicit positive therapeutic outcomes in clients is predicated on building positive

therapeutic relationships with clients. In viewing the process of building rapport with

clients through the lens of the LMX theory, a recreational therapist should also focus on

building rapport with coworkers, subordinates, and interns.

Authentic Leadership

　　　　While the benefits of being authentic are not new to the idea of leadership, the

theory of Authentic Leadership is a newer theory, by comparison. The term Authentic

Leadership has only been introduced within the last three decades (Baron & Parent, 2015;

Gardner et al., 2011). It is classified as an ethical/moral type of theory (Dinh et al., 2014),

and suggests that authentic leaders have a positive effect on the people and culture around

them, while non-authentic leaders have a negative effect (Chan et al., 2005).

　　　　Several definitions have been applied to Authentic Leadership throughout the

years. Most of which refer to a function or process that requires the leader to have self-

awareness, be true to themselves, and to demonstrate moral and ethical behavior, thereby

influencing their subordinates to do the same, which contributes to a positive working

environment (Gardner et al., 2011). Chan et al. (2005) suggest that authenticity is

something that can be taught through a practical process that incorporates *leadership

multiplier*s. These are described as leadership traits (such as authenticity) that lead to

positive responses from followers, therefore multiplying the effectiveness of a leader's

efforts. Examples of leadership multipliers include consistency and whether the leader's

behavior matches their beliefs (Chan et al., 2005). Additionally, Ilies et al. (2005)

proposed that self-awareness, unbiased process, authentic behavior, and relational

authenticity (i.e., developing trust by being open and honest about one's good and bad

qualities) can be used to promote authentic leadership. Essentially, to be an authentic

leader means to be an ethical leader and it is appropriate to apply Authentic Leadership to

CS in RT because RT is considered an allied health profession (Bureau of Labor

Statistics, 2017; CAAHEP, 2017; U.S. Department of Education, 2017), and as such, is

morally obligated to follow a code of ethics. While ATRA provides a professional *Code

of Ethics* that are specific to the field of RT (ATRA, 2009), healthcare organizations

typically develop and implement their own ethical codes of conduct. When considering

antecedents that lead to high-quality LMX relationships, based on the above descriptions,

leadership multipliers, self-awareness, unbiased process, authentic behavior, and

relational authenticity can also be considered antecedents to high-quality relationships,

while the absence of these behavioral traits and characteristics would lead to low-quality

relationships.

Application of Authentic Leadership has shown promise among organizations. For example, in a study that looked at the perceptions of 324 subordinates of their manager's leadership style, Authentic Leadership was associated with increased organizational performance, follower satisfaction, quality of work life, positive attitudes and positive behaviors (Datta, 2015). However, criticism for this theory is that it is newer, and therefore, has not been subject to the same level of empirical scrutiny as other, more prominent, leadership theories (e.g., LMX). While the application of Authentic Leadership seems appropriate for research in CS, there is still more to be discovered about the impact of follower authenticity on relationship development and maintenance (Gardner et al., 2011), thus pairing nicely with LMX theory. While the Authentic Leadership theory describes leadership traits, the Functional Leadership theory addresses the actions of a leader that can lead to high or low-quality relationships and is described in the next section.

Functional Leadership

This theory is based on two leader functions, monitoring and taking action (Santos et al., 2015). Essentially, Functional Leadership focuses on what leaders do (Barnett & McCormick, 2016), as opposed to personality traits or characteristics and leadership behaviors (i.e., Authentic Leadership), or relationship building (i.e., LMX). This theory has applications to the relationship between RT supervisor and intern because the expectation is that the supervisor demonstrates good observational skills in order to evaluate the performance of the intern. The supervisor will need to observe for appropriate interactions with the client. Specifically, the supervisor will observe that the

intern is performing the appropriate assessment, implementation, and evaluation

techniques, as well as monitor for any signs of psychological distress or maladaptation as

a result of their experiences or interactions with others. This includes interactions with

their supervisor, with clients, or any other organizational/environmental influence. With

monitoring also comes anticipation of needs, and taking action when needed (Santos et

al., 2015). In relating this concept to a RT internship, the taking action phase would

resemble the supervisor providing feedback to the intern regarding their performance in

the areas previously listed. It can be argued that during an internship the supervisor will

always need to provide feedback (i.e., take action) as this will either serve as a

reinforcement of current behavior/performance or to correct poor behavior/performance.

Taking action could also resemble the supervisor stepping in during an assessment or

intervention with a client, or even an interaction with a co-worker, and performing the

tasks that are needed at that time.

While the role of functional behavior has been discussed in previous leadership

research (Lord, 1977), the theory of Functional Leadership has a much smaller pool of

empirical data than LMX, or even Authentic Leadership. Additionally, the majority of it

seems to be applied to group leadership (Barnett & McCormick, 2016; Lord, 1977;

Santos et al., 2015), as opposed to individual leadership (as is the case with RT interns).

However, some of this research has yielded positive results, and would have implications

for individual leadership structures as well. For example, the use of Functional

Leadership in teams was supported by Barnett and McCormick (2016), who found that

clear expectations and feedback increased the followers understanding of their role within

the team. This process also supported the follower's individual growth, as well as their

understanding of others' roles. Furthermore, Santos et al. (2015) found the application of

Functional leadership to be an effective tool for leadership training. This suggests that in

a RT internship the intern can simultaneously learn how to be a good leader, as well as

how to be a clinician. The next section discusses the application of the LMX through the

lens of both the Authentic Leadership theory and the Functional Leadership theories.

A Leadership Framework for Clinical Supervision

As described above, Graen and Uhl-Bien (1991, 1995) use the model of

Leadership Making to describe the process, or even a continuum, of leadership

development between two people within the context of the LMX. The model describes

the dyad starting out as strangers, developing into acquaintances, and eventually

developing a mature relationship (Graen & Uhl-Bien, 1991). To address the criticism that

the LMX alone does not do a good job of focusing on traits (Barling et al., 2011; Schyns,

2016), the following framework applies the model of Leadership Making through the lens

of both the Authentic Leadership and Functional Leadership theories to assist in

understanding the clinical supervisory process from a leadership perspective. Applying

this to the internship process in RT, the following describes the application of Authentic

Leadership and Functional Leadership at each stage of the LMX Leadership Making

model.

Stranger

At this stage the relationship is truly transactional and void of any type of

leadership, and is considered the 'role-finding' phase (Graen & Uhl-Bien, 1991), as the

intern and supervisor are, in most cases, not previously acquainted with one another prior

to the start of the internship. Regardless of their level of acquaintance, this is the start of a

new relationship, and what the leader does and says at this stage to create a first

impression is most important in predicting the future of the dyad's relationship

(Nahrgang et al. 2009). Because of the fragility of the relationship at this stage, the

supervisor must act authentically by ensuring that their words match their behaviors, and

be self-aware (Ilies et al. 2005) of how their actions affect intern development. Feedback

is an important piece to the clinical supervisory process, so it is especially important at

the stranger stage for the supervisor to set clear expectations and provide feedback based

on adherence to expectations (Barnett & McCormick, 2016). As a functional leader, it is

also important at this stage to monitor the intern for signs of maladaptation and provide

psychosocial support as needed, which will aid in the development of trust (Liden et al.,

1993). Consideration of other antecedent behaviors should also be done at this time, such

as agreeableness and delegation on the part of the leader (Bauer & Green, 1996). For the

supervisor-intern dyad this may manifest as the supervisor being flexible as the intern

becomes familiar with the daily processes, and learns the responsibilities associated with

their role, as well as trusting the intern to perform simple tasks independently. Such tasks

could include leading a portion of a treatment group that is based on the interventions

planned by the supervisor and/or reporting the progress of a particular client from that

group at the next treatment team meeting, and assigning the intern to observe a set

number of individual therapy sessions or groups and then practice writing progress notes.

Acquaintance

At this stage, the supervisor-intern dyad enters the 'role-making' phase. Initially this will continue to resemble somewhat of a transactional type of relationship (Graen & Uhl-Bien, 1991), but as the dyad continues to develop their relationship it is important for the leader to demonstrate good interpersonal interactions. Authentic Leadership fits into this stage as an antecedent to the development of a high-quality LMX relationship for two reasons. The first is that personality has been found to be the greatest indicator of success for a manager or leader (Hogan et al., 2011). This means that the supervisor must be mindful to have good interpersonal skills with others as well (e.g., clients, client's family members, other therapists, etc.), as the leader's behavior toward others contributes to the intern's opinion of their leader (Ilies et al., 2007). The second reason is that behaving authentically and working to develop high-quality relationships with subordinates can influence intern/employee behavior and organizational culture (Neubert et al., 2008). To be a functional and authentic leader at this stage means to observe the intern completing assessments and facilitating treatment sessions, thoroughly review the intern's documentation, and provide consistent, honest, and clear feedback to the intern. Feedback should reinforce what they are doing well and provide suggestions for how to improve. Signs for psychosocial distress or maladjustment should continue to be monitored. If indicated, the supervisor should be prepared to address these concerns or to assist/take over for the intern during an assessment or treatment session/group if the intern is not performing well.

Mature Relationship

At this stage the dyad is engaging in 'role-implementation' and their relationship has become more transformational (Graen & Uhl-Bien, 1991). There is a mutual level of trust, respect, and understanding that is based on shared positive and authentic experiences. The intern becomes more independent in their role, and the supervisor, as a functional and authentic leader, continues to monitor the intern, and provides feedback and assistance as needed, though it should be minimal at this stage in the internship. The functional leader is also able to anticipate the needs of the intern (Santos et al., 2015), and vice-versa. At this stage the intern is moving closer to becoming a competent and independent entry-level practitioner. At this time, the authentic and functional leader will serve as a professional mentor who assists in guiding and educating the intern to understand the importance of continuing education, professional involvement, and contributing to the advancement of the profession. The idea here being that promoting a positive view of the profession will contribute to a positive professional culture (Chan et al., 2005).

A Conceptual Framework for Recreational Therapy

In RT, most supervisor-intern dyads start as strangers. The progression of their relationship depends on several factors, and it is important to understand the process conceptually. It is common for researchers to couple the LMX theory with other theories (i.e., role theory, social exchange theory, self-determination theory) for the purpose of strengthening the theoretical and conceptual foundations of their research, and to explain the mediators between leader/follower traits that lead to the development of high-quality relationships (Martin et al., 2016; Nahrgang & Seo, 2016). The use of the LMX theory,

coupled with the Authentic and Functional Leadership theories, within this proposed

study assist in understanding the progression of the working relationship between clinical

supervisors and RT interns. The rationale for applying the aspects of the Authentic and

Functional Leadership theories to the Leadership Making process was to enhance the

understanding of what traits and behaviors (i.e., antecedents) lead to the development of

high-quality relationships during the RT internship process. Based on the analysis of

these three theories (LMX, Authentic Leadership, and Functional Leadership),

supervisor-intern dyads in RT will develop high-quality relationships when the supervisor

demonstrates authentic behavior, maintains a positive leadership presence (i.e., observes

but does not hover), takes the appropriate actions at the appropriate time, and provides

feedback to the intern based on things they are doing well and areas where they can

improve.

Authentic behavior from the RT internship supervisor will manifest as self-

awareness, honesty about one's strengths and limitations, trustworthiness, providing clear

communication, and having realistic expectations of their intern. Functional behavior

from the supervisor will manifest in the supervisor observing the intern complete job

tasks and providing feedback, as well as intervention when needed. Specifically, the

supervisor is expected to provide an orientation by making the intern aware of what is

expected of them and educate the intern on the policies and procedures that apply to their

specific job functions, as well as any organizational policies and procedures. The

supervisor is also expected to educate the intern on RT specific functions, such as client

assessment, program planning and implementation (group and one on one interventions),

program and client evaluation, and documentation. Education on these tasks comes in the

form of written policies, verbal instruction, and allowing the intern to observe the

supervisor complete each of these job tasks. All of this would take place during the

stranger phase of the leadership making process.

After orientation and initial education, the intern is then expected to demonstrate

knowledge of these newly learned tasks. During this time, the supervisor's role as a

functional leader is to observe the intern completing their tasks and providing daily

feedback. This feedback can be provided during a formal one on one meeting, or

informally during down times throughout the day. Although, it is probably best at this

stage of learning for the intern to receive immediate feedback so they can reflect on their

performance while the interaction is still fresh in their mind. For confidentiality and

dignity considerations, the supervisor should be mindful to provide this feedback in a

confidential setting so others may not overhear the discussion. The supervisor should also

conduct a scheduled meeting with the intern at least once per week to conduct a formal

performance review. The intern should be made aware of the agenda items prior to the

meeting and be provided with an opportunity at this time to evaluate their own

performance.

As the intern begins to demonstrate competency, their supervisor will gradually

provide the intern with more responsibility. These types of exchanges will lead the dyad

into the acquaintance stage. Examples of RT specific tasks by the supervisor during the

acquaintance stage would include the supervisor assisting the intern in developing better

assessment skills, such as paraphrasing client responses, how to probe for more

information, and reading a client's body language or voice inflection to identify possible signs of distress. Another example is learning how to write progress notes based on objective observations of the client, with consideration of each client's individual treatment goals. Also, depending on the service setting, an intern may be expected to learn safe handling techniques when transferring clients (i.e., sit to stand, wheelchair to bench, etc.) during physical activity interventions, or learn behavioral de-escalation techniques. As the dyad progresses in their working relationship, the authentic leader will maintain consistency in their approach and treatment of others, continue to provide a supportive learning environment for their intern, and not engage in gossip. The intern will begin to take notice of how the supervisor interacts with clients and other staff. As an authentic leader, the supervisor's behaviors and interactions with others should be consistent with beliefs that the supervisor has shared with the intern. Additionally, the supervisor is expected to demonstrate knowledge of the profession and to be honest with their intern about areas in which they have less knowledge. In this case, the supervisor should also know where to direct the intern to find the information on their own.

Once the supervisor-intern dyad enters into the maturity, or mature relationship, stage the previously mentioned job tasks will become easier and almost automatic for the intern. The supervisor will have confidence that the intern can perform their job tasks effectively and independently, therefore promoting mutual trust and respect between the two. The supervisor will continue to demonstrate authentic behavior toward the intern, as well as others within the organization. Support from the supervisor will begin to resemble that of a colleague, as the intern begins to perform more and more like an independent

and competent recreational therapist. In the mature stage, the intern will take initiative to complete job tasks without being told and is confident enough in their skills to seek guidance from their supervisor when needed. The functional leader/supervisor steps back and allows the intern to work independently, while providing distant supervision, as well as feedback when needed. A weekly one to one meeting should still be taking place. However, at this stage, the focus of these meetings should be on the intern's continued skill development after the conclusion of the internship, as well as how to become an active member and/or leader within local and national professional organizations. See Figure 2.1 for a visual depiction of this framework.

Research on LMX has also demonstrated the importance of followership behaviors (Schyns, 2016). Authentic behavior from the intern (i.e., follower) includes the intern being honest about their own strengths and limitations, knowing when to ask for help, and accepting that help. If an intern makes a mistake, they need to be comfortable approaching their supervisor and reporting all of the details of the incident (i.e., not excluding things that the intern may be embarrassed of). The intern is also expected to demonstrate authentic behavior when working with other staff (i.e., PT, OT, ST, etc.) and/or interns, and have good interpersonal skills when doing so. An additional dynamic here would be the intern knowing when to seek advice from, or when to plan a co-treatment session with, another discipline that is for the benefit of the client.

Functional behavior from the intern's perspective would be observation of their clients during treatment sessions and promoting independence in their clients, much like their supervisor is promoting the intern's independence. When working with a client the

intern may provide verbal instruction, demonstration, and either watch their client

perform the task or assist the client in performing the task. Tasks (as part of an

intervention) can be cognitive or physical in nature, which will dictate the manner in

which the intern may have to intervene (i.e., verbal cues or physical prompts). By

learning how to be an independent clinician, the intern is simultaneously learning how to

be an effective leader. The intern will likely adopt the habits of their supervisor, which is

why it is so important for clinical supervisors to be competent, confident, and authentic

leaders. The following section discusses research on LMX measurements.

Figure 2.1

Leadership Making during Recreational Therapy Internship
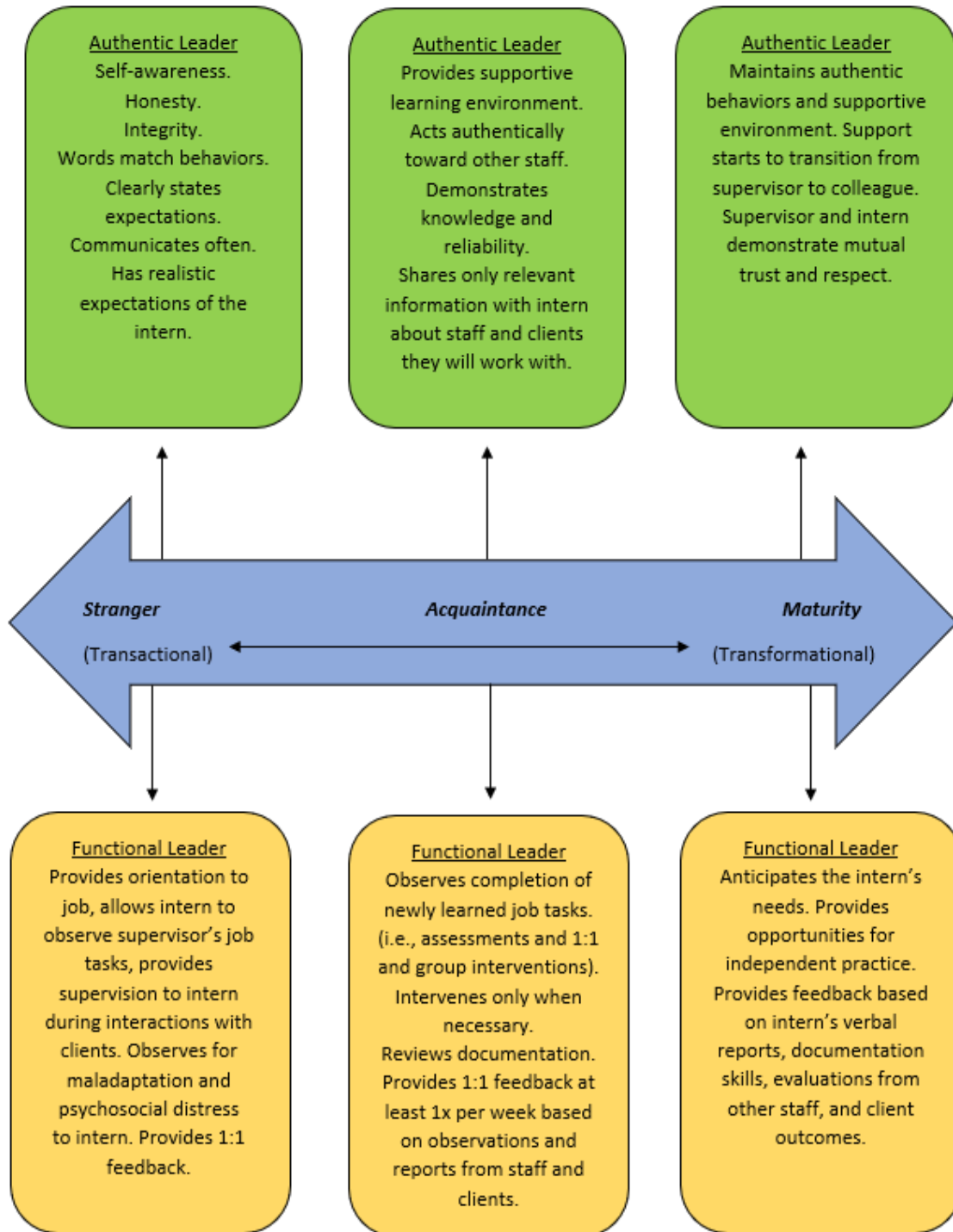
LMX Measurements

As a result of extensive LMX research it is recommended to measure LMX using a dyadic approach, therefore capturing the perspective of both the leader and the follower (Liden et al., 2016; Scandura & Schriesheim, 1994; Schriesheim et al., 1998). Several tools have been developed for the LMX to measure the quality of the dyadic relationship, some of which have come under scrutiny for focusing too heavily on leader perceptions (Liden et al., 2016; Northouse, 2007). A meta-analytic review of LMX by Gerstner and Day (1997) showed that the perceived status of leader and follower relationships using LMX measurement resulted in little agreement between the two perspectives (i.e., leader-follower). Early LMX research attributed these differences in leader-follower perceptions to error variance (Liden et al., 2016). However, it was Graen et al. (1972) who first considered that the differences seen in follower LMX scores (i.e., follower perceptions of their leader) might actually be due to a difference in the follower's perception of their relationship with their leader vs how the leader views the relationship (Liden et al., 2016).

The two most common measures used in LMX research are the LMX-7, which is a 7-item scale, and the LMX-MDM, which is a 12-item scale (Liden et al., 2016). In deciding which measurement tool to use for this study, the LMX-7 was chosen because it is a slightly shorter measurement than the LMX-MDM, and each item is written in a manner that allows the leader or the follower to complete the questionnaire with little to no modification needed. Additionally, the LMX-7 and the LMX-MDM were found to be highly correlated, indicating that both instruments are accurate in measuring LMX

working relationships (Joseph et al., 2011; Martin et al., 2016). Further description of the

LMX-7 can be found in the Methods chapter.

Summary and Conclusions

There is a clear need for additional research in the field of RT to identify the

current clinical supervisory practices among supervisors. There is an additional need to

identify competency outcomes among RT interns, and what variables effect those

outcomes (i.e., supervisor competencies and/or supervisor's leadership behaviors). The

LMX research provides strong evidence that leadership behaviors can significantly

impact work satisfaction, turnover, and organizational commitment. Additionally, the

LMX research supports the theory that the quality of the relationship developed between

the supervisor and subordinate is dependent on behaviors and actions of both parties, and

not only that of the supervisor. By using the LMX theory to study the supervisor-intern

dyad, and the RT Competency Assessment measure (discussed previously and in the

Methods section), the goal of this study is to help fill the gap in CS research in the RT

field. Specifically, this study seeks to evaluate which supervisor and intern behaviors are

most conducive to intern competency development, as well as to evaluate the impact of

supervisor competencies on intern competency development. Based on this literature

review, the ideal clinical supervisor is authentic, moral, and focuses on relationship

development (i.e., healthy supervisor-intern dyads), while also possessing the knowledge,

skills, and abilities to promote the development of clinical competencies.

Chapter Three

Methods

This dissertation was a mixed-methods study that used an explanatory sequential design to understand the association between the leadership behaviors and competencies among clinical supervisors, the relationship quality between supervisors and interns, and how that impacts competency development among RT interns. The perspectives of multiple interns and supervisors were examined in order to identify factors that influenced the quality of the dyadic relationship. Because this study used an explanatory sequential mixed-methods design, there were two phases in the study that included a quantitative and qualitative data collection phase (Creswell & Plano Clark, 2018). The quantitative portion of the study used a standardized leadership measure, called the LMX-7, to evaluate the quality of the supervisor-intern relationship, as well as a tool to measure RT competency among supervisors and competency development among interns over the course of the internship. The qualitative portion of this study utilized semi-structured interviews with interns intended to build upon and explain the relationship between variables identified in the quantitative data. The interview questions in the qualitative phase of the study were designed to help explain how leadership behaviors lead to high or low-quality relationships, as well as how leadership behaviors influence competency development.

Research Rationale and Purpose

As discussed in chapter two, there is limited research in the RT field that is specific to CS, and how different leadership behaviors or supervisor competency may

impact the development of clinical competencies of RT interns. Therefore, the purpose of this study was to understand the association between the leadership behaviors and competencies among clinical supervisors, the relationship quality between supervisors and interns, and how those impact competency development among RT interns. IRB approval was obtained through Clemson University.

Design of the Study

To measure the quality of the relationship between the supervisor and the intern, the LMX-7 was used to identify whether each dyad had a high versus low quality relationship. High-quality relationships denote high LMX agreement and low-quality relationships denote low LMX agreement (Graen & Uhl-bien, 1995). The extent to which the supervisor and the intern have a high or low-quality relationship is denoted by the level of LMX agreement between clinical supervisors and RT interns on the LMX-7 (Gerstner & Day, 1997; Graen & Uhl-bien, 1995). Therefore, the quality of the relationship was evaluated in comparison to its effect on the interns' perceived development of identified competencies in the field of RT, using the *Guidelines for Competency Assessment and Curriculum Planning in Therapeutic Recreation* (West et al., 2008). Hereafter, this measure will be referred to as the RT Competency Assessment. These measures are fully explained later in this chapter (see Measures section).

This explanatory sequential mixed-methods study utilized a correlational and phenomenological research approach to describe the experiences of RT interns during their internship and the impact of those experiences on intern competency development. The focus of this study was to evaluate the impact of supervisors' perceived competency

on the interns' perceived competency using a paired sample, retrospective, pre-post

design. Correlational design is a non-experimental quantitative approach that involves an

evaluation of the relationship between two variables, typically the predictor (i.e.,

independent) and criterion (i.e., dependent) variables, which are not manipulated by the

researcher (Fitzgerald et al., 2004). The phenomenological tradition is used to make

meaning of the experiences of the study participants (Creswell, 2013). In this case, the

lived experience involves RT interns who received CS during the internship. The

phenomenological approach is well-suited to explain the impact of the relationship

between supervisors and interns, and self-perceived competency development among RT

interns. Also true to phenomenology, the RT interns are seen as experts of their own

experience (Hesse-biber, 2010). The quantitative data coupled with explanations of their

experience, from a sample of study participants, provided a rich understanding of

competency development during the clinical supervisory process (Groenewald, 2004;

Hesse-biber, 2010; Yuksel & Yildirim, 2015) among these study participants grounded in

their individual experiences.

Research Questions

The overarching mixed-methods research question asked: *what are the prominent*

leadership behaviors and competencies among clinical supervisors in RT and how do

those behaviors and competencies impact the competency development in RT interns?

The following three sub-questions assist with answering the overarching mixed methods

research question. Research questions 1-2 address the quantitative portion of the study,

while research question 3 addresses the qualitative portion of the study. Plans for

publishing the results of this study are found in Table 3.1.

RQ1: What is the association between relationship quality and interns perceived

competency development?

RQ2: What is the relationship between an interns' perceived competency

development and the supervisors' perceived competency level?

RQ3: What are the experiences of RT interns in relation to competency

development and the perceived leadership behaviors of their clinical supervisor?

Table 3.1

Articles for Publication

Title of Article	Research Question	Relevant Data
Predictive Factors in Competency Development among Recreational Therapy Interns	What is the association between relationship quality, supervisor competency, and intern competency development during RT internships?	LMX-7 regression model results
A Mixed Methods Study on Competency Development During Recreational Therapy Internships	What is the experience of recreational therapy intern's competency development as related to the intern's perception of their supervisor's leadership behaviors and competency in recreational therapy?	Quantitative regression findings, LMx-7 scores, Qualitative themes, and mixed data results
Clinical Supervision and Leadership: Developing a Clinical Supervision Model for Recreational Therapy	A review article presenting a model of CS in RT	Findings and recommendations from previous CS studies in RT, as well as the relevant leadership theories

Inclusion Criteria

To be included in this study, interns had to be scheduled to complete their

internship during the summer or fall of 2018, or previously completed their internship in

the spring of 2018. Supervisors had to be employed no less than 30 hours per week, per

NCTRC requirements (NCTRC, 2017). Both the intern and the supervisor had to agree to

be in the study in order for one or the other to be included. All study participants had to

be able to read, write, and speak in English, in addition to signing an informed consent

(see Appendix H) indicating their understanding of the study and their acknowledgement

and approval of the PI's intent to publish the results of the study. A copy of the informed

consent was available at the beginning of the demographic survey. To indicate consent,

participants had to click "yes" in order to continue with the rest of the survey. If they did

not provide consent, the survey simply ended.

Exclusion Criteria

Participants could be excluded from the study based on any of the following

criteria. If the internship was halted at any time prior to completion of their university's

or the internship sites requirements, as the dyad would then be deemed ineligible. If a

student did not complete all course requirements and NCTRC requirements, or if a

practitioner had not been a CTRS for at least one year. Furthermore, if either member of

the dyad declined to sign the informed consent, they were not eligible for the study. The

informed consent was especially important in this study, as there could be a natural

dynamic between the supervisor and their intern where the intern may feel compelled to

participate if their supervisor agrees to participate. Specific language was used in the

informed consent (Appendix H) to address this possibility.

Incentives

To encourage enrollment in the study, RT students were offered an opportunity to

enter a drawing to have their NCTRC certification exam registration fee covered by the

PI, at a cost of $325. Participants were only eligible for the drawing following successful

completion of their internship, and completion of the study. Additionally, RT clinical

supervisors had the opportunity to enter a drawing to have their ATRA membership paid

for one year, at a cost of $125. For both the NCTRC exam and the ATRA membership,

one name from each group (i.e., interns and supervisors) was randomly selected upon

completion of the study using an online randomizer tool. Those selected were contacted

via email.

Methods Overview

Both quantitative and qualitative methods were used to answer the research

questions. The quantitative methods in this study include the use of a demographic

questionnaire, the LMX-7, and the RT Competency Assessment. The qualitative portion

of the study used individual follow up interviews to gather information from supervisors

and interns in order to expand on the data collected during the quantitative stage. Each

dyad was assigned a number to be used to identify them each time they completed a

questionnaire or individual interview. For example, CS-1 and In-1 represented Clinical

Supervisor One and Intern One. Participants were assigned their number when they were

provided with the links to the survey tools. It should be noted that the supervisor

interviews were not included in the data analysis, it was determined that this data was not

pivotal in answering the research questions.

Quantitative Methods

The quantitative portion of this study used two measurement tools to answer

research questions one and two. The following sections describe those measurement

tools, as well as the quantitative sampling and recruitment methods, as well as the

procedures for data collection and analysis.

Quantitative Sampling and Recruitment. The target sample size was 128

participants, with 64 clinical supervisors and 64 RT interns. For two-tailed hypothesis

testing it is recommended to use at least 64 participants per group when completing a

causal-comparative type of study, where the goal is to evaluate the correlations between

two variables (Onwuegbuzie & Collins, 2007). While it was expected that the intern's

perceived competency would increase over the course of the internship, a two-tailed

hypothesis was appropriate in this case because of the possibility that intern's perceived

competency could decrease.

RT interns and clinical supervisors were selected from all settings where RT

internships are offered. The sample of participants used in this study were recruited

primarily through email and word of mouth, including direct contact with personal

networks. This was a convenience-based sample, as any RT student who completed their

560-hour internship during the Spring, Summer, or Fall semester in 2019 were eligible to

participate, as well as the CTRS who supervised them during their internship. In order for

the intern to be enrolled in the study, their site supervisor also needed to agree to participate.

To recruit participants for phase one of this study, a modified snowball, convenience sampling technique was used (Collins & O'Cathain, 2009). First, the PI made direct contact with personal colleagues, as well as the program coordinators and directors at various universities across the United States who offer a RT program. A list of universities was obtained from the website of the American Therapeutic Recreation Association (ATRA, 2018). RT practitioners, and program coordinators and directors, were contacted via email, with a recruitment letter attached that explained the purpose of the study, as well as instructions on how to contact the PI. Each program coordinator and director were asked to recommend the research opportunity by forwarding the email and recruitment letter to all of their students who were completing their internship in the summer or fall of 2018 or had completed their internship in the spring of 2018. They were also asked to share the recruitment letter with the network of RTs who supervise their interns. RT practitioners were asked to share the research opportunity and recruitment letter with their colleagues, as well as any potential intern.

Interns and clinical supervisors who received the recruitment letter had access to the description of the study and the PI's contact information, with instructions to contact the PI directly if they were interested in participating in the study. All RT practitioners who agreed to participate in the study were asked to recommend the study to their intern, and any other practicing RTs who met the inclusion criteria. All RT interns who agreed to participate in the study were asked to recommend the study to their fellow RT students

who also met the inclusion criteria for the study. To maintain confidentiality, and to observe the Family Educational Rights and Privacy Act (FERPA), at no time were faculty members, department coordinators or directors, RT practitioners, or students asked to relinquish student or clinical supervisor information.

   Quantitative Data Collection. Three forms of quantitative measurements were used in phase one of the study. These quantitative measurements included participant demographic information, the LMX-7, and the RT Competency Assessment. These measures and all demographic information were made available to the study participants via an online survey software called Qualtrics. The demographic questionnaire was converted using the exact language from the original tool. The RT Competency Assessment was converted using the exact same language, however the format was altered to allow the pre and post questions to be asked simultaneously, as the interns were to complete the pre-test retrospectively. The content of each question and scaling remained the same. See Figure 3.1 for an example of one of the questions and see Appendix C for a copy of the original tool. The LMX-7 was converted with minor changes to the manner in which the questions were asked, in order to elicit a specific type of response from the participants. These changes are described in more detail below. The data from Qualtrics was then transferred to an Excel spreadsheet for initial data checking, including a check for missing data. The Excel spreadsheet was protected with a password on a computer that also requires a password to access. This computer was only accessed by the PI, and deidentified data was only shared with the faculty at Clemson University who are listed on the title page.

The retrospective pre-post design was chosen because it was thought that interns would have a more accurate measure of their baseline competency after they completed the internship (Thomas et al., 2019). For example, an intern could begin their internship believing they know all there is to know about client assessments. Any gap in their knowledge or skills in assessment may not be apparent to them until the end of their internship, after they have had a chance to increase their competency in this area.

Demographics. A list of the demographic information collected in this study can be found in Table 3.2 and the exact demographic questions can be found in Appendix A. The demographic information depicted in Table 3.2 is important because each RT program has a different curriculum, with different requirements for their students, such as the number of RT courses required. Because recruitment occurred throughout the summer of 2018, each participant completed the demographic questionnaire at different timepoints, which was based on when they enrolled in the study, as depicted in Table 3.2.

While most of the interns had just completed their senior year prior to starting their internship, juniors and graduate students were also eligible to participate if they were completing their internship during the summer of 2018. Students who had previously completed their internship during the spring 2018 semester, or those whose internship extended into the fall 2019 semester were also eligible. It is important to capture this information because the difference in age and/or education level could be a factor that impacts intern performance and/or their competency development. It is also important to know if either the intern or their supervisor had any type of training, including any academic coursework in CS, as the central focus of this proposed study is

CS. Due to there being two options for program accreditation in RT, it was important to capture whether the intern and/or the clinical supervisor attended a program that was accredited by either the Committee on Accreditation on Recreational Therapy Education (CARTE) or the TR option of the Council on Accreditation of Parks, Recreation, and Tourism (COAPRT). There is also the possibility that the program is in the process of seeking accreditation from one of these two organizations, and in some cases the student or CTRS may be unaware of whether or not their program is/was accredited by either agency. Each of these accrediting bodies have different educational standards and requirements for RT/TR programs, which could impact the results of the study. The question that asked interns "*When is the last week of your internship*?" was used to determine when to send the survey link for the LMX-7 and RT Competency Assessment. The question that asked interns to report their grade point average (GPA) was optional and was added as an addendum to the initial IRB approval. It was thought that the intern's GPA could also be a predictor in competency development.

Table 3.2

Demographic Information

Intern Demographics	Supervisor Demographics
• Age	• Age
• Gender	• Gender
• University Attended	• Years of experience as a CTRS
• Class standing at time of internship	• Years working at current facility
• Program's accrediting body (CARTE/COAPRT)	• Facility type
• Type of clinical supervision education	• Population served
• RT course content areas	• Education level of supervisor (BS, MS, Doctorate
	• Which degrees in RT?
	• University where RT degree was obtained

o Foundations of Practice • Attended accredited program?

- o Foundations of Practice
- o Assessment
- o Planning
- o Implementation
- o Evaluation
- o Managing RT Practice
- Last week of internship
- GPA

- Attended accredited program?
- If yes, which agency (CARTE or COAPRT)
- Type of CS education or training
- Uses the SOP? If yes, which parts of the ATRA-SOP are implemented in practice

Note: SOP = Standards of Practice, ATRA = American Therapeutic Recreation Association, BS = Bachelor of Science, MS = Master of Science, CS = Clinical Supervision.

Quantitative Measures. The quantitative portion of this study used two quantitative measures, called the LMX-7 and the RT Competency Assessment. The LMX-7 is an instrument that measures the quality of the relationship between the leader and a follower (Liden et al., 2016) and is free for use (Graen & Uhl-Bien, 1995). The RT Competency Assessment is an instrument used to measure an individuals perceived competency in RT (West et al., 2008). The LMX-7 was used to answer the first research question, while the RT Competency Assessment was used to answer research question two.

LMX-7. The LMX-7 is a leadership survey that measures the perceived relationship quality between a leader and a follower, or a leader and multiple followers. In this study the LMX-7 was used to measure the relationship quality between the interns and the clinical supervisors.

The LMX theory posits that good leadership and follower behavior will lead to high quality relationships, while poor leadership and follower behavior will lead to low quality relationships (Bauer & Erdogan, 2016b). The LMX-7 is one of several evaluation

tools designed for evaluating the quality of relationships between supervisors and

subordinates using the LMX theory (Liden et al., 2016). The LMX-7 was chosen over

other LMX measurements due to its popularity and accuracy (Martin et al., 2016) in

measuring the quality of the relationship between leader-follower dyads. Additionally the

LMX-7 was found to have an internal consistency of .86 (Schriesheim et al., 2000), and

.89 for the member version and .78 for the leader version of the LMX-7 (Gerstner & Day,

1997). Historically, correlational data (i.e., the difference in scores between leader and

follower) have been low (Gerstner & Day, 1997; Munshi & Haque, 2017), suggesting

either measurement error or an actual difference in the LMX (i.e., relationship quality)

perspectives between the leader and the follower. Both the clinical supervisor and the RT

intern completed the LMX-7, as a single measurement for each participant during or after

week 14, as depicted in Table 3.3. An example of the LMX-7 can be found in Appendix

A.

Table 3.3

Timeline of Measurements

Internship Week		1	2	3	4	5	6	7	8	9	10	11	12	13	14	Post
Demographics	Interns	←		collected after recruitment and consent									→			
	Supervisors	←		collected after recruitment and consent									→			
LMX-7	Interns														x	
	Supervisors														x	
RT Competency Assessment	Interns														Pre-post	
	Supervisors														x	

Individual	Interns		X
Interviews	Supervisors		X

Note: Demographic information will be collected one time only for each supervisor and

intern, at the time that they agree to participate in the study, which could occur at any

time, up to the conclusion of the study.

Scores for the LMX-7 range from 7-35 points, with 7-14 being *Very Low*, 15-19

being *Low*; 20-24 being *Average*, 25-29 being *High*, and 30-35 being *Very High* (Graen

& Uhl-bien, 1995). Individual scores were not released to participants or their counterpart

but were used by the PI to calculate each dyad's LMX-7 score. The questions on the

LMX-7 were recreated in Qualtrics so the intern and supervisor could access the tool

online.

The current version of the LMX-7 uses six different scales. These include scales

that range from *rarely* to *very often*, *not a bit* to *a great deal*, *none* to *very high*, *strongly*

disagree to *strongly agree*, and *extremely ineffective* to *extremely effective*. Following a

review of the literature, as well as two pilot tests by the PI, it was determined that the

current version of the LMX-7 would need reworded to increase the accuracy of

participant's understanding of what each question asks. Additionally, it was noted by

Liden et al. (2016) that some LMX researchers felt that the wording and varied use of

scales on the LMX-7 is confusing and awkward.

Pilot Testing and Survey Distribution. For the first pilot test, the PI had one

CTRS, who was not a participant in this study, complete the LMX-7 in its original

format. This CTRS was chosen because of their experience in supervising RT interns and

it was thought that this experience would lend insight into how a clinical supervisor

would interpret the survey during data collection. Feedback from the first pilot test

confirmed that the wording on the LMX-7 was confusing. The PI then created an

alternate form of the LMX-7 using mirrored language described by Liden et al. (1993).

The wording of the questions were changed in order to use a single traditional Likert type

scale (i.e., *strongly disagree* to *strongly agree*) to allow for easier interpretation of the

questions and responses (Liden et al., 2016). For example, item two on the original LMX-

7 asks, "*How well does your leader (follower) understand your job problems and needs*?"

With altered wording the statement read, "*My leader (follower) understands my job

problems and needs*." This method for changing the wording essentially changed the

items from questions to statements.

Following creation of the mirrored version of the LMX-7, a second pilot test was

conducted with seven different CTRSs, who also were not participants in this current

study, but who also had previous experience supervising interns, as well as working in

the field. Each CTRS was asked to complete the original version of the LMX-7 and then

the mirrored version of the LMX-7. After each CTRS completed both forms, the PI spoke

with each CTRS individually to ask which form was easier to understand. Feedback from

each CTRS revealed that the wording of the mirrored version of the LMX-7 was easier to

understand, and that the use of "leader (follower)" on each question was also confusing.

One CTRS also reported that the first question on the LMX-7 created additional

confusion because it is a double-barreled question. For example, the first question on the

original LMX-7 states "Do you know where you stand with your leader (follower)…

[and] do you usually know how satisfied your leader (follower) is with what you do?"

In summary, feedback from these pilot tests resulted in the following suggestions; 1) use the mirrored language for each question, as described by Liden et al. (1993) (with the exception of number six because it is already worded using an "I" statement); 2) split the questionnaire into a supervisor version and an intern version to eliminate the use of "leader (follower)" in each question; 3) use the labels "intern" and "supervisor" on the respective versions of the LMX to make the survey specific to the population being studied; and 4) split question number one into two questions. This last suggestion is supported by Bauer and Green (1996), who used a revised version where the first question was split into two questions. This eight item scale previously demonstrated high reliability with a Cronbach's alpha score of .92 (Liden & Maslyn, 1998).

Two out of four suggestions were implemented. The two suggestions that were not implemented included using "intern" and "supervisor" and splitting question number one into two questions. The rational for this was due to a recommendation from one of the committee members to limit the number of changes so as not to change the integrity of the tool itself. This committee member is considered a subject matter expert on leadership theories and their measurement tools. The next section discusses the other quantitative measure being used in this study, which evaluated competency levels among interns and clinical supervisors.

RT Competency Assessment. The RT Competency Assessment was used in this study to measure the perceived competency levels among clinical supervisors, as well as the perceived competency levels among interns at the start of their internship as compared to the end of their internship. Supervisors and interns completed the RT

Competency Assessment near the end or after the end of the student's internship. The

intern version of the RT Competency Assessment asked them to rate their level of

perceived competence at the beginning of their internship, as well as at the end of their

internship. This resulted in two competency scores per each intern (i.e., pre and post).

The purpose of using this pre-post design was to allow the intern to be able to reflect on

and more accurately rate their level of perceived competency at the start of their

internship. The demographics recorded for each participant were used as covariates

during data analysis (see Table 3.2 for full list of demographics), and the final stage

involved mixing and comparing the results of the two previous data collection stages.

As mentioned in the literature review, the RT Competency Assessment is an

assessment tool found in *The Guidelines for Competency Assessment and Curriculum

Planning in Therapeutic Recreation: A Tool for Self-Assessment* (West et al., 2008) that

was used to measure perceived competence in RT, among interns and professionals who

hold the CTRS credential. While there is another competency assessment tool that is

available in the ATRA-SOP, the competency assessment tool in *The Guidelines* was

chosen because it contains a more comprehensive list of the knowledge, skills, and

abilities that an RT intern can develop over the course of their internship, and each

section mirrors the CARTE standards (CAAHEP, 2017).

The RT Competency Assessment consists of seven main sections and nine

sections of Support Content, for a total of 16 sections with a varying number of items per

section. The first seven sections include *Foundations of Professional Practice* (29 items),

Individualized Patient/Client Assessment (23 items), *Planning Treatment Programs* (20

items), *Implementing Treatment/Programs* (23 items), *Modalities and Facilitation Techniques* (43 modalities listed, and 27 facilitation techniques/theories listed), *Evaluating Treatment/Programs* (11 items), and *Managing Recreational Therapy Practice* (21 items). Since *Modalities and Facilitation Techniques* were divided into two sections within the tool itself, these two subsections were entered separately when the tool was converted to Qualtrics. This resulted in eight main sections of the RT Competency Assessment.

The nine Support Content sections include, *Knowledge of the Functional Aspects of the Human Body* (12 items), *Human Growth and Development* (6 items), P*sychology, Cognitive/Educational Psychology and Abnormal Psychology* (16 items), *Counseling, Group Dynamics and Leadership* (10 items), *First Aid and Safety* (7 items), *Disabling Conditions* (8 items), *Pharmacology* (4 items), *Understanding Health Care Services and Systems* (7 items), and *Recreation and Leisure* (10 items). It was determined by the PI that it was not feasible or necessary to use the entire self-assessment tool for this study. Specifically, the PI decided to not use the Support Content portion because the topics listed are not specifically related to RT practice. There was also concern that the length of the tool with the inclusion of the Support Content would cause survey fatigue. Additionally, to account for any variation in exposure to specific treatment modalities or facilitation techniques among the different service settings, these two subsections of the questionnaire had an additional option for interns to choose "*was not exposed to this*". This additional option represented a "6" as the sixth option on what was originally a 1-5 Likert scale. Unfortunately, during the data analysis phase it was discovered that adding

this option to these two subsections and not to the others fundamentally altered the entire instrument. All "6" responses were subsequently changed to "1", which represented "*no perceived competence*". The rationale for this change was to ensure that the total points were accurately represented by using the original Likert scale. It also stood to reason that any participant who responded with "*was not exposed to this*" during the course of their career or internship would also have "*no perceived competence*" in that area.

To date, there has been no studies to evaluate the reliability of this self-assessment tool. When discussing this with the editors of the RT Competency Assessment, they feel that the self-assessment tool has face validity because the original version was developed by an expert panel of RTs chosen by ATRA. Additionally, the current revisions (2008) are the result of a modified Delphi review that included the ATRA Board of Directors, ATRA Past Presidents, ATRA Chapter Affiliates, and ATRA Treatment Networks (now called Treatment Sections) (R. West, personal communication, March 20, 2018). A copy of the self-assessment tool can be seen in Appendix C.

Implementation of RT Competency Assessment. Supervisors completed the RT Competency Assessment at one timepoint, during or after week 14. The RT intern completed the RT Competency Assessment using a retrospective pre-post design, where the students completed the pre and the post assessment, simultaneously, during or after week 14. For each question, the content area was stated and was then followed with "Before the start of your internship" and "At the end of your internship". Each of these had their individual Likert scale that ranged from *no perceived competence* to *very high perceived competence*. See Figure 3.1 for an example. Completing the retrospective pre-

post assessment in this manner allowed the student to perform a more accurate measure

of any changes in their competencies (Bhanji et al., 2012; Howard et al., 1979).

Figure 3.1

Retrospective Pre-Post Example

Knowledge of the historical foundations and evolution of the RT/TR profession.

	1= No perceived competence	2= Minimal perceived competence	3= Average perceived competence	4= High perceived competence	5= Very high perceived competence
Before the start of your internship	○	○	○	○	○
At the end of your internship	○	○	○	○	○

After converting all measurement tools into Qualtrics, the PI previewed each

survey to check for errors and to time approximately how long it would take to complete.

It was determined that the LMX-7 would take approximately 5 minutes to complete, and

the RT Competency Assessment would take approximately 30 minutes to complete.

There was concern that the length and content of the survey would deter some from

completing it in full. While the length could not be changed, it was probable that some

participants (both interns and supervisors) might feel inadequate if they did not perceive

themselves to be competent in most, or all, of the areas. To combat this, specific language

was added at the beginning and then half way through the survey that said, "*It is not*

expected that you are proficient in everything."

   Pilot Testing the Online Measurements. The next step was to have both surveys

pilot tested via Qualtrics with three CTRSs who were not participants in the current

study. Two were active CTRSs in the field and one was an educator. The purpose of this

was to ensure that the instructions were clear on how to complete the survey, and to catch

any potential typing errors. Some of the feedback for the LMX-7 survey could not be

applied, as it would change the language, and therefore alter the tool. For example, two of

the CTRSs felt that use of "leader" and "follower", instead of "intern" and "supervisor"

in the LMX-7 was awkward and could possibly be confusing to study participants. To

help decrease any confusion the following message was placed in the instructions at the

beginning of the LMX-7 survey for the intern version, "*This survey uses the term 'leader'*

in place of 'supervisor'" and at the beginning of the supervisor version the message read,

"*This survey uses the term 'follower' in place of 'intern'.*"

Another CTRS felt that some of the follower questions might be outside of the

realm of what an intern might feel comfortable doing. The following message was placed

in the instructions at the beginning of the LMX-7 survey, "The purpose of the following

survey is to gain a better understanding of the quality of mentor-student relationships

during the internship process in Recreational Therapy." The hope was that this message

would remind participants to focus on their mentor-student relationship, and not on

hierarchical or organizational expectations.

Other feedback regarding the presentation and flow of the survey, as well as the

instructions on how to complete it, reinforced notifying participants of approximately

how long each survey would take to complete and writing more clearly the instructions

for how to exit, save, and re-enter the survey. One of the CTRSs reported that the

reminders about not being expected to be competent in all content areas of the RT

Competency Assessment were encouraging. This same individual suggested that the

reminders be placed at the beginning of each section to deter participants from self-

judgement. As a result of this feedback, the reminder was placed at the beginning of each

section, and it was written differently to make it specific to its corresponding section.

Such phrases included, "*Remember that it is okay if you don't have strong competencies*

in all areas of client assessment" and "*Program and treatment evaluations vary greatly*

across settings, so it is okay if you do not have knowledge in some of these areas."

     Distribution of Surveys. Each supervisor-intern dyad who previously completed

the demographic survey received the link to the LMX-7 and RT Competency Assessment

surveys during the last week of the RT student's internship. Participants were emailed

one link to both surveys and were instructed to complete the LMX-7 and RT Competency

Assessment surveys within one week of receiving the link. The email also reminded them

of their assigned participant numbers and informed them that upon completion of the

LMX-7, Qualtrics would automatically redirect them to the RT Competency Assessment.

They would also receive an email upon completion of the LMX-7 that contained the same

survey link, which they could use to re-enter the survey if they chose to exit and save.

The instructions at the beginning of each survey, within Qualtrics, informed them that it

would take approximately five minutes to complete the LMX-7 survey and 30 minutes to

complete the RT Competency Assessment. If a participant did not complete the survey

within one week, they received a single reminder email, along with the original survey

link. If the participant did not respond and/or did not complete the survey after the

reminder email, they were not contacted again.

Quantitative Data Analysis. Following completion of the study, all quantitative data from the LMX-7 and the RT Competency Assessment, as well as the demographic information, was downloaded from Qualtrics and stored in Excel spreadsheets. All data was stored on the PI's personal computer, which requires a password to access. The data was organized and checked for missing responses. At this time, the PI also double checked that each participant had agreed to the terms by clicking "yes" to the informed consent. Next, the LMX-7 and RT Competency Assessment surveys were reviewed for missing or incomplete responses. If a participant did not complete either survey in full, their data was not included in the analysis. Once all completed pairs were identified, LMX-7 scores were calculated for each intern-supervisor dyad. This yielded three LMX-7 scores; one from the intern, one from the clinical supervisor, and the LMX agreement score (i.e., difference between supervisor LMX-7 score and intern LMX-7 score), which was calculated by using a subtraction formula in Excel.

The totals for each subsection of the supervisor's competency assessment were then calculated using an addition formula in Excel. Once each section was totaled, an overall competency score was then calculated for each supervisor. To calculate the intern's competency change score, their pre score was subtracted from their post score. The sum of each subsection revealed the intern's overall competency change score. Percentages were also calculated, as this was believed to be more accurate than comparing mean scores due to the variation in possible scores for each section of the RT Competency Assessment. Within each of the eight sections, the total possible points are Foundations of Professional Practice (145), Individualized Patient/Client Assessment

(115), Planning Treatment/Programs (100), Implementing Treatment/Programs (115),

Modalities (200), Facilitation Techniques/Theories (135), Evaluating

Treatment/Programs (55), Managing Recreational Therapy practice (105). The total

points for Modalities would have been 215, however, due to the three missing modalities,

the total was 200. Percentage scores were calculated for overall competency assessment,

as well as for each subsection. These percentages were calculated by taking the mean and

dividing it by the total number of possible points.

$$\% = \frac{Mean}{Total}$$

For the percentage of change in intern competency from pre to post, the following

formula was used. The formula represents the pre competency score (v1) subtracted from

the post competency score (v2), divided by the absolute value of the pre competency

score, multiplied by 100.

$$\frac{(v_2 - v_1)}{|v_1|} \times 100$$

Once all calculations were complete, the data from all three surveys were

transferred to IBM SPSS Statistics (Version 26) for statistical analysis. See Table 3.4 for

a breakdown of each data analysis described in this section.

Normality and Correlations. Once all data was transferred to IBM SPSS

Statistics (Version 26), descriptive statistics were completed for each variable, and tests

for normal distribution were completed for the three main variables in this study (i.e.,

intern competency development, supervisor competency level, and LMX scores).

Normality testing for each of these variables was completed using IBM SPSS Statistics

(Version 26), specifically, the Shapiro-Wilk score was used. Once normality testing was completed, the following parametric tests were used to answer research questions number one and two. Because one or more of the variables was found to have a non-normal distribution, the Spearman's Correlation test was used, as this is a standard non-parametric test used to test for correlations between variables. To answer research question number one, a Spearman's correlation was used to test for possible relationships between intern competency change score and LMX-7 scores (both intern and supervisor), intern competency change score and LMX difference score. To answer research question number two, Spearman's correlation was used to test for possible relationships between intern competency change score and clinical supervisor competency score (i.e., supervisor competency level). Spearman's correlations were also tested between intern pre and post competency scores, and intern post competency score and supervisor competency. Additionally, correlations were tested for each of the eight subsections of the RT Competency Assessment. Specifically, the intern competency change score for each section was compared to the scores in each section of the clinical supervisor competency.

Standard Multiple Regression. Once the correlation coefficient between variables were established, a standard multiple regression was conducted to simultaneously answer research questions one and two. The first standard multiple regression model tested intern competency change score as the dependent variable and five independent variables, which included intern pre-competency assessment, clinical supervisor competency assessment, clinical supervisor LMX-7, intern LMX-7, and intern GPA. A second

standard multiple regression model was tested using only the intern competency change

score as the dependent variable and intern pre-competency and intern LMX-7 as the

independent variables. These variables were chosen based on the results of the first

model. Based on the results of the second model, a third standard multiple regression

model was conducted using intern competency change as the dependent variable and the

eight subsections of the RT Competency Assessment as the independent variables.

     Paired Samples T-Test. A paired samples t-test was used to compare the means

between intern pre and post competency assessment scores. Specifically, the intern pre

and post means for each of the eight subsections of the RT Competency Assessment were

compared, as well as the overall competency score (i.e., the total of all eight subsections).

Table 3.4

Quantitative Data Analysis

Test	Variables	Purpose
Subtraction formula	• LMX-7 scores	Identify level of LMX agreement between supervisor and intern
Subtraction formula	• Pre-Post Intern competency	Identify intern competency change
Descriptive Statistics	• All demographics, LMX-7 scores, and RT competency assessment (supervisor/intern)	For reporting and data analysis
Percentage scores	• Mean scores of interns' pre and post and supervisor competency	To determine overall competency percentages, for making comparisons and data analysis
Percentage change	• Intern pre and post competency scores	To determine the amount of intern competency

		change over the course of the internship
Normality tests, including Shapiro-Wilk, Histograms	• LMX-7 (supervisor/Intern) • LMX Agreement (i.e., difference) • Intern pre and post competency scores • Intern competency change • Supervisor competency scores • Subsections for RT CA	Test for normal distribution of all variables to determine the use of parametric vs non-parametric testing
Spearman's Correlation	• LMX-7 (supervisor/intern) • Intern pre and post competency scores • Intern competency change • Supervisor competency scores • Subsections for RT CA	Test for relationships and collinearity between competency scores
Standard Multiple Regression (model 1)	• Intern competency change (DV) • Intern GPA (IV) • Intern LMX-7 (IV) • CS LMX-7 (IV) • Supervisor competency (IV) • Pre-Intern competency (IV)	Test predictability of IVs on the DV
Standard Multiple Regression (model 2)	• Intern competency change (DV) • Intern LMX-7 (IV) • Pre-Intern CA (IV)	Test predictability of IVs on the DV
Paired Samples t-test	• Pre and post averages of each subsection of the intern competency	Compare mean scores in each section of intern competency
Pared Samples t-test	• Overall average of the intern pre and post competency	Compare means of pre and post-test

Note: CA = Competency Assessment, DV = Dependent Variable, IV = Independent

Variable, LMX = Leader-Member Exchange.

Qualitative Methods

The qualitative portion of this study consisted of individual follow up interviews with a convenience sample of interns and supervisors who had completed all three of the surveys in full and agreed to complete an interview. The following sections provide details of the qualitative sampling and recruitment methods, as well as the qualitative data collection and analysis procedures.

Qualitative Sampling and Recruitment. Based on the response rate for survey completions, intern and supervisor pairs were contacted via email to participate in the qualitative portion of the study. Essentially, all participants who completed all three quantitative surveys, in full, were contacted via email and asked to participate in a follow up interview. Since this study evaluated dyads, the target sample was 12-20 participants, with 6-10 being RT interns and 6-10 being clinical supervisors. To increase the response rate for follow up interviews, interns and their clinical supervisor were emailed in pairs, as opposed to one large group email. One email was sent to each pair, inviting them to participate in an individual follow up interview and providing them with a link to the PI's Google calendar. An event was created using Google calendar that consisted of specific days and times (in one-hour increments) that the participants could choose from. This allowed participants to select a time for the follow up interview that was convenient for them. Once a participant selected a day and time, the PI received an email notification. The participant was then sent an email to confirm the day and time that they selected, along with a list of definitions for terms that may be referenced during the interview and a Zoom link so they could access the video conference on the day of their follow up interview. A full list of the definition of terms can be found in Appendix E. To decrease

response bias during the interviews, and to maintain the confidentiality of participant

responses, participants were not informed of their LMX-7 score or whether their LMX

agreement with their supervisor/intern was high or low.

Qualitative Data Collection. Individual follow up interviews were conducted

following completion of quantitative data collection via a video conferencing software

called Zoom. In phenomenology, it is customary for the researcher to also make

observations of the study participants that are used to support or add richness to

participant responses (Creswell, 2013). It was also thought that being able to see the

participant, and subsequently providing the participants the ability to see the researcher,

would aid in developing mutual trust and rapport. This, in turn, could help to relieve any

anxiety that the participant might have about being interviewed on this topic.

In preparation for the interviews, the researcher created an interview guide (see

appendix D) containing two sets of semi-structured interview questions; one set for the

supervisor and one for the intern. The questions for both the supervisor and intern

attempted to access the same phenomena, so the questions on each interview guide were

designed to parallel or mirror each other. An example supervisor interview question is,

"*How would you describe the intern's RT competency development during her/his*

internship?" and an example intern interview question is, "*In what ways has your*

supervisor influenced your competency development?" The interview questions were

developed with assistance from a committee member who has extensive experience with

qualitative research. The list of questions was approved by the committee chair and then

pilot tested on two active CTRSs in the field who were not participants of the current

study.

   Pilot Testing Follow up Interviews. The two pilot tests (i.e., practice interviews)

were conducted via Zoom. The practice interviews were video and audio recorded, with

consent of the participant. The purpose of doing these two pilot tests was threefold. The

first purpose was to ensure that the questions were yielding the type of information

necessary to answer the research questions. The second purpose was to give the PI an

opportunity to develop interview skills related to this specific topic, prior to the first

follow up interview (Pietkiewicz & Smith, 2012). The third purpose was to give the PI

two opportunities to practice using the record and auto-transcription features in Zoom, as

well as to identify any potential difficulties with using the Zoom software and subsequent

means of troubleshooting. As it happens, during one of the practice interviews the audio

did not work so the PI and the CTRS spoke via phone while still using Zoom so the two

could still see each other during the interview. Additionally, to give authenticity to the

practice interviews, both CTRSs were asked to think of their most recent intern while

answering the interview questions. Following completion of each practice interview the

CTRS was asked to provide feedback to the PI regarding style and flow, as well as

content of the interview questions. Per their feedback, interview content was adequate.

However, they mentioned that it was difficult to think of specific examples (per the

interview questions) regarding their most recent intern, as it had been some time since

either CTRS had directly supervised an intern. This comment brought attention to the

importance of scheduling the follow up interviews quickly following the end of the internship.

Following completion of the two pilot tests the video links for both interviews were sent to two committee members for review. The benefit of having other committee members review the videos was to receive feedback on the PI's interview style and process for taking notes. The PI also reviewed the videos to identify potential ways to improve the manner in which the interviews are conducted, or even the content of the interview questions themselves. First, the PI noticed that typing notes on the computer during the interviews created excess noise in the video, which was distracting and would make transcription difficult. Committee members noticed this as well, so it was decided that all notes during follow up interviews would be hand written on a printed version of the interview guide. One of the committee members also noted two important points. First, that the PI seemed to display flat affect during the interviews, and second, that the terminology used in the interview questions may not be understood by all study participants. Based on this feedback, the PI was encouraged to be more engaging with the participants during the interview. Additionally, the PI created a list of definitions for the participants to read prior to the interview and, if needed, to reference during the interview. This list of definitions was sent to each participant as an attachment to their confirmation email for their interview day and time. See Appendix E for a full list of these definitions.

Follow-up Interviews. The video conferencing tool used in this study is called Zoom. It was free for the participants to log in and allowed them to participate via their

computer or smartphone. This software also allowed for the interviews to be recorded and auto-transcribed. When using the record feature, Zoom also creates an audio file. In addition to this, the PI also used the audio recording on their personal laptop, as a backup. Both the Zoom files and the audio recordings on the laptop were password protected, of which the PI is the only person who knows the password. The benefit of using Zoom is the availability of the video, which allowed the PI and the participant to see each other during the interview. This method was chosen as the primary method of qualitative data collection over using the telephone because a face to face conversation allowed the PI to observe the participants facial expressions and some of their body language during the interview. Video conferencing also allowed the PI to view and later describe participants environment at the time of the interview, as well as provide a way for the PI to observe the participant for signs of physical or emotional distress (Pietkiewicz & Smith, 2012). Interviews would be stopped if any of the following events occurred, the participant requests for the interview to stop, or if the participant became physically or emotionally distressed to the point where they could not continue the interview in a safe manner. In the event that equipment failures are so great that the interview cannot be video, or audio recorded, the interview would be rescheduled.

Each interview was scheduled for at least 60 minutes, but participants were informed the interview would last as long as was needed for them to answer the interview questions, or to address any other questions that arose. Once the participant and the PI were logged into Zoom, the PI took a few minutes for formal introductions and engaged the participant in informal conversation, with the purpose of decreasing anxiety

(Moustakas, 1994), reducing tension, and building rapport and trust between the PI and

participant (Pietkiewicz & Smith, 2012). Prior to beginning the formal portion of the

interview, the PI read, verbatim, the script at the beginning of the Individual Interview

Guide (see Appendix D). The script described the purpose of the interview, which is to

gain an understanding of their experience as an intern or a clinical supervisor. During this

time, participants were reminded that all information collected during the study would be

kept confidential between the participant and the PI. Deidentified data would only be

seen by the PI and possibly the Clemson faculty assisting with the research project.

Participants were encouraged to share any and all thoughts related to the study.

Participants had the opportunity to pause the interview at any time to ask a clarifying

question or to take a break. Prior to starting the audio and video recordings, the PI

obtained verbal consent from the participant. Once approval was obtained, the PI began

recording, and then performed an audio and video check to ensure that both parties could

hear and see each other and that the recordings were working properly.

Once recording began, the PI verbally stated the participant number and then

wrote the participant number on the interview guide to assist with accurate labeling and

storage of data (Groenewald, 2004). For consistency, and to decrease confusion,

participants kept the same participant number for their interview as they had during the

quantitative portion of the study. During the interview, the PI took notes on a paper copy

of the interview guide. Notes included facial expressions and body language, follow up

questions that arose during the interview, and any other notes that are relevant to the

study. Follow up questions were asked throughout the interview, usually following the

statement by the participant that required additional explanation. However, if there was not an opportunity for interjection while the topic was being discussed, the PI asked follow up questions during a natural pause in the conversation or at the end of the interview. For participants who are reluctant to respond to questions or did not provide enough context, the PI used prompts to elicit conversation. Sample prompts included "*could you elaborate more about that experience*?" "*Can you provide some specific examples of how you identified this competency development*?" "*Which of your leadership behaviors do you think have been the most influential*?" Additional probing questions (i.e., prompts) can be found on the interview guide on Appendix D.

All notes taken during the interviews were hand written and labeled with the participant number and date. Notes taken by the PI were both descriptive and reflective. Descriptive notes described the participants environment and body language, and reflective notes consisted of the PIs interpretation of the participants environment, body language, and responses to interview questions (Groenewald, 2004). Once all interview and follow up questions were asked, participants were asked if there was additional information that they would like to share that they were not asked about. They were also given the opportunity to ask questions or to seek clarification on anything of which they were unsure. Interviews continued until all interview questions and follow up questions were answered. At the end of the interview, participants were informed that the interview was over and that the recording would then stop. They were thanked for their participation and informed that they would receive an email from the PI that contained the transcription of their interview. Participants were informed during the interview, and

again in the email, that they had one week to respond to the email with any changes to the

transcription. If the participant did not respond within one week it would be assumed that

the participant agreed with the content of the transcription.

Dependability of the Qualitative Results

Various processes were implemented in order to ensure accuracy and

trustworthiness of the qualitative data. First, all follow up interviews were conducted

using Zoom, where they were audio and video recorded with the participant's verbal

consent. Additional audio recordings were obtained using the record feature on the PI's

personal computer, as a backup. Additionally, all interviews were based on the same list

of interview questions. The PI then implemented bracketing following each interview, a

process for organizing and storing the data, transcribing the interviews, and then member

checking to ensure accuracy.

Bracketing

After the participant logged out of Zoom, the PI recorded all thoughts, feelings,

and comments related to the interview that just occurred (Pietkiewicz & Smith, 2012)

using hand written notes. A separate interview guide was used for each participant so that

all after-interview notes could be taken directly on the interview guide that was used

during the course of that interview. The purpose of this process, known as bracketing, is

to ensure that the data is analyzed objectively by identifying all personal biases, thoughts

or feelings that may impact data analysis. These thoughts and feelings can then be set

aside while the PI attempts to understand the experience from the point of view of each

participant, therefore enhancing the trustworthiness of qualitative data (Yuksel &

Yildirim, 2015).

Data Organization and Storage

Following the completion of each interview all audio files were saved to the PI's

laptop and labeled using the participant number and the date the interview was

conducted. All Zoom files were saved to the Zoom Cloud, which is also password

protected. Only the PI has the password to access either of these. Once the Zoom

program completed the auto-transcription, the PI received an email notification. The text

of the transcription was then transferred to a Word document, organized, and edited. Each

transcription document was saved separately, using the participant number and date

(Groenewald, 2004). Back up files were saved to a flash drive that also belongs to the PI.

Files and recordings were deidentified and were only shared with the committee members

listed on the title page.

Transcribing

The auto-transcript from each Zoom recording was downloaded from Zoom.

Information within the transcript was then organized and checked for accuracy. Each

video was watched between two and three times, while ensuring that the content of the

transcript was accurate. Each transcript was checked for accuracy while watching and

listening to the video of the interview at least two times. Grammatical errors, on the part

of the software, were corrected. Otherwise, the transcriptions included the participant's

responses and the researcher's questions, verbatim. The notes taken during each

interview were also used to check for accuracy in the transcriptions. The process of

reading and checking for accuracy required the PI to read the transcripts multiple times, which assisted the PI in becoming familiar with the data (Pietkiewicz & Smith, 2012).

Member Checking

Once each transcription was finalized it was emailed to the corresponding participant in the form of a Word document. The email contained instructions to the participant to review the transcript and provide any feedback or clarification to ensure that the essence of the participant's experience was captured accurately. Participants were reminded that they had a deadline of one week to respond to the email with any changes or concerns regarding the transcription of their interview. Participants were encouraged to verify that the information was correct, or to clarify any information that was not represented accurately. Participants were informed that if they did not respond within seven days from the date of the email, it was assumed that the participant was satisfied with the content of the transcription. Three participants responded with minor corrections related to program names at their facility, eight participants responded that the information was accurate, and nine participants did not respond at all. In the event that a participant reported that any portion of the summary was inaccurate they provided written clarification in their response email.

This member-checking process helps to validate the results of the study by improving the credibility of the data (Creswell, 2014; Groenewald, 2004; Yuksel & Yildirim, 2015). Once the accuracy of the transcription was confirmed by the participant, or if a participant did not respond within one week of receiving the email (i.e., an

assumption that the participant agreed with the transcription of their interview), the PI

moved forward with data analysis.

Reflexivity Statement

Reflexivity in qualitative research aims to increase the credibility of the results by

making transparent the beliefs held by the researcher based on their own experiences with

the phenomenon being studied (Reid et al., 2018). In keeping with this theme, the PI

wrote a three and a half page reflexivity journal entry, prior to the start of data analysis,

that can be found in Appendix F. This reflexivity statement describes this researcher's

experience as an RT intern, as an RT practitioner, and as a clinical supervisor, for the

purpose of identifying potential biases that could impact the results of this study (Gilbert,

2009). As the PI, the following things were completed to protect personal bias from

influencing the results. Following each interview this researcher documented all thoughts

that were derived from the interview with the participant, and then reflected on how

personal biases either fit with the topics discussed and/or how personal biases that could

influence data analysis (i.e., bracketing).

Qualitative Data Analysis

Once the member checking process was completed each transcription was read at

least two times prior to starting data analysis to increase the PI's familiarity with the

content of each. Additionally, the notes from each interview were referenced during the

qualitative data analysis to check for accuracy or discrepancies in the data (Yuksel &

Yildirim, 2015). After reviewing the transcriptions and notes of all intern follow up

interviews, the data was coded using a process of open coding and then axial coding.

First, important chunks of information relevant to the research question were highlighted within each individual transcription. Specifically, while reviewing each transcription, relevant words, phrases, statements and/or quotes (Tesch, 1990), also known as meaning units (Usher & Jackson, 2014; Van Manen, 2012) were highlighted that referenced the central phenomenon in this study, which was, what affects competency development in RT interns? Each of these meaning units helped to explain the lived experiences of interns and the supervisors during the internship process.

Once these chunks of data were isolated the information from each intern interview was pulled together and reviewed again with the purpose of identifying common themes that trended across the data. In order to do this, the PI transferred the highlighted chunks of data from each transcript to a coding template in a separate Word document. This process was used to identify which meaning units could be clustered together and subsequently formed into meaningful themes. The coding template was developed by the PI and another member of the dissertation committee. The coding template was used to analyze each transcription, individually. An example of the coding template can be found in Appendix I.

After each transcript was coded and themes identified in their individual templates, the themes that emerged were then transferred to a single Excel document. This allowed for the overall themes to be viewed in a single location. Participant quotes from each participant were subsequently added to this document to show support of each theme that emerged. Once all themes were identified, they were assigned a label that accurately describes the collective meaning of the participant responses.

Data Mixing

Quantitative and qualitative data were summarized and then used to answer the overarching mixed methods research question. Results from the individual interviews were used to explain the results of the self-assessment measures from the quantitative portion of the study. This data is presented in a side by side joint display table that demonstrates the convergence and divergence of the results of the study (Creswell & Plano Clark, 2018). Each piece of quantitative data in the joint display table is accompanied by a supportive piece of qualitative data, as well as a description of whether or not the paired data points are convergent or divergent.

Limitations

The limitations of this study are the diverse nature of each dyads working environment, the level of education of each supervisor and intern, and the amount of CS education and/or training that each supervisor or intern received prior to participation in this study. The use of convenience sampling and self-assessment measures were also a limitation. The environment for each dyad can have a significant impact on the performance and development of each intern, as well as the management, leadership, or supervisory style of each clinical supervisor. Education levels can potentially influence study results among interns who are seeking a bachelor's degree compared to interns who are completing a master's degree. There can also be a difference in how supervisors approach CS based on their own experience as an intern and/or whether they received education and/or training on how to provide CS. Also, convenience sampling limits the ability to generalize the results of the study. However, convenience sampling was chosen

because not all RTs supervise interns and it was logical to recruit participants from a pool

of personal professional contacts, as well as through the RT programs at various colleges

and universities in the United States. Additionally, self-assessment measures can pose a

risk for response bias, based on individual perceptions and implicit biases. However, due

to the nature of this particular study, the use of self-assessment measures was necessary

to understand the perspective of each study participant. Another limitation is the risk of

survey fatigue. The RT Competency Assessment is lengthy, and participants could

become lax in their responses toward the end of the assessment, therefore affecting the

accuracy of their responses. However, the Competency Self-Assessment was chosen over

the competency assessment in the ATRA-SOP because the RT Competency Assessment

is a more comprehensive instrument that was tested at least for face validity, and each

section mirrors the CARTE standards (CAAHEP, 2017).

Chapter 4

Manuscript 1

Predictive Factors in Competency Development among Recreational Therapy

Interns

This article will be submitted to the American Journal of Recreational Therapy

Abstract: Clinical supervision (CS) is important to student interns and novice professionals, as it provides guidance for competency development. However, in recreational therapy (RT), there are few requirements for a CTRS to be qualified to provide CS to interns. There is also minimal research regarding the effectiveness of current clinical supervisory and leadership practices in RT, or their effect on competency development in interns. The purpose of the current study was to identify the factors of CS that predict competency development during the 560-hour internship in RT. Purposive sampling was used to recruit supervisor-intern dyads (N=24). Self-assessment surveys were used to measure relationship quality between each supervisor and intern pair, as well as supervisor competency and intern competency change. Intern competencies at the beginning of the internship were measured retrospectively, followed by a post-internship measure. Regression analysis was used to determine what factors predict competency development. Results indicate that competency prior to internship and intern's perception of relationship quality are the two strongest predictors of competency development among RT interns. Applications to RT and CS requirements are discussed.

Introduction

Clinical supervision (CS) is a vital component to clinical practice and internships and is typically provided by an experienced clinician to help students and healthcare professionals develop the necessary knowledge, skills and abilities related to their scope of practice (Bernard & Goodyear, 2014b). The relationship between the clinicians and the focus on competency building are among the key aspects of CS, as identified in the following definition of CS,

> The formal provision by senior/qualified health practitioners of an intensive
> relationship-based education and training that is case-focused and which supports,
> directs and guides the work of colleagues (supervisees); quality control;
> maintaining and facilitating the supervisees' competence and capability; and
> helping supervisees' to work effectively (Milne, 2007, p. 440).

CS can be provided to a novice or a seasoned professional who is looking for guidance on how to improve skills, increase competencies, or approach a difficult clinical decision (Edwards, 2013). CS also applies to recreational therapy (RT) student interns whereby supervision is provided to students during their fieldwork experience (i.e., internship) (Hutchins, 2005). The leadership behaviors exhibited by a clinical supervisor can have a positive or a negative impact on the developing professional(s) they supervise.

Leadership and Clinical Supervision

Both leadership and CS are concepts and practices that have been defined repeatedly by several authors and researchers. Northouse (2019) offers a simplified definition of leadership, stating that, "leadership is a process whereby an individual

influences a group of individuals to achieve a common goal" (p. 5). While the topic of leadership is vast and encompasses a myriad of theories, leadership theories can easily be applied to any setting, dyad, or group, and offers a foundation for studying CS. In this study, the following theory served as a guiding framework.

Leader-Member Exchange Theory

Graen and Uhl-bien (1991, 1995) characterize the Leader-Member Exchange Theory (LMX) by the development of high and low-quality relationships between leaders and followers. Uhl-Bien and Maslyn (2003) found that high quality relationships developed as a result of mutual interest, perceived organizational support, and altruism, while low-quality relationships develop when the dyad's interactions are devoid of these things. This unique approach describes the relationship as more of a partnership by focusing on the roles of both the supervisor and the subordinate, rather than focusing on leader behaviors only. This theory has applications for the RT internship because the supervisor serves as the leader and the intern serves as the follower. The CS requirements and practices in RT may also impact the intern-supervisor relationship.

Clinical Supervision in Recreational Therapy

CS requirements in RT are established by the Committee on Accreditation of Recreational Therapy Education (CARTE) and the National Council for Therapeutic Recreation Certification (NCTRC). To qualify as a clinical instructor (i.e., supervisor), CAAHEP (2017) requires the supervisor to have their Certified Therapeutic Recreation Specialist (CTRS) credential for one year, in addition to one year of directly providing RT services. NCTRC requires the supervisor to have their CTRS credential for at least

one year, be employed at least 30 hours a week (full time) and provide direct RT services at least 50% of the time. RT students must complete required coursework and then complete a 14-week, 560-hour, internship under the supervision of a qualified CTRS (NCTRC, 2017c). The orientation requirement by CARTE is not content specific and not all universities have CARTE accreditation. It should also be noted that some RT programs have an internal requirement for clinical supervisors to have a minimum of two or even three years of experience in the field (Zabriskie & Ferguson, 2004); however, there are currently no CS training requirements for internship supervisors, so the competencies of the clinical supervisor are unknown.

Beyond these requirements, there is a minimal amount of research in RT regarding the effectiveness of CS. For example, previous research revealed that RT educators in both graduate and undergraduate programs think CS education (i.e., lecture or course) is important, yet it was only provided in approximately half of the RT education programs (Gruver & Austin, 1990). Jones and Anderson (2004) found that approximately 25% of CTRSs were currently receiving CS from another CTRS or another professional at their facility, especially among RTs with more than 13 years of experience in the field. Additionally, Bedini and Anderson (2003) found that CTRSs in executive or administrative roles were more likely to receive mentoring, a component of CS. Bedini and Anderson also found that mentorship improved job satisfaction and organizational commitment. For those who provided CS to others, approximately 43% received their education or training through a conference session or workshop, especially those with a master's and doctorate degree (Jones & Anderson, 2004).

While the previous studies evaluated CS education and training, and the prevalence of how much it was provided, Hutchins (2005) identified and suggested 54 specific competencies for CS. Some of the identified competencies fell into the categories of *personal attributes* (e.g., awareness of their professional capabilities, positive attitude toward the profession, effective interpersonal skills, professional development), *professional practice* (e.g., uses various assessment methods, interprets client information to design treatment, collaborates with others, demonstrates ethical behavior, evaluates clients and program), *supervision* (e.g., provides specific and direct feedback to students, communicates effectively with student, monitors internship outcomes, initiates action to resolve conflicts), and *professional resources* (e.g., NCTRC certification, ATRA Code of Ethics, ATRA Standards of Practice, and professional membership). Interestingly, CS itself was highlighted in Hutchins' study as a necessary competency for a CTRS to be an effective internship supervisor. While these findings are important, it should be noted that there is no measure for these identified competencies.

In reviewing each of these studies, it is apparent that CS in RT is considered important among professionals and educators, however it is inconsistently taught, provided, and received. While competencies and leadership seem important for high quality CS, no study has examined the extent that these factors contribute to competency development. Therefore, the purpose of this study was to identify the factors that predict competency development among RT interns.

Methods

This study measured the impact of supervisor competency and relationship quality on intern competency change. The findings reported in this study are part of a larger study on CS in RT. This article reports the findings associated with the research question: *What is the association between relationship quality, supervisor competency, and intern competency development during RT internships*? A university research review board approved the study.

Recruitment and Participant Selection

Educators at approximately 80 universities and 82 CTRSs were contacted via email. These individuals were asked to either participate in the study or to share information about the study with their RT colleagues and/or interns. The following eligibility requirements applied to this study: a) interns had to complete their internship during the Spring, Summer, or Fall of 2018; b) supervisors had to be employed no less than 30 hours a week and have their CTRS credential for one year; c) both intern and supervisor had to agree to participate in the study together; d) all participants had to read, write, and speak in English; and e) consent to be in the study.

Two incentives were provided to encourage participation in the study. Interns and supervisors who completed the study were each entered into a drawing. Interns were offered payment of their NCTRC certification exam registration fee covered at a cost of $325. Supervisors were offered coverage of their annual ATRA membership at a cost of $125. One individual from each group was selected by an online randomizer tool.

Measurements

Three surveys were used in this study, which were distributed using an online

survey management program called Qualtrics. The first survey asked participants to

report demographic information and contained the informed consent. The second and

third surveys measured relationship quality and competencies in RT, respectively.

Relationship Quality Assessment. The quality of the relationship between dyads

was measured using the LMX-7, developed by Graen and Uhl-bien (1995). The LMX-7

is a seven-item instrument that uses six different Likert-type scales. These include scales

that range from *rarely* to *very often*, *not a bit* to *a great deal*, *none* to *very high*, *strongly*

disagree to *strongly agree*, and *extremely ineffective* to *extremely effective*. There is

concern among LMX researchers that the varied use of Likert scales is confusing (Liden

et al., 2016). Due to this concern, the wording of each question was changed using a

technique described by Liden et al. (2016) as mirrored language. The context of each

question stayed the same; however, the items were changed from questions to statements.

These changes allowed for use of a single Likert-type scale (i.e., *strongly disagree* to

strongly agree). In order to determine if readability had improved, both versions were

reviewed by seven CTRSs who had previous experience supervising RT interns, and

were not participants in the study. Their feedback confirmed that the wording of the

mirrored version improved readability. The survey was then separated into an intern

version that used the term "follower" and a supervisor version that used the term

"leader." These changes did not alter the scoring of the instrument, which measures the

quality of the relationship from 7-14 as *Very Low*, 15-19 as *Low*; 20-24 as *Average*, 25-

29 as *High*, and 30-35 as *Very High* (Graen & Uhl-bien, 1995).

Competency Assessment. *The Guidelines for Competency Assessment and Curriculum Planning in Therapeutic Recreation: A Tool for Self-Assessment* (RT Competency Study) (West et al., 2008) was used to measure RT practice competency in this study. This measurement tool contains eight subsections of RT specific competencies and nine subsections of Support Content that is more general to the human services industry. This self-assessment was used to measure the perceived competency levels among supervisors and interns. The eight subsections include: foundations of professional practice, client assessment, planning, implementation, specific modalities, facilitation techniques and theories, evaluating treatment/programs, and managing RT practice. The Support Content subsections include topics related to anatomy, human growth and development, psychology, counseling, first aid and safety, specific diagnoses, pharmacology, understanding healthcare, and recreation and leisure. The Support Content items were not included in the competency measure because these areas were not related to RT specific practice. There was also concern that the length of the tool including the Support Content would cause unnecessary survey fatigue.

The RT Competency Assessment was also divided into a supervisor version and an intern version. The intern version utilized a retrospective pre-test and a traditional post-test design (Bhanji et al., 2012; Mason, 2002; Thomas et al., 2019). Each question asked the intern to rate their level of perceived competence at the beginning of their internship, as well as at the end of their internship. This resulted in two competency scores per each intern (i.e., pre and post). The retrospective design was used to promote a more accurate reflection of their perceived competency at the start of their internship

(Bhanji et al., 2012; Howard et al., 1979; Thomas et al., 2019). The supervisor version only asked supervisors to rate their perceived competency at the end of the internship.

Data Collection

Each dyad received the link to the demographic survey and informed consent by email. During the final week of their internship, dyads who completed the first survey in full (including the informed consent) received a second link via email that directed them to the LMX-7 survey. Following completion of the LMX-7, participants were automatically directed to the RT Competency Assessment survey. All participants were instructed to complete both surveys within one week. After one week, a reminder email was sent to all participants who had not yet completed both surveys.

Data Analysis

Using IBM SPSS Statistics (Version 26), data was first checked for normality with the Shapiro Wilk test and histograms. Due to some variables being non normally distributed, the non-parametric test Spearman's correlation was used to test for relationships between the independent and the dependent variables. Based on the results of the Spearman's correlation, a standard multiple regression model was used to determine if the independent variables (i.e., intern and supervisor LMX-7 scores, supervisor competency, intern GPA, and intern pre-competency and competency change scores) were predictive of the dependent variable (i.e., intern competency change). Standard multiple regression was used to test the independent variables in the model simultaneously, as opposed to hierarchically (Tabachnick & Fidell, 2013). The percentage of change in intern competency was calculated using the intern pre and post

mean scores in the following formula (represented in Table 2). The formula represents

the pre competency score (v1) subtracted from the post competency (v2) score, divided

by the absolute value of the pre competency score, multiplied by 100.

$$\frac{(v_2 - v_1)}{|v_1|} \times 100$$

Finally, a paired samples t-test was used to determine the significance of the change in

mean intern competency from pre to post.

Results

Recruitment efforts yielded 48 dyads, however, only 24 dyads completed the

study by completing all three surveys. There were 24 interns representing 15 universities,

and 24 supervisors representing various facility types, client populations, and age groups.

Additionally, only 13 supervisors and seven interns received any type of CS education or

training at the time of this study. The most common form of training for interns was

undergraduate lectures and classes, while the most common form of training for

supervisors was obtained from a conference session or workshop. Table 4.1 represents

additional demographics for supervisors and interns.

Table 4.1

Participant Demographics

Demographic	Range/Frequency	Mean	Standard Deviation
Intern			
Age	21-32	24	2.93
Female	21 (87.5%)		
Male	3 12.5%)		
GPA		3.39	.316
Intern class standing at time of internship			

Senior	23 (95.8%)		
Graduate Student	1 (4.2%)		
Supervisor			
Age	24-60	36	9.89
Female	20 (83.3%)		
Male	4 (16.7%)		
Years as a CTRS	2-36	11.58	9.46
Supervisor Education Level			
Bachelor's Degree	18 (75%)		
Master's Degree	4 (16.7%)		
Doctoral Degree	2 (8.3%)		

Note. *Intern GPA was only reported by 22 of the 24 interns.

LMX-7 and Competency Scores

Overall, the intern's average LMX-7 score, based on their perceived relationship quality with their supervisor, fell into the *Very High* category (Graen & Uhl-Bien, 1995). The supervisor's average LMX-7 score, based on the supervisor's perceived relationship quality with their intern, fell into the *High* category of relationship quality. The averages for both intern and supervisor LMX-7 scores indicate a positive relationship, on average, between interns and clinical supervisors. Table 4.2 displays the intern and supervisor LMX-7 scores.

Table 4.2

LMX-7 and Competency Assessment Scores

Response Type	Range	Mean	Standard Deviation	% Change
Intern LMX-7	23-35	31.75	3.48	
Supervisor LMX-7	10-35	29.13	6.17	
Pre-intern competency	354-840	545.08	116.63	56.19
Post-intern competency	498-951	673.00	98.31	69.00
Intern Competency	22-233	127.91	55.49	23.46
Supervisor Competency	352-833	666.12	113.97	67.00

Note. LMX-7 Ranges 7-14 (Very Low), 15-19 (Low); 20-24 (Average), 25-29 (High),

and 30-35 (Very High).

Intern and supervisor LMX-7 scores both yielded significant Shapiro Wilk scores

(see Table 4.3), indicating these scores were not normally distributed. As a result,

Spearman's Correlation was used to measure relationships between the independent and

dependent variables. Results from Spearman's Correlation test revealed intern pre-

competency to be moderately correlated with intern competency change (r = -.585, p =

.003). No other variables were significantly correlated.

Table 4.3

Shapiro Wilk Scores for Independent and Dependent Variables

Variable	Statistic	df	Sig
Intern LMX-7	.834	22	.002*
Supervisor LMX-7	.831	22	.002*
Supervisor Competency Total	.938	22	.182
Intern GPA	.932	22	.135
Pre-Intern Competency Total	.931	22	.131
Intern CA Change	.965	22	.597

Note. **p $\leq$ .01; *p$\leq$.05.

Spearman's Correlation

The LMX-7 scores were not normally distributed, so the non-parametric

Spearman's correlation test was used to evaluate the strength of the relationship between

the independent and dependent variables. Related to research question one, intern post-

competency scores and intern LMX-7 scores showed significant correlation (r = .539, p =

.007). There was no correlation between intern competency change and any of the LMX-

7 scores (i.e., intern LMX-7 r = -.184, p = .389, supervisor LMX-7 r = -.165, p = .441).

Related to research question two, intern post competency scores showed significant

correlation with pre-competency score (r = .819, p =.000). Additionally, there was a

negative correlation between intern competency change score and intern pre-competency

score (r = -.585, p = .003). Table 4.4 highlights the relevant correlations discussed in this

section.

Table 4.4

Spearman's Correlation Results

Variable	Intern Competency Change	Intern Post Competency	Intern LMX-7	Supervisor LMX-7
Supervisor Competency	-.190	.163	.249	.417**
Supervisor LMX-7	-.165	.159	.217	
Intern LMX-7	-.184	.539**		.217
Intern GPA	-.045	.066	.204	-.135
Intern Pre-Competency	-.585**	.819**	.596**	.315
Intern Post Competency	-.112		.539**	.159
Intern Competency Change		-.112	-.184	-.165

Note. **p ≤ .01; *p≤.05.

Standard Multiple Regression

Two standard multiple regression models were used to test which variables were

predictive of intern perceived competency development. Some of the Spearman's

correlation results showed limited to no relationship between some of the dependent and

independent variables listed in Table 4.3 (i.e., Supervisor Competency, Supervisor LMX-

7, Intern LMX-7, and Intern GPA. Despite this finding, these variables were used in the

regression model to fully test the hypotheses and research questions of this study. Due to

the small sample size, this study used a 90% confidence interval to interpret significance

for each model (Hair et al, 2009; Hazelrigg, 2009). Results from both regression models can be found in Table 4.5.

The first regression model included intern competency change score as the dependent variable and five independent variables, including intern pre-competency total, supervisor competency total, supervisor LMX-7, intern LMX-7, and intern GPA. These five variables significantly accounted for approximately 46% of the variance in the intern competency change scores (R^2=.457, $F(5,16)$= 2.68, p=.060). Intern pre-competency (β= -.797, p= .003) and intern LMX-7 (β= .472, p=.062) yielded significant results, while the other variables did not.

To test a more parsimonious model, a second standard multiple regression model tested entering only intern pre-competency and intern LMX-7 as the independent variables due to their significance in the first model. Model two accounted for approximately 38% of the variance observed in intern competency change (R^2=.338, $F(2,21)$= 6.664, p=006). Additionally, intern pre-competency remained a significant factor in predicting intern competency change (β= -.738, p= .002), as well as intern LMX-7 scores (β= -.364, p= .086). The size and direction of the relationships between these two independent variables confirmed the findings of the first model. While both variables were significant at the 90% confidence level, intern pre-competency was the strongest predictor of intern competency change.

Table 4.5

Regression Models with Intern Competency Change as Dependent Variable

	R Square	F	Sig.	β	Part	Sig.
Model 1	.457	2.688	.060			

Intern GPA [a]				-.181	-.214	.393
Intern LMX-7 [b]				.472	.448	.062
Supervisor LMX-7				-.067	-.080	.753
Supervisor Competency				-.154	-.214	.490
Pre-Intern Competency				-.379	-.617	.004**
Model 2	.388	6.664	**.**006**			
Pre-Intern Competency				-.738	-.623	.002**
Intern LMX-7				.364	.366	.086

Note: **p $\leq$ .01, [a] Grade Point Average, [b] Leader-Member Exchange

Paired Samples T-Test

A paired samples *t*-test was used to compare the means of intern pre and post competency assessment scores, specifically to test the significance of the 23.46% competency increase (Table 2). The intern pre-competency mean score was 545.08 and the intern post competency mean score was 673. The t-test revealed a significant difference ($t(23) =11.29$, p=.000) between interns' pre and post competency scores.

Discussion

The purpose of this study was to identify the factors that predict competency change among RT interns. Results from the first and second regression models indicated that intern competency prior to internship was the best predictor of perceived change in intern competency. Interns who rated themselves lower in their competency prior to internship were more likely to have a higher competency change score. These results suggest that interns with lower competency prior to internship had more room for growth over the course of the internship. It was hypothesized that supervisor competency would be a predictor of intern competency change. However, the findings in this study showed a small and insignificant relationship between intern competency change and supervisor competency.

While there are no previous studies in RT that measure intern competency before

and after internship, the available literature within the RT field supports the importance

of the internship (Hutchins, 2005; Zabriskie & Ferguson, 2004). While discussing

undergraduate curriculum, Russell (2010) stated "students learn from what they *do* in

college" (p. 191), highlighting the importance of task-based learning experiences (i.e.,

fieldwork experiences and internship). Additionally, the importance of the internship

experience was highlighted by the finding that GPA had no relationship with intern

competency development.

The curriculum requirements and national standards for RT curriculum have

changed over the years to require an additional number of core RT courses, as well as a

longer internship (Richard, 2016; Wilder et al., 2015). However, the inconsistencies

among RT curriculums have long been documented, most notably, in the number of

required core RT courses, the length of internship, and the amount of fieldwork

experiences/hours required of students prior to beginning their internship (Hawkins et al.,

2018; Stumbo et al., 2004; Wilder et al., 2015; Zabriskie & Ferguson, 2004). These

inconsistencies can be seen as a barrier to the advancement of the profession, as well as a

barrier to intern competency development. More specifically, the varied requirements in

RT curriculum and fieldwork experience prior to internship could explain the varied

competency levels in the current study that were reported by interns at the beginning of

their internship.

The most recent investigation into the needs and effectiveness of RT curriculum

and fieldwork experiences were reported by the ATRA Higher Education Task Force

(Hawkins et al., 2018). Results from the Task Force's study highlighted the need for improved and consistent fieldwork experiences within RT curriculums. Additionally, the findings in the current study echo the recommendations from the Higher Education Task Force. First, the Task Force recommended to increase the amount of fieldwork experiences in the bachelor's RT curriculum, while also improving the quality of those experiences. Improving the amount and quality of fieldwork experience prior to internship could reduce the variability in competencies among students entering their internship. Second, the findings in the current study highlight the importance and the impact of the 560-hour internship on intern competency development, further supporting the need to ensure that all RT students receive a quality internship that consistently meets academic and accreditation standards. Third, the Task Force also focused on improving the supervision provided to students during fieldwork experiences, which would include the quality of clinical supervision during the 14-week, 560-hour, internship. Improving the quality of supervision provided by the internship supervisor could also improve the quality of the relationship that develops between the intern and their supervisor. The impact of relationship quality on competency development was identified in this current study using the intern LMX-7 ratings, further supporting the recommendation by the Task Force to improve the quality of fieldwork supervision.

Intern LMX-7 ratings were the second largest predictor of competency change in interns, while supervisor LMX-7 ratings had no relationship with intern competency change. Using a 90% confidence interval, intern perception of their relationship quality with their supervisor (i.e., intern LMX-7 score) had a moderate association with their

ability to develop competency. Based on the LMX literature, these high-quality

relationships seen among interns and supervisors developed as a result of mutual trust

(Liden et al., 1993; Nahrgang & Seo, 2016), leader delegation (Bauer & Green, 1996),

and interpersonal interactions (Ilies et al., 2007). Collectively, interns with lower

competencies entering internship and strong relationships with their supervisor exhibited

higher competency development over the course of their internship.

In summary, the findings from this current study suggest four important things.

First, the interns' self-assessed competency change scores reveal that interns have the

capacity to recognize growth within themselves and their ability to perform skills.

Second, the competency scores prior to internship highlight the varying levels of

competency among students entering their internship. This finding echoed the findings of

previous RT curriculum studies. Third, the internship plays a significant role in intern

competency development, especially for students who enter their internships with lower

competencies. Fourth, intern GPA had no relationship with intern competency change,

suggesting that GPA does not predict competency development. This finding is

encouraging for students who may not perform well in the classroom and indicates that

all students have the potential for skill development during their internship, regardless of

GPA. These last two findings also provide support for the value and importance of the

internship, as well as other fieldwork experiences that occur throughout the RT

curriculum. Since the internship is another way to rate student performance, it highlights

students' capacity for skill development during fieldwork experiences.

Recommendations

While the majority of supervisors in this study had some training on CS, it is not currently required for them to do so. The findings in this study help support the need for a CS training (Hutchins, 2005). More specifically, the training could include competencies related to relationship building and guidance on how to mentor interns with advanced competencies at the start of the internship. Requiring internship supervisors to complete a training on how to be an effective clinical supervisor, prior to supervising an intern, would help ensure they are performing effectively. This requirement would also meet the recommendations of the Higher Education Task Force as it relates to improving the quality of fieldwork experiences. Additionally, having a competency standard for CS is an area that could be further explored by CARTE, especially since CARTE sets the standards for knowledge, skills, and performance of both the intern and the supervisor.

CARTE currently requires university programs to provide an orientation to clinical supervisors (CAAHEP, 2017). However, there are no guidelines on how to provide this orientation (i.e., number of hours, in person, online), or what content should be included. A CS orientation or training could focus on enhancing leadership and mentorship skills. These skills could promote the development of high-quality relationships with interns.

Furthermore, the results of this study show that students enter their internship with a range of competencies. Intern competencies at the beginning of their internship ranged from 354-840 (Table 4.2). This wide variation in competencies among students entering their internship suggests a wide variation in the academic experiences of RT students. Additionally, since competency prior to internship was the greatest predictor of

intern competency change, each RT program could implement competency measures of their students before the internship. Then complete a retrospective pre-internship measure followed by a traditional post measure, as was completed in the current study. This practice would provide insight into the effectiveness of their curriculum, as well as the individual internship experience.

This study also highlighted the need for a new competency measure that is better suited for research. The competency assessment tool used in this study was designed for students and practitioners to identify gaps in their knowledge, as well as for curriculum development and evaluation. While it served an important role in this study, developing a research related competency measure would allow for rigorous testing to determine validity and reliability of the tool. Such a tool could be used by other researchers to conduct additional CS and competency studies in RT. The tool could also be used as a self-measure for clinical supervisors and students to determine their areas of strength and deficit in the field.

Limitations

One of the major limitations in this study is the small sample size. The sample size was affected by limited recruitment time, as well as the need for paired samples of intern and supervisor dyads. Requiring paired dyad samples made it difficult to use random sampling. Therefore, convenience sampling was used, limiting the generalizability of the results. Due to the convenience sampling, it is also possible that the participants represented only supervisors and interns who felt confident in their knowledge and skills. A study of this nature, where one's vulnerabilities may be brought

to light, could have been a barrier for some to volunteer. The diverse nature of each

participant's working environment also limits the ability to generalize study results based

on service setting or population served. Finally, the use of self-assessments may have

limited the reliability of the data, as participants could have over or under-rated their

competency in one or more areas.

Conclusion

The purpose of this study was to identify whether relationship quality and

supervisor competency could be used to predict intern competency development in RT.

Results suggested that intern competency prior to internship and perceived relationship

quality were the prominent factors in predicting intern competency development. Further

research is needed to understand how competencies are developed among RT students, as

well as research to inform a training for clinical supervisors in RT. Future research

studies should continue to use supervisor-intern pairs to further understand the impact of

relationship quality on intern competency development. Additional research should also

focus on identifying additional variables, such as self-efficacy, that could predict intern

competency development during their internship experience.

Chapter 5

Manuscript 2

A Mixed Methods Study on Competency Development During Recreational

Therapy Internships

This article will be submitted to the Therapeutic Recreation Journal

Abstract: Clinical supervision (CS) in recreational therapy (RT) is a minimally studied topic, and the quality of supervision provided to RT interns during their internship experience is unknown. The purpose of the current study was to understand the prominent leadership behaviors and competencies among clinical supervisors in RT and how those behaviors and competencies impact competency development in RT interns. Quantitative results from a larger mixed methods study were combined with newly presented qualitative results. Interns who completed the quantitative portion of the study were recruited for an individual follow up interview. Semi structured interviews were completed with 10 RT interns via Zoom video conferencing software. Five themes emerged from the qualitative data. Qualitative reports indicate that supervisor communication style, demonstrated RT competencies, mentorship, personality, and scaffolded learning approach all contributed to intern competency development. Both quantitative and qualitative results are compared to highlight how these themes contribute to high-quality relationships or intern competency development. Implications for the RT profession are discussed.

Key Words: Clinical Supervision, Competencies, Internship, Recreational Therapy, Supervision, Mixed Methods.

Introduction

Clinical supervision (CS) is important to the delivery of training and development of accountability in young professionals (Bernard & Goodyear, 2014a). In recreational therapy (RT), the CS provided by an internship supervisor is a necessary component of the internship. CS can be provided to not only interns, but also professionals who demonstrate the need for guidance in making clinical decisions. Novice professionals may need mentorship as they develop skills beyond what their education provided. Seasoned professionals may need guidance to help them through a situation where difficult decisions need to be made (Edwards, 2013). Among those who provide CS to interns, there are various styles of leadership that can impact the quality of the relationship between intern and supervisor dyads.

The Leader-Member Exchange Theory

While there are multiple leadership theories, the Leader-Member Exchange (LMX) theory has implications for the intern-supervisor dyad because it uniquely focuses on the behaviors of both individuals. More specifically, the LMX theory focuses on the quality of the relationship between a leader and a follower (Graen & Uhl-bien, 1991, 1995). The LMX theory also states that leaders naturally interact differently with different followers, as a result of various factors, thereby demonstrating different leadership behaviors with different followers (Martin et al., 2016; Northouse, 2019).

To better understand the applications of LMX theory and how high- or low-quality relationships develop, LMX researchers identified specific leader and follower traits known as antecedents. More specifically, antecedents are the actions, behaviors,

and personality traits displayed by a leader or a follower that impact the quality of their

relationship (Nahrgang & Seo, 2016). There are several antecedents identified in the

LMX literature. For example, positive interpersonal interactions between a leader and a

follower (Ilies et al., 2007), perceived organizational support, mutual interest in task

oriented behaviors or supporting each other's needs (Uhl-Bien & Maslyn, 2003), mutual

trust, respect, mentorship, and good communication (Tse & Troth, 2013) all lead to high

quality dyadic relationships. Positive interpersonal interactions, specifically, result from

leaders who are viewed as trusting, cooperative, agreeable, pleasant (Nahrgang et al.,

2009) and supportive (Tse & Troth, 2013). From the leader's perspective, high quality

relationships develop when the follower is viewed as extraverted, enthusiastic, and

engaged (Nahrgang et al., 2009). Additionally, personality was found to be the greatest

predictor of success among managers (Hogan et al., 2011).

Based on LMX literature, there are several antecedents that lead can impact the

quality of the supervisor-intern relationship. During the 560-hour internship in RT, the

supervisor is often considered the leader and the intern is the follower. The LMX theory

relates to the clinical supervisory process during the RT internship because the quality of

the supervisor-intern relationship can impact intern competency development (Bright et

al., 2020)

Clinical Supervision in Recreational Therapy

In RT, there are few studies that provide a picture of the CS environment for

established professionals or student interns. Research on this topic within RT is limited,

and the available research is quite dated. Subsequently, little is known about the

frequency or effectiveness of CS education taught at the bachelor's or master's level. As

of 1990, only half of the RT programs provided courses or lectures in their curriculum

(Gruver & Austin, 1990) and only half of the Certified Therapeutic Recreation Specialists

(CTRSs) providing CS to other RT professionals received any type of CS training (Jones

& Anderson, 2004). Another study, by Bedini and Anderson (2003), measured the effects

of mentorship in the workplace. They found that job satisfaction and organizational

commitment was higher among CTRSs who received mentorship. However, CTRSs in

executive or administrative roles were more likely to receive mentorship. Likewise, Jones

and Anderson (2004) found that CTRSs with 13 or more years in the field were more

likely to receive CS than novice professionals.

Regarding supervision during internships, it is unknown whether the minimum

requirements to qualify as an internship supervisor results in quality CS for RT interns. In

RT, there are two organizations that set the qualification requirements for a CTRS to

provide CS to an intern. The National Council for Therapeutic Recreation Certification

(NCTRC) requires the CTRS to be credentialed for one year, be employed at least 30

hours (full time) at their organization, and spend the majority of their time providing

direct care (NCTRC, 2017c). The Committee on Accreditation of Recreational Therapy

Education (CARTE) requires the CTRS to be credentialed for at least one year and have

one year of experience providing direct RT services (CAAHEP, 2017). Beyond these

guidelines, there are no requirements or CS-based competency or qualifications for a

CTRS prior to supervising an RT student during their 560-hour internship.

While there are no competency requirements in the field, Hutchins (2005), identified 54 practice and CS competencies that a CTRS should possess if they intend to supervise RT interns. Some examples of the competencies identified in Hutchins' study include; positive attitude toward the profession, effective interpersonal skill, demonstrates ethical behavior, provides specific and direct feedback to students, communicates effectively with student, and demonstrates genuineness, empathy, and caring. Interestingly, some of these competencies are similar to the leadership behaviors identified in the LMX research discussed previously.

The available research in RT reveals a nominal focus on CS in undergraduate and graduate education. There is also a limited number of CTRSs who receive CS education or training. One study identified the competencies that an internship supervisor should possess (Hutchins, 2005), and another study identified the positive effects of mentorship in the workplace (Bedini & Anderson, 2003). For the CTRSs who supervise or provide CS to interns, there are minimal requirements that establish them as a qualified internship supervisor. Among the CTRSs who do supervise interns, there is no research that identifies the current clinical supervisory practices being used, or the impact of those practices on intern competency development. Therefore, the purpose of the current study was to understand the prominent leadership behaviors and competencies among clinical supervisors in RT and how those behaviors and competencies impact competency development in RT interns.

Methods

This study presents the qualitative and mixed methods portions of a larger study (Bright et al., 2020). This study expands on the previous study by utilizing a phenomenological explanatory sequential mixed methods design (Creswell & Plano Clark, 2018). In qualitative research, phenomenology refers to the study of a specific phenomenon where the researcher seeks to explain the lived experience of a group of individuals (Creswell, 2013; Husserl, 1964). In explanatory sequential designs, the quantitative data is collected first, followed by the qualitative data, and then both sets of data are combined to provide a richer explanation of the phenomenon being studied (Creswell & Plano Clark, 2018). The phenomenon in this study was the experience of RT intern's competency development during their internship. The overarching mixed-methods research question asks: *what are the prominent leadership behaviors and competencies among clinical supervisors in RT and how do those behaviors and competencies impact the competency development in RT interns?* The research question driving the qualitative research methods and results of this study was *what is the experience of recreational therapy intern's competency development as related to the intern's perception of their supervisor's leadership behaviors and competency in recreational therapy?* A university research review board approved the study prior to data collection.

Recruitment

Convenience sampling was implemented for the qualitative portion of the study, as all interns who completed the quantitative portion of the study were invited via email to participate in a follow-up interview. Participants were provided with a link to a Google

calendar and instructed to select a day and time of their choosing. Once they scheduled

their follow-up interview, the intern received a confirmation email that included the day

and time they selected, the Zoom link for the video conference, and a list of terms and

definitions that might be referenced during the interview. The terms included

competencies, competency development, leader, leadership behaviors, follower, follower

behaviors. The list of terms was important to the interview process by ensuring the intern

understood the meaning behind the terms being used by the interviewer.

Data Collection

Given the mixed methods design used in this study, the qualitative data built upon

the quantitative data. To understand the significance of the qualitative and mixed

methods results, the quantitative methods are reported below. Quantitative data was

collected using three measurements tools. The first was a demographic survey and the

second was a modified version of the LMX-7, which is based on the Leader-Member

Exchange (LMX) theory. The ratings for the LMX-7 include 7-14 (Very Low), 15-19

(Low); 20-24 (Average), 25-29 (High), and 30-35 (Very High). The third was a tool

referred to as the RT Competency Assessment, which can be found in *The Guidelines for*

Competency Assessment and Curriculum Planning in Therapeutic Recreation: A Tool for

Self-Assessment (West et al., 2008). The full quantitative methods for this study are

reported in Bright et al. (2020).

The qualitative follow-up interviews utilized semi-structured interview questions

that can be found in Table 5.1. Interviews were conducted via Zoom, an online video

conferencing program. Participants were from various locations across the country. Using

Zoom allowed for face to face interviews, despite participant location. At the consent of each participant, interviews were audio and video recorded via Zoom, with a backup audio recording on a laptop. Participants were informed of their right to end the interview at any time. At the end of the interview participants were given the opportunity to share information pertinent to the study that was not asked during the interview, or to ask questions of their own regarding the study.

After each interview, a form of bracketing was implemented where all of the researcher's thoughts, feelings, and comments related to the interview were handwritten onto the participants individual interview guide (Pietkiewicz & Smith, 2012). The purpose of this process was to ensure that the data was analyzed objectively by identifying all personal biases, thoughts or feelings that may impact data analysis. These thoughts and feelings can then be set aside while attempting to understand the experience from the point of view of each participant, therefore enhancing the trustworthiness of qualitative data (Yuksel & Yildirim, 2015). In this particular study, the handwritten notes from each interview were reviewed during the transcription phase and the analysis phase to ensure that interpretations were solely based on participant reports.

Table 5.1

Semi-Structured Interview Guide

Questions
1. How would you specifically describe your competency development during your internship? Provide examples.
2. In what ways has your supervisor influenced your competency development?
3. How has your supervisor's competency in RT practice impacted the development of your own competencies during this internship? Provide examples.

4. Can you think of any examples where you think your development as an intern would be improved if your supervisor was stronger in specific competencies?
5. What role do you think your supervisor's leadership behaviors have played in your competency development during internship?
6. Which of those behaviors do you think influenced your development the most?
7. Can you think of any leadership behaviors that negatively impacted your development as an intern?
8. What ways have you developed competencies during your internship that were unrelated to your supervisor's influence?
9. Were there any environmental or administrative factors that you think impacted your ability to learn and develop competencies, as it specifically relates to RT/TR?
10. What prepared you to receive clinical supervision?
11. What leadership behaviors would you likely mimic based on how these behaviors made you feel and/or their effect on your competencies?

Member Checking

Follow up interviews were initially transcribed using the auto-transcription feature in Zoom. Transcriptions were later reviewed for accuracy while also viewing the video recordings two to three times each. Once each transcription was finalized it was emailed to the corresponding participant in the form of a Word document. The email contained instructions to the participant to review the transcript and provide feedback or clarification to ensure that the essence of their experience was captured accurately in their original interview statements. Participants were informed at the time of the interview and again via email, that they had a deadline of one week to respond with changes or concerns regarding the transcription of their interview. If they did not respond within seven days, it was assumed that the participant was satisfied with the content of the transcription. This member-checking process helped to validate the results of the study by improving the credibility of the data (Creswell, 2014; Groenewald, 2004; Yuksel &

Yildirim, 2015). Four interns responded that the information was accurate, and six did not respond.

Qualitative Data Analysis

Once the member checking process was complete, each transcription was read at least two times prior to starting data analysis. Data was coded using a process of open coding and then axial coding. First, important chunks of information relevant to the research question (i.e., what affects competency development in RT interns?) were highlighted within each individual transcription. Specifically, while reviewing each transcription, relevant words, phrases, statements and/or quotes (Tesch, 1990), also known as meaning units (Usher & Jackson, 2014; Van Manen, 2012) were highlighted that referenced the central phenomenon in this study.

Once meaning units were isolated the information was coded and then reviewed to identify common themes that trended across the data. Once all themes were identified, they were assigned a label that accurately described the collective meaning of the participant responses. The quantitative and qualitative data was then summarized and combined to answer the overarching mixed methods research question. Specifically, results from the individual interviews were used to explain the results of the self-assessment measures from the quantitative portion of the study. This data is presented in a side by side joint display table that demonstrates the convergence and divergence of the results of the study (Creswell & Plano Clark, 2018).

Results

The quantitative results from this study were published in a previous article (Bright et al, 2020), which focused on identifying the factors that predict competency development among RT interns. Using correlation analysis and regression models, the quantitative phase of the study found that the best predictor of intern competency change was intern pre-competency scores, followed by intern LMX-7 scores (i.e., intern-perceived relationship quality with their supervisor) (Bright et al., 2020). Specifically, the qualitative data is presented as exemplary quotes alongside the corresponding LMX-7 rating for the intern who provided the quote. For reference, LMX-7 scores for the 10 interns ranged from 27-35, which falls in the *Average* to *Very High* range of relationship quality on the LMX-7 scale. Also, the competency change measured at the beginning of their internship as compared to the end of the internship represented a statistically significant 23.46% increase ($t(23) = 11.29$, p=.000) in intern competency. The data was mixed and presented in this manner to provide context for the perceived relationship quality contained within each quote.

Qualitative recruitment efforts yielded interviews with 10 RT interns. All interns were undergraduate students. Two reported receiving some type of clinical supervision education, while eight reported zero clinical supervision education prior to starting their internship. Additional demographic information is provided in Table 5.2, however, other demographic details of each participant (e.g., university attended, population, setting) were kept confidential to ensure complete anonymity of research participants (Morse, 2008). The demographic information for all study participants in the mixed methods study can be found within the quantitative results published by Bright et al (2020).

Table 5.2

Demographic Data for Intern's Interviewed in Qualitative Phase

Demographic	Average	Range
Age	24	21-28
GPA	3.4	3.0-3.8
Intern LMX-7	32.7	27-35
Pre-Competency	552.8	354-817
Post-Competency	673.5	561-866
Competency Change	120.7	28-211

Each interview ranged between approximately 30 to 75 minutes. All participants were asked the same core set of semi-structured interview questions (Table 5.1). Five themes emerged as a result of the qualitative coding process. The five themes included *open, honest, and authentic communication; scaffolded learning; modeling skills and recognizing deficits; professional mentoring; and personality traits and leadership*. The following sections provide descriptions of each theme with direct quotes from participants to further contextualize and provide evidence of their experiences. To protect the origin of each quote all gender-identifying pronouns were changed to [CS], referring to the clinical supervisor.

Open, Honest, and Authentic Communication

Each intern reported that their CS provided them with feedback that helped to improve their skills and develop competency. Interns related that this feedback was open, honest, and authentic. For some interns, communication was direct and immediate (i.e., when working with the client or directly afterwards) and for others, it occurred during a daily check-in or a weekly meeting. Regardless of when it occurred, the purpose of

providing feedback was so the intern could improve their skills, as well as reinforce and/or highlight the areas in which the intern performed well. One intern stated;

> I got a lot of feedback from my supervisor…after each session I would do by myself, or even if we did it together, [CS] would give me feedback each time… 'oh you improved on this' or 'here's something to keep working on.

Another intern reported that their supervisor gave feedback during sessions with clients. However, the supervisor first explained to the client what was happening and why the interjection was needed. One intern explained, "Sometimes it [feedback] was positive reinforcement… 'That was a really great question.' or 'That was a really good observation that you just had.'"

While the style of feedback varied among supervisors, receiving authentic and honest feedback was welcomed by interns, as it was impactful to their competency development. For example, one intern stated "Without [CS] being honest, I don't think I would have learned half the things that I learned." Interns also felt that this open style of communication allowed them to feel more comfortable when asking questions of their supervisor, promoting the development of a positive relationship. This next quote highlights, specifically, the value that one intern placed on receiving authentic and honest feedback.

> Being honest with us. I mean, completely open and honest with us, you know. And [CS] didn't baby us or beat around the corner. When we did something wrong or if we didn't do something so well, [CS] wouldn't tell us, 'Oh, it's going

to be okay. It'll be okay for the next time.' [CS] would say, 'okay what did you do

wrong and how are you gonna fix it?'

Scaffolded Learning

Several interns reported that their supervisors used a systematic approach that led

to their competency development and independence as a clinician. Many interns received

an orientation at the beginning of their internship, similar to that of a new employee. In

some cases, an initial orientation was required by the organization. One intern related,

"...we had this list of competencies from [organization] that they want their interns to

learn… when I met with [CS] we walked through each thing on the list and checked it

off." In other cases, the supervisor had created an internship manual to guide the initial

orientation and to check off competencies as they were met or addressed. Some

orientations included a tour of the facility, which helped the intern become familiar and

comfortable with their environment, "…[CS] told me… the do's and the don'ts, and the

where's and where to go and where not to go, as far as the hospital." For other interns,

their orientation consisted of reading about the clients in which they would be working,

including the client's diagnoses, "[they] provided me information on the residents...

Things to be sensitive of before I implement an intervention." Regardless of how

organized or detailed the orientation was, the orientation seemed to lay the foundation for

competency development.

As the intern's skills progressed, and they demonstrated more competency, the

supervisor gradually relinquished responsibilities to the intern. The intern's path to

independence was reliant on the supervisor recognizing the intern's skill progression and

being willing to step back so the intern could perform tasks independently. One intern

related her experience with this gradual progression, "The longer I was in the internship,

the more I see patients and the less [CS] sees patients… It was really me as the rec

therapist for the day… [CS] kind of stepped back and let me do everything." This gradual

increase in responsibility was a welcomed challenge, which helped interns to emerge as

independent clinicians. This next quote describes how that progression occurred for one

intern, "…[CS] challenging me… obviously throughout the internship you grow

competency and your expectation is… you know more. And like, okay, 'I'm not going to

assist you as much'… I loved how [CS] did that. I like being challenged." And another

intern state, "[CS] started to push me out on my own. Like, 'you're coming up with an

intervention today' or 'you're going to do the assessment today.'" Once interns were

given the freedom to perform job tasks independently, they found pride and

accomplishment in not having to constantly check in with their supervisor for each

decision or action.

Modeling Skills and Recognizing Deficits

Another way in which interns developed knowledge, skills, and abilities was by

watching their supervisor perform specific tasks, such as assessments, planning

programs/interventions, implementing programs/interventions, using terminology in

documentation, client interactions (i.e., building rapport), and advocating. Areas in which

supervisors demonstrated or communicated that they had deficits included regulatory

knowledge, managerial skills, and advocacy skills. Skills and deficits were included

together in this theme because they seemed to be in concert with one another.

Skills

Interns progressed in their competency by working alongside their supervisor, observing and asking questions. Interns found particular value in watching their supervisor interact with clients, as they were previously unsure of an appropriate level or style of interaction needed for the situations they observed. Other interns discussed watching their supervisor complete various levels of the assessment, planning, implementation, evaluation, and documentation (APIED) process. Specifically, several interns reported learning how to connect with their client and build rapport while completing an initial assessment. One intern stated, "our very first day we watched [CS] do an assessment and I noticed [CS] was very, very personable with them." Another intern reported that, "[CS]'s patience… and even… doing… assessments… just being… real personable… helped me to see… a different style of approach." While a third intern reflected on the clinical supervisors' conversational skills during the initial assessment, "[CS] could literally talk for… 60 minutes… elaborate on literally what they had for dinner and… make a connection through that. [CS] is… really personable so I feel like [their] intake interviews were… what I learned."

Beyond assessment skills, some interns noticed that their supervisor possessed a talent for advocacy. This was apparent from one intern who recounted her observations during a budget meeting, "…to see… how to interact with your boss, and how… you talk about a budget? How do you stand your ground and be like, 'alright, well… this is why this is?'… advocating for this program."

Deficits

Interns also recognized areas of knowledge or skill deficit in their supervisors. Some supervisors were cognizant of their deficit areas and were honest with their interns about this reality. This recognition provided opportunities for growth among interns and their supervisors. One intern described the meek personality of their supervisor as a barrier to advocacy, "[CS] is… a little bit quiet… soft spoken, I guess. So… in team meetings… afterwards [CS] had told me [their] thoughts, but [CS] didn't… share them with the team. But [CS] also told me [CS] knows that about [themselves]."

Some supervisors who openly recognized their deficits provided opportunities for their intern to learn from another staff member or provided resources for the intern to seek the knowledge independently. In one case, the intern was encouraged by their supervisor to seek information pertinent to the NCTRC$^{©}$ exam.

> [CS] was pretty clear in 'there are things that I cannot teach you, so you should go to my supervisor and learn these things'... [CS] told me that I should schedule an appointment with [their] supervisor… Because of the fact that [their] supervisor was going to be able to give me a lot more knowledge when it comes to CARF and Joint Commission, and how they budget everything, and how [their] supervisor] runs the Rec Therapy program and that there was going to be a lot that could help me in the future and can help me on the [NCTRC] exam.

In other cases, there was a lack of humility demonstrated by the supervisor. One intern reported that their supervisor seemed overly confident in their knowledge and was often unwilling to change their opinion. This experience provided the intern with an opportunity for self-reflection regarding the kind of professional they wanted to be.

[CS] is… very approachable, but… not afraid to share [their] opinion and kind of

be stern about it…. If [CS] sees things [CS] doesn't like or… if there's a TR that

did something that [CS] didn't agree with… [CS] would definitely… talk to me

about it… which was kind of confusing because… [CS] is talking about this TR,

but… I'm friends with [them] … It challenged me because it allowed me to see

like, okay… Do I agree with this or do I want to practice this?

Professional Mentoring

Interns reported that mentorship also contributed to their competency

development. This theme, while possessing some similarity with the *open, honest, and*

authentic communication theme, identified mentorship provided by supervisors that was

not related to feedback on the intern's performance. Mentorship strategies used by

supervisors ranged from professional advice, to sharing personal information, or listening

to the intern vent frustrations. This next quote describes the dedication of one supervisor,

"not only is [CS] like a supervisor, but [CS] was also like a mentor to me… every single

day [CS] wanted me to learn something new, every day. And [CS] was very inclusive

with me."

Other forms of mentorship involved pushing the student to make independent

decisions and to have confidence in their decision-making. One intern recounted, "I

would kind of ask [CS] questions or think out loud, you know, and then [CS] [responds]

'I don't know, what do you think?' 'Come on… push yourself… you know the answer to

the question you just asked me.'" Forcing the intern to rely on their own knowledge and

resources and to make independent decisions, allowed them the opportunity to learn from

failure. One intern recounted an interaction with their clinical supervisor where they were forced to make a decision on their own;

> [CS] really pushed us to learn and… to figure things out… I would come to [CS] with an idea for something and I'd say, 'is this a good idea?' And [CS] would say, 'I don't know. Is it?' … 'No. No. Tell me, is it a good idea?' [CS] says, 'I don't know. Figure it out. Is it a good idea? Run an activity and see if it's a good idea.'

Interns also reported feeling closer to their supervisor when they were able to know each other on a personal level, "… it felt like [CS] was my colleague, but it felt also like a peer." This sense of personal connection and investment in the intern's future promoted a professional relationship of mutual respect between supervisor and intern. One intern reported, "…we talked about… patients and stuff, but we'd also… get to know each other too, which is really nice. So, I feel like knowing [CS] on a personal level, as well as a professional level, was… really important." Another intern talked about the impact that having a good relationship has on the communication that occurs between an intern and a supervisor, "Having the relationship outside of just work, I think that that opens up a lot of communication between supervisors and their interns. Like, I definitely felt comfortable asking [CS] questions."

Personality Traits and Leadership

Interns reported various personality traits and leadership styles among their supervisors. The supervisor's personality seemed to guide their leadership style, and the leadership style of the supervisor seemed to affect the quality of the relationship between

intern and supervisor. In some cases, the intern felt that their personality style matched their supervisor's personality;

> I think we were a good mix because we're both kind of… shy and soft spoken at first, and it takes time to build up… it wasn't ever uncomfortable because we were both kind of that same way until we got used to each other.

> While other times the intern felt that they had different personalities but were still able to work together. Sometimes the supervisor adjusted their leadership style to match the intern's personality, "[CS] leadership style worked really well with me and my personality. And I think [CS] also kind of adapted [themselves] to me a little bit… I think [CS] is really good at reading people."

As previously mentioned, decision-making was a source of stress for some interns. One intern reported having a more positive outlook on work environments and feeling more comfortable making decisions knowing that their supervisor would openly support their decision if it was questioned by others;

> [CS] even said… 'if you kick somebody out of the group… or… if you do something and it's questioned by like upper management… I will defend you…' [CS] wasn't gonna throw you under the bus. Like, [CS] would jump in front of the bus before anything… to see that, like, it can be like that and be a family and like a team and tight knit, like really changed my outlook on work.

The approaches used by supervisors were largely advantageous to the intern's knowledge and skill development. However, there were some instances where the

supervisor's approach left the intern questioning their supervisor's professional behavior. For example, one intern related;

> There was kind of like a lack of humility I think, from [CS]… I think sometimes [CS] just maybe thought… "I'm right" … "you're wrong." And… seemed like a know it all. And maybe sometimes didn't want to… talk to other TRs if [CS] didn't… really like them.

In other cases, interns felt their supervisor was not available when needed or was oblivious to the struggles the intern experienced when interacting with other staff at the facility. One intern described their supervisor's leadership style as Laissez Fair and recounted frustrations felt as a result of another staff member not doing their share of department work. The intern stated, "I think that's just who [CS] is. [CS] is a relaxed person…. [CS] didn't stand up for certain things unless [they] … absolutely had to." Based on these intern reports, the supervisor's personality and leadership style affected the quality of the dyad's relationship. Their relationship quality was a reflection of the level of comfort the intern felt when interacting with their supervisor, as well as the level of respect interns had for their supervisors.

Data Mixing

The purpose of this study was to address the overarching mixed methods research question: *what are the prominent leadership behaviors and competencies among clinical supervisors in Recreational Therapy and how do those behaviors and competencies impact competency development in Recreational Therapy interns*? In order to answer this question, the quantitative and qualitative results are discussed below. A joint display

model was used to assist in communicating where the quantitative and qualitative results converged and where they were diverged. In this explanatory sequential mixed methods study, the qualitative results were used to give a deeper meaning and understanding to the quantitative (i.e., statistical) results.

Convergent Results

Similarities between the quantitative and qualitative results were revealed through the data mixing process. Average intern LMX-7 scores were 31.75 out of 35 total possible points indicating very high-quality relationships between intern and clinical supervisor (Bright et al, 2020). To help explain this result, during the qualitative stage, interns often reported that their supervisors had an agreeable personality, effective leadership behaviors, had open, honest, and authentic communication, and provided professional mentorship. These qualitative results help make a connection that these qualities and supervisory practices contributed to interns having a positive regard for their supervisor. It is possible that the positive interactions that most interns experienced led to them viewing their relationship with their supervisor as high quality. Perhaps when a supervisor demonstrated a commitment to their intern's professional development and future success the intern was more likely to perceive a high-quality relationship with their supervisor.

Additional quantitative analysis revealed that higher intern LMX-7 scores were associated with greater perceived competency increase at the end of the internship. Related to this, reports from interns during the qualitative phase indicate that when

interns perceived their supervisor as a good leader with an agreeable personality, they also perceived learning to be easier.

Statistical analysis of intern competency pre and post scores demonstrated a large 23.46% increase in the interns' overall perceived competency score at the end of the internship. Qualitative reports from interns indicate that this increase in competency could have been a result of the scaffolded learning approach implemented by supervisors. Once the intern demonstrated enough competence in one area the supervisor added to their responsibility or gave them more difficult tasks.

Divergent results

Statistical analysis demonstrated that supervisor competency was not a strong factor in intern competency development. However, within the *Modeling Skills and Recognizing Deficits* theme, several interns discussed observing their supervisor demonstrate specific skills. Interns indicated that having the ability to observe their supervisor, specifically during client interactions, was something that helped them develop competency in these areas. An additional divergent finding was the quantitative result that reported intern pre-competency assessment as a strong predictor for intern competency change at the end of the internship. During follow up interviews, interns did not discuss their preexisting knowledge, skills, and abilities at the beginning of their internship as something that they felt impacted their competency development. In the *Modeling Skills and Recognizing Deficits* theme, interns reported that their supervisor's competency had an impact on their own competency development. The convergent and divergent findings are displayed in Table 5.3.

Table 5.3

Model of Quantitative and Qualitative Results

QUAN finding: Intern (M=31.75/35) and supervisor (M=29.13/35) LMX-7 scores fell into the Very High range on the LMX-7 rating scale, suggesting high quality relationships among most dyads	**QUAL finding**: Professional Mentoring
Convergent Interpretation: Professional Mentoring was a common theme reported among interns. The more an intern felt that their supervisor was invested in their future, the better the intern viewed their relationship, and therefore the intern rated their supervisor higher on the LMX-7.	
QUAN finding: Intern (M=31.75/35) and supervisor (M=29.13/35) LMX-7 scores fell into the Very High range on the LMX-7 rating scale, suggesting high quality relationships among most dyads	**QUAL finding**: Personality Traits and Leadership
Convergent Interpretation: Higher intern LMX-7 ratings means that interns felt they had a high-quality relationship with their supervisor. Likewise, interns reported positive leadership traits among their supervisors.	
QUAN finding: Intern LMX-7 scores were a predictive variable in intern Competency Change (β=.364, p=.086)	**QUAL finding**: Open, Honest, and Authentic Communication
Convergent Interpretation: Intern competency increased due in part to the intern having a high-quality relationship with their supervisor. Qualitative findings indicated that authenticity and open communication between intern and supervisors promoted the development of a positive relationship.	
QUAN finding: Intern Competency Change (23.46% increase)	**QUAL finding**: Scaffolded Learning
Convergent Interpretation: Interns demonstrated an increase in perceived competency assessment, overall, as well as within the eight subsections of the RT Competency Assessment. The Scaffolded Learning theme from the qualitative data suggests that intern competency change was due to their supervisor methodically introducing skills to the intern and then building on those skills once the intern demonstrated mastery.	

QUAN finding: Pre competency assessment scores were a predictor of intern competency change (slope=-.738, p=.002)	**QUAL finding**: Modeling Skills and Recognizing Deficits

Divergent Interpretation: Students who began their internship with lower perceived competency had the greatest improvement at the end of the internship. Qualitative reports from interns did not discuss their own knowledge, or lack thereof. Intern reports focused on their supervisor's competence as one of the things that impacted their competency development.

QUAN finding: Supervisor competency assessment scores were not a predictor of intern competency change in the regression model (slope=-.154, p=.490)	**QUAL finding**: Modeling Skills and Recognizing Deficits

Divergent Interpretation: Despite the clinical supervisor's perceived competency not being a predictive factor in intern competency change, interns reported learning a great deal from observing and talking with their supervisors about specific skills.

Discussion

This article reported on the qualitative and mixed methods findings from a larger study on CS in RT. Qualitative findings revealed that one of the factors that led to the development of high-quality relationships was the initial interactions between intern and supervisor. For example, supervisors provided interns with an orientation that helped them learn about the organization and what is expected of them in their role. This action set the foundation for the development of mutual trust, which occurred as a result of open and honest communication with each other. Later in the internship, as the intern demonstrated increased competency in certain areas, the supervisor delegated more and more tasks to the intern through a scaffolded learning process. The recognition of competency in the intern and the delegation of tasks and responsibilities also likely

contributed to the development of mutual trust. Additionally, most interns reported

leadership behavior from their supervisor that often resembled that of a mentor. This

mentorship behavior went beyond traditional skill development and focused on the

intern's development as a professional in the field. The positive effects of mentorship

found in this study were also found in Bedini and Anderson's study (2003), where those

who received mentorship had higher job satisfaction; and by Ragins (2016) who

highighted the role of mentorship in developing "professional identity." Furthermore,

Heeneman and De Grave (2019) emphasized the importance of developing mentor

competencies and regularly evaluating the effectiveness of individual and organizational

mentorship processes.

The qualitative results in this study also complements the Hutchins (2005) study

by identifying competency areas related to CS. For example, this study found that open,

honest, and authentic communication, professional mentoring, and personality and

leadership style influenced competency development among interns. Hutchins' study

identified effective interpersonal skills (i.e., personality traits and leadership),

demonstrates ethical behavior, provides specific and direct feedback to students,

communicates effectively with student (i.e., open, honest, and authentic communication),

and demonstrates genuineness, empathy, and caring (i.e., professional mentoring). In

comparing the findings from both studies, interns and clinical supervisors believe positive

leadership behavior, honesty, and communication style to be important factors in the

clinical supervisory and competency development process.

Another theme that emerged was personality traits and leadership, which impacted competency development and supervisor-intern relationship quality. This finding is similar to previous leadership research that reported personality to be the greatest indicator of success for a manager or leader (Hogan et al., 2011). The cumulative reports from interns revealed that supervisors in this study displayed various personality traits and leadership behaviors. Some interns reported that their supervisor adjusted their behavior and approach to supervision based on the intern's personality. This finding is supported by Martin et al. (2016) who found that leaders tend to interact with or behave differently when interacting with different followers. The ability to adjust behavior based on recognition of intern or follower personality seems to be a leadership strength that contributes to high quality relationships among dyads.

Implications and Recommendations

The results of this study have implications for educators, supervisors, and for the profession. For educators, CARTE requires university programs to provide clinical supervisors with an orientation and evaluation (CAAHEP, 2017). Based on this study, recommendations for the content of this orientation could include: (a) faculty expectations of clinical supervisors (i.e., frequency of intern evaluations, guidance on the special project, reviewing weekly reports); (b) suggestions for effective communication with interns; (c) how to be a mentor versus a supervisor; (d) how to adjust leadership style based on intern personality; (e) contents of the initial orientation for the intern; and (f) how to develop an internship manual with a skills checklist.

For supervisors, it is recommended to complete a CS training prior to supervising their first RT intern. This recommendation is also supported by previous researchers (Austin, 2004; Austin et al., 2016; Hutchins, 2005; Jones & Anderson, 2004; Jones & Harvey, 2007). The findings in this study, combined with the competencies developed by Hutchins (2005) and the findings on mentorship by Bedini and Anderson (2003), could potentially be used to develop a training to better prepare CTRSs to provide CS to RT students completing their internship. A training could enhance the supervisor's skills as a leader and help prepare them to provide guidance and mentorship. It could also benefit supervisors, and interns, to use an internship manual. Contents of an internship manual could include steps for initial orientation, a checklist of competencies, and important documents that the intern needs to be familiar with. The orientation could include an introduction to the organizations policies and procedures, a tour of the facility, introduction to clients, and an intern job description. CARTE (2017) also recommends that clinical supervisors provide a job description that outlines the expectations, responsibilities, and duties of the intern. Additionally, utilizing a competency checklist could promote systematic skill development (i.e., scaffolded learning).

The biggest recommendation for the profession is to develop and implement a CS training program. While additional research is needed to determine the content of such a training, some recommendations can be made based on the results of this study, including: (a) how, when, and in what manner to provide feedback that is constructive and promotes growth in the intern; (b) how to communicate in an authentic manner that promotes mutual trust and respect; (c) how to systematically introduce competencies that

build upon one another (i.e., *scaffolded learning*); (d) the importance of modeling skills

and professional behaviors; (d) how to locate resources that will expose the intern to

skills and competencies in which the supervisor themselves is deficient; (e) when and

how to intervene during an interaction with a client (i.e., assessment or intervention) that

does not diminish the intern's authority with the client; (f) how to adjust their style and

approach based on intern personality and situational needs; (g) evidenced-based research

on leadership theories and leadership behaviors that promote the development of high-

quality relationships; (h) understanding the difference between serving as a professional

mentor versus a clinical supervisor; and (i) how to mentor interns who enter the

internship at a higher competency level.

To provide further support for the development of a CS training program, the

ATRA 2025 strategic planning document calls to "improve the infrastructure for a

graduated progress of quality fieldwork experiences" (p. 27). Two additional

recommendations mentioned in this document, that have implications for the current

study, include the development of a "competencies-based internship supervisor training

program" and an accreditation requirement that all supervisors complete this training. In

summary, ATRA could develop a CS training program, CARTE could then require

supervisors to complete the training prior to supervising their first intern, and NCTRC

could then offer continuing education units (CEUs) toward recertification.

Limitations

Additional limitations of this study include the small sample size and the use of

purposive sampling, which limit the ability to generalize the results of the study to the

greater population of RT interns. While the use of paired samples was unique, it

prohibited the use of random sampling, further limiting the generalizability of the results.

It is also possible that interns who had positive experiences with their supervisor were

more likely to participate in the qualitative interviews than interns who had negative

experiences. Other potential limitations include the reliability of self-assessments of

competency and possible survey fatigue caused the length of the RT Competency

Assessment. Finally, while this study was intended to be phenomenological in nature, the

explanation from interns regarding their experience spoke directly to their competency

development, but did not always echo the traditional meaning of the lived experience of

the participants. In retrospect, the interview questions did not present the opportunity to

ask students to share their overall internship experiences, but instead asked questions

targeting their perception of how they developed competencies during internship. While

their responses to the interview questions helped to answer the research's purpose, the

overall lived experience of being an intern was not completely captured.

Conclusion

The purpose of this mixed methods study was to understand the prominent

leadership behaviors and competencies among clinical supervisors in RT and how those

behaviors and competencies impact competency development in RT interns. The use of

qualitative interviews and data mixing provided a preliminary understanding of what is

currently being practiced by RT internship supervisors. The small amount of CS research

in RT limited the ability to compare these results to previous research. However, the

findings in the current study do support the need for CS and leadership education.

Additional research is needed to identify the most effective content and structure of this

education, as well as the effectiveness of the current clinical supervisor practices.

Chapter 6

Manuscript 3

Clinical Supervision and Leadership: Developing a Model for Recreational Therapy

This article will be submitted to Therapeutic Recreation Journal

Abstract: The purpose of this article is to present what is currently known about clinical supervision (CS) in recreational therapy (RT) through a review of previous CS research in the field. The current internship supervisor requirements in RT are presented, along with discussions regarding the application of relevant leadership theories. The previous CS research and literature in RT are discussed and used to inform the recommendations made in this article. Relevant findings are used to propose a new model of CS for RT.

Key Words: Clinical Supervision, Competencies, Internship, Recreational Therapy, Supervision, Mixed Methods.

Introduction

The act of providing supervision and guidance to emerging and novice professionals is a long-standing tradition among allied health professions. Emerging and novice professionals can include new graduates beginning in their field, or students completing an internship. The concept of clinical supervision (CS) was adopted as a more formal process to develop competent and independent practitioners. CS is a dynamic process where the goals of learning and clinical skill development, on the part of the student intern, must also benefit the clients they serve (Edwards, 2013). Essentially, the interns' learning objectives cannot take precedence over client goals. CS is an important ethical and educational balance, and leadership can play a key role. In recreational therapy (RT) there is minimal research on the status of CS or the effectiveness of the supervisory practices among CTRSs. The purpose of this article is to present the available research on CS in RT and discuss the application of relevant leadership theories in the development of a model for CS in RT. Previous CS research and literature in RT are presented and used to inform the recommendations made in this article.

Clinical Supervision and Internship Requirements

CS is a complex process that is used to help students and professionals develop or improve skills and competencies (Edwards, 2013). A widely accepted definition of CS by Bernard and Goodyear (2004) states that CS is:

> An intervention provided by a more senior member of a profession to a more
> junior member or members of that same profession. This relationship is
> evaluative, extends over time, and has the simultaneous purposes of enhancing the

professional functioning of the more junior person(s), monitoring the quality of

professional services offered to the clients that she, he, or they see, and serving as

a gatekeeper for those who are to enter the particular profession (p. 8).

The type of or amount of training required of the clinical supervisor can affect the

quality of CS (Kuo et al., 2016). As it relates to internships, specifically, several allied

health professions have supervision requirements, which vary by field of study.

In RT, internship and supervisor requirements are established by the National

Council for Therapeutic Recreation Certification (NCTRC) and the Committee on

Accreditation for Recreational Therapy Certification (CARTE). To qualify as an

internship supervisor, the recreational therapist must have their CTRS credentials for at

least one year, be employed at least 30 hours (full time), with 50% or more of their time

allotted to providing direct RT services (NCTRC, 2017c). CARTE requirements are

similar to NCTRC, in that the CTRS must have their credentials for at least one year,

while providing direct RT services (CAAHEP, 2017).

Clinical Supervision Literature in Recreational Therapy

Jones and Anderson (2004) defined CS in RT as "a dynamic, enabling, and

ongoing process that is interpersonally focused and professional, in which therapeutic

recreation specialists who are skilled and knowledgeable facilitate another's therapeutic

competence in order to maintain or enhance effective practice" (p. 329-330, adapted from

Gruver & Austin, 1990). In RT, CS is typically associated with student interns

completing their 560-hour internship (Hutchins, 2005) but is also associated with the

guidance provided from one practitioner to another (Jones & Anderson, 2004). There are

undoubtedly various styles of CS used by CTRSs throughout the field, whether it is for an

intern or another CTRS. Despite the existence of several CS models that could serve as a

guide or framework for any clinical supervisor (Bernard & Goodyear, 2004), most

professionals do not reference these models, as they tend to rely on the CS techniques

used by their supervisor when they were interns (Edwards, 2013). Such inconsistent

approaches to CS will invariably lead to diverse and inconsistent internship experiences

for RT students. While little is known about the effects of these varied clinical

supervisory and leadership practices in RT, some professionals have contributed to the

scant body of research available in the field (Bright, et al., 2020; Gruver & Austin, 1990;

Hutchins, 2005; Jones & Anderson, 2004).

From the perspective of providing CS education at the bachelors and masters

level, Gruver and Austin (1990), brought attention to the need for CS to be included in

RT educational curriculum. They recognized that other allied health professions were

making CS a "critical component of clinical practice" (p. 19) and that CS contributes to

quality assurance, as it relates to client goals and organizational outcomes. Their study

found that both graduate and undergraduate RT programs viewed CS as important, but it

was only offered as a course or a lecture in approximately half of the RT curriculums.

From the perspective of providing CS to established RT professionals, Jones and

Anderson (2004) found that approximately 55% of CTRSs were not currently receiving

CS, and approximately 25% of them were. Among recreational therapists receiving CS,

41% of them received it from a CTRS, while the remainder received CS from another

professional within the organization. Also, recreational therapists with the greatest

amount of experience in the field (13+ years) were more likely to receive CS. Among the

CTRSs who reported having provided CS to others, approximately 43% had completed

CS training. The most common method of training was a workshop or conference

session. Additionally, recreational therapists with a master's and doctorate were more

likely to have received CS training than those with a bachelor's degree. A similar study

by Bedini and Anderson (2003) identified the prevalence of mentorship provided to

recreational therapists. They found that professionals in executive or administrative roles

were most likely to receive mentoring, followed by RT professionals in middle

management, and then entry level practitioners. Recreational therapists who did not

receive mentoring were more likely to have intent to leave their job and had lower

organizational commitment.

From the perspective of RT internships, a later study by Hutchins (2006)

addressed the competencies necessary for a CTRS to provide CS to a RT intern. While

several competencies were identified in this study, the categories with the most

competencies rated as *extremely important* included, personal attributes, professional

practice, supervision, and professional resources. Most recently, Bright, et al. (2020)

found that the two greatest predictors of intern competency development were intern

competency level at the start of their internship and the intern's perception of their

relationship quality with their supervisor. More specifically, RT students who entered

their internship with low self-perceived competency demonstrated the highest increase in

competency at the end of their internship. Additionally, interns who perceived a high-

quality relationship with their supervisor demonstrated greater competency increase at the end of their internship.

It should be noted that three of the four CS studies presented are quite dated. While the results of those studies provide insight for making recommendations, the amount of CS education and the provision of CS is likely different now. Nevertheless, the results of these studies show that CS is important to the field and to the development of students and professionals. These studies also highlight the need for formal CS education and training to be provided more consistently. Considering the results from Bright, et al. (2020), a portion of the CS education and training should include components of leadership theory.

A Framework of Leadership and Recreational Therapy

Leadership can be defined simply as "…a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2019). For the purposes of this paper, three leadership theories were selected with consideration of the knowledge, skills, and abilities required to be a CTRS, as well as their two main roles of practitioner and supervisor to interns. The three theories include the Leader-Member Exchange (LMX), Authentic Leadership, and Functional Leadership. The LMX considers the relationship between supervisor and intern from the perspective of both parties, while the Authentic Leadership theory focuses on the traits of the supervisor, and the Functional Leadership theory focuses on the actions of the supervisor. Each theory was chosen to aid in understanding how the intern-supervisor relationship develops as they progress through the internship process.

Leader-Member Exchange. The LMX is classified as a relational theory (Barling, Christie, & Hoption, 2011), with focus on the dyadic relationship between the supervisor and the subordinate (i.e., follower). Specifically, LMX theory focuses on the impact that both the leader and the follower have on the quality of the relationship (Liden et al., 2016; Schyns, 2016), rather than focusing on leader behaviors only. LMX researchers found that leaders naturally develop different types of relationships with different followers (Martin et al., 2016). Because of its versatility, the LMX theory can be applied to multiple settings and organizations (Northouse, 2007), such as settings where RT services are provided.

The LMX theory is characterized by the development of high and low-quality relationships between leaders and followers (Graen & Uhl-Bien, 1991, 1995). High quality relationships developed as a result of mutual interest, perceived organizational support, and altruism, while low-quality relationships develop when the dyad's interactions are devoid of these things (Uhl-Bien & Maslyn, 2003). To understand how relationships develop under the LMX theory, Graen and Uhl-Bien (1991, 1995) developed the Leadership Making model, which consists of three stages of relationship development. These stages are labeled *stranger, acquaintance,* and *maturity*. At the *stranger* stage, the relationship is more transactional, formal, and contractual. Dyads enter the *acquaintance* stage once they begin engaging in dialogue with each other that supports the interdependence of each other's roles (i.e., exchanging information, support, or favors). A *mature* relationship or "mature partnership" is achieved when the dyad makes even exchanges with a sense of mutual respect, trust, and loyalty. During this final

stage the relationship becomes transformational. The Leadership Making model has

applications to an RT internship because the dyad typically begins as strangers. The dyad

develops mutual trust and rapport through positive interactions and structured learning

experiences. Toward the end of the internship the dyad, hopefully, has developed a

professional bond that continues beyond the experiences of the internship.

   Antecedents. Additional attempts to understand how high or low-quality

relationships develop include the identification of antecedents. Antecedents refer to the

personality traits and behaviors that impact the dyadic relationship (Nahrgang & Seo,

2016). Some antecedents include the opinion that subordinates and leaders have about

each other prior to meeting or working with one another. These preconceptions can be

based on reputation alone (Liden & Maslyn, 1998), and can impact the amount of respect

the dyad has for the other, even prior to formal introductions. In this case, the

professional reputation of the leader or the follower could have a significant impact on

whether a high-quality relationship develops.

   Nahrgang et al. (2009) found additional evidence that initial interactions can

predict relationship quality between the leader and the follower. Specifically, high-quality

relationships were made when followers were viewed as extraverted, and when leaders

were viewed as agreeable. In the initial stages of the relationship, high-quality

relationships were also predicted by leader and follower expectations of one another,

perceived similarities, mutual trust and liking (Liden et al., 1993; Nahrgang & Seo, 2016)

and similarities in personality (Bauer & Green, 1996). Interestingly, similarities between

the leader and the follower were found to be the strongest predictors of relationship

quality, specifically at the beginning of the dyad's relationship (Nahrgang & Seo, 2016).

Additional LMX research identified antecedents that impact the development of

high-quality relationships beyond the initial stages of the relationship. For example, the

extent of leader delegation (Bauer & Green, 1996), mutual trust, when the follower is

task oriented and produces quality work (Dulebohn et al., 2012; Nahrgang & Seo, 2016),

follower performance and effort, leadership behaviors (Nahrgang & Seo, 2016), and

follower competence (Dulebohn et al., 2012; Gerstner & Day, 1997). Martin et al., (2016)

found that trust in the leader accounted for the highest amount of variance in the

development of high-quality relationships, with motivation, empowerment, and job

satisfaction also emerging as strong mediators.

In summary, high-quality relationships develop as a result of multiple factors on

the part of the leader and the follower. Several antecedents were identified in the

literature as predictors to high or low-quality relationships. As it relates to RT, clinical

supervisors differ in their personality and leadership style. Likewise, interns come from

various backgrounds and experiences with different approaches to work ethic.

Generational differences can also contribute to the personality and performance of

interns, and the expectations of their supervisors (Venne & Coleman, 2010).

To further understand the development of relationships within the LMX theory, it

is common to pair it with other theories (Graen, 1976). The following sections present the

Authentic Leadership and Functional Leadership theories as part the framework because

of their application to the dyadic relationship in RT internships.

Authentic Leadership. While the benefits of being authentic are not new to the idea of leadership, the theory of Authentic Leadership is a newer theory, by comparison. The term Authentic Leadership was only introduced within the last three decades (Baron & Parent, 2015; Gardner et al., 2011). It is classified as an ethical/moral type of theory (Dinh et al., 2014), and suggests that authentic leaders have a positive effect on the people and culture around them, while non-authentic leaders have a negative effect (Chan et al. 2005).

Several definitions have been applied to Authentic Leadership throughout the years (Northouse, 2019). Most of which refer to a function or process that requires the leader to have self-awareness, be true to themselves, and to demonstrate moral and ethical behavior, thereby influencing their subordinates to do the same, which contributes to a positive working environment (Gardner et al., 2011).

Authentic Leadership has also been associated with increased organizational performance, follower satisfaction, quality of work life, positive attitudes and positive behaviors (Datta, 2015). Chan et al. (2005) suggest that authenticity is something that can be taught through a practical process that incorporates *leadership multiplier*s. These multipliers are described as leadership traits (similar to antecedents) that lead to positive responses from followers, therefore multiplying the effectiveness of a leader's efforts. Examples of leadership multipliers include consistency and whether the leader's behavior match their beliefs (Chan et al., 2005). Additionally, Ilies, Morgeson, and Nahrgang (2005) proposed that self-awareness, unbiased process, authentic behavior, and relational authenticity (i.e., developing trust by being open and honest about one's good and bad

qualities) can be used to promote authentic leadership. These are all traits that would be expected of a clinical supervisor in RT.

Authentic behavior from the intern (i.e., follower) involves the intern being honest about their own strengths and limitations, knowing when to ask for help, and accepting that help. If an intern makes a mistake, they need to be comfortable approaching their supervisor and reporting all of the details of the incident (i.e., not excluding things that may be embarrassing to the intern). The intern is also expected to demonstrate authentic behavior when working with other staff and/or interns, as well as having good interpersonal skills when doing so. An additional consideration would be the intern knowing when to seek advice from, or when to plan collaborative sessions with, another staff member for the benefit of client outcomes.

Functional Leadership. While the Authentic Leadership theory describes leadership traits, the Functional Leadership theory addresses the actions of a leader that can lead to high or low-quality relationships. This theory is based on two leader functions, monitoring and taking action (Santos et al., 2015). Essentially, Functional Leadership focuses on the actions taken by leaders (Barnett & McCormick, 2016), as opposed to personality traits or leadership behaviors (i.e., Authentic Leadership), or relationship building (i.e., LMX). This theory has applications to the relationship between RT supervisors and interns because the expectation is that the supervisor demonstrates good observational skills in order to evaluate the performance of the intern. The supervisor must observe for appropriate interactions with the client. Specifically, the supervisor ensures that the intern is conducting assessments appropriately, implementing

high-quality care, and utilizing effective evaluation techniques. The supervisor also monitors the intern for signs of psychological distress or maladaptation as a result of their experiences or interactions. Which includes interactions with their supervisor, with clients, or any other organizational/environmental influence. With monitoring also comes anticipation of needs, and taking action when needed (Santos et al., 2015).

The taking action phase, as it relates to RT internships, would resemble the supervisor providing feedback to the intern regarding their performance in the areas previously listed. It can be argued that during an internship the supervisor will always need to provide feedback (i.e., take action) as this will either reinforce current behavior/performance or correct poor behavior/performance. Taking action could also resemble the supervisor stepping in during an assessment or intervention with a client, or even an interaction with a co-worker, and performing the tasks that are needed at that time.

Functional Leadership theory has a much smaller pool of empirical data than LMX, or even Authentic Leadership, and the majority of it has been applied to group leadership (Barnett & McCormick, 2016; Lord, 1977; Santos et al., 2015). However, some of this research has yielded positive results, and has implications for individual leadership structures (i.e., supervisor and intern). For example, Barnett and McCormick (2016) found that when functional leaders provided clear expectations and feedback, followers experienced individual growth, and had an increased understanding of their role, as well as others' roles, within the team.

Functional behavior from the intern's perspective would be observation of their

clients during treatment sessions and promoting independence in their clients, much like

their supervisor promotes the intern's independence. When working with a client, the

intern may provide verbal instruction, demonstration, and either watch their client

perform the task or assist the client in performing the task. Tasks (as part of an

intervention or program) can be cognitive or physical in nature, which will dictate the

manner in which the intern may have to assist (i.e., verbal cues or physical prompts). By

learning how to be an independent recreational therapist, the intern is simultaneously

learning how to be an effective leader. The intern will likely adopt the habits of their

supervisor, which is why it is important for supervisors to be competent, confident, and

authentic leaders.

A Framework of Leadership and Clinical Supervision

The rationale for applying the aspects of the Authentic and Functional leadership

theories to the Leadership Making process was to enhance the understanding of what

traits and behaviors (i.e., antecedents) lead to the development of high-quality

relationships during the RT internship process. It is common for researchers to couple the

LMX theory with other theories for the purpose of strengthening the theoretical and

conceptual foundations of their research. The proposed framework couples the LMX

theory, specifically the Leadership Making model, with the Authentic and Functional

Leadership theories. Coupling these theories helps to explain the leader/follower traits

(i.e., antecedents) that lead to the development of high-quality relationships (Martin et al.,

2016; Nahrgang & Seo, 2016). More specific to RT, the coupling of these theories assists

in understanding how these traits affect the relationship between supervisors and interns. Essentially, this framework proposes that high-quality relationships develop when the supervisor demonstrates authentic and functional leadership behavior. Specifically, high quality relationships develop when the supervisor provides direction without hovering, intervenes at the appropriate time, and provides feedback to the intern regarding things they are doing well and areas where they can improve. The following sections describe the progression of the supervisor-intern relationship at each phase of the Leadership Making model through the lens of the Authentic and Functional Leadership theories. While the LMX focuses on the role of the leader and the follower, the focus of this model is on the leader's behaviors and actions. Justification for the model is due, in part, to the findings in the meta-analysis by Dulebohn et al. (2012) that the variance in relationship quality was influenced most by leader variables. Applying these theories to the internship process in RT presents the initial stages of a CS model for RT. See Figure 1 for a visual depiction of this model.

The Recreational Therapy Clinical Supervision Model

As described above, Graen and Uhl-Bien (1991, 1995) use the model of Leadership Making to describe the process, or even a continuum, of leadership development between two people within the context of the LMX theory. Their model describes the dyad starting out as strangers, developing into acquaintances, and eventually developing a mature relationship (Graen & Uhl-Bien, 1991).

Stranger Phase

Most supervisor-intern dyads begin their relationship as strangers. What the leader does and says to create a first impression is most important in predicting the future of the dyad's relationship (Nahrgang et al., 2009). The beginning of their relationship is transactional and is considered the 'role-finding' phase (Graen & Uhl-Bien, 1991). Because of the fragility of the relationship at this stage, the supervisor must demonstrate good interpersonal interactions (Nahrgang et al, 2009), self-awareness of how their actions affect intern development and act authentically by ensuring that their words match their behaviors (Ilies et al., 2005). Authentic leadership behavior and self-awareness from the RT supervisor will manifest as honesty about one's strengths and limitations, trustworthiness, providing clear communication, and having realistic expectations of their intern.

This stage of the relationship may consist of the intern completing orientations and responding to directives from their supervisor, with little to no conversation occurring outside of the supervisor providing instructions. The supervisor provides an orientation to make the intern aware of what is expected of them. Including an education on the policies and procedures that apply to their specific job functions, as well as any organizational policies and procedures. The supervisor also educates the intern on RT specific functions, such as client assessment, program planning and implementation, program and client evaluation, and documentation. Education on these tasks comes in the form of written policies, verbal instruction, and observing the supervisor. After orientation and initial education, the intern is then expected to begin demonstrating knowledge of these newly learned tasks.

During the stranger phase, the supervisor's role as a functional leader is to observe the intern completing their tasks, intervene when needed, and provide daily feedback. Feedback is an important piece to the clinical supervisory process, so it is especially important at the stranger stage that the supervisor sets clear expectations and provides feedback based on adherence to those expectations (Barnett & McCormick, 2016). Feedback can be provided during a formal one on one meeting, or informally throughout the day. Immediate feedback allows the intern to reflect on their performance while the interaction is still fresh in their mind. Feedback should be provided where it cannot be overheard by clients and other staff to maintain confidentiality with the intern. Additional CS meetings should occur at least once per week as a formal performance review, to provide mentorship, and/or to address concerns from the intern. The intern should be made aware of the agenda items prior to the meeting and be provided with an opportunity to evaluate their own performance toward competency development.

As a functional leader, it is also important at this stage to monitor the intern for signs of maladaptation and provide psychosocial support as needed, which will aid in the development of trust (Liden et al., 1993). Other antecedent behaviors should also be considered at this time, such as delegation of tasks (Bauer & Green, 1996). The supervisor should be flexible as the intern becomes familiar with the daily processes, and learns the responsibilities associated with their role. At this stage it is also important for the supervisor to trust the intern to perform simple tasks independently. Such tasks could include leading a portion of an intervention or program and/or reporting the progress of a particular client at the next treatment team meeting. Another example would be to task

the intern with writing session notes on clients they observed during a program. As the

intern demonstrates competency, the supervisor gradually provides the intern with more

responsibility. These types of exchanges will lead the dyad into the acquaintance stage.

Acquaintance Phase

At the acquaintance stage, the supervisor-intern dyad enters the 'role-making'

phase. The dyad reaches this stage once both parties have proven themselves to be

knowledgeable and reliable. The dyad's interactions will continue to resemble somewhat

of a transactional type of relationship (Graen & Uhl-Bien, 1991). As the dyad continues

to develop a sense of trust for one another, and they begin to anticipate each other's

needs, it is important for the leader to continue demonstrating good interpersonal

interactions. Which includes having good interpersonal skills with clients, family

members, and staff, as the leader's behavior toward others contributes to a follower's

opinion of their leader (Ilies et al., 2007).

Examples of RT specific tasks by the supervisor during the acquaintance stage

would include the supervisor assisting the intern in developing better assessment skills,

such as paraphrasing client responses, how to probe for more information, and reading a

client's body language or voice inflection to identify possible signs of distress. Another

example is teaching the intern to write progress notes based on subjective and objective

observations of the client, with consideration of each client's individual treatment or care

goals. Depending on the service setting, the supervisor may need to teach the intern safe

handling techniques when transferring clients (e.g., sit to stand, wheelchair to bench)

during physical activity interventions, or behavioral de-escalation techniques.

As the dyad progresses in their working relationship, the authentic leader will maintain consistency in their approach and treatment of others, continue to provide a supportive learning environment, and not engage in gossip. The intern will begin to take notice of how the supervisor interacts with clients and other staff. As an authentic leader, the supervisor's behaviors and interactions with others will be consistent with beliefs that the supervisor has shared with the intern. The supervisor is expected to demonstrate knowledge of the profession and to be honest with their intern about areas in which they have knowledge deficits. In this case, the supervisor should also know where to direct the intern to find the information on their own.

Functional leaders at this stage should observe the intern during client interactions and intervene when needed. Intern observations may include client assessments and individual or group program sessions or other therapeutic programs, reviewing the intern's documentation, and consistently providing direct, honest, and clear feedback to the intern regarding their performance. Feedback should reinforce what the intern is doing well and provide suggestions for improvement. Signs for psychosocial distress or maladjustment should continue to be monitored. If necessary, the supervisor should be prepared to address these concerns or to assist/take over for the intern during an assessment, treatment session/group or program, if the intern needs support or is not performing well. Additionally, an internship supervisor should recognize when it is necessary to make the faculty supervisor aware of their concerns.

Mature Relationship Phase

At the mature relationship stage, the dyad is engaging in 'role-implementation' and their relationship has become more transformational (Graen & Uhl-Bien, 1991). There is a mutual level of trust, respect, and understanding based on previous positive and authentic experiences. This stage of the relationship resembles colleagues who are respectful and trustful of one another. The dyad works together to help clients achieve their goals, as well as the goals of the organization. The intern becomes more independent in their role as they continue to develop competencies. Most job tasks will become easier and almost automatic for the intern. Likewise, the supervisor will have confidence that the intern can perform their job tasks effectively and independently, therefore promoting mutual trust and respect between the two. The supervisor will continue to demonstrate authentic behavior toward the intern, as well as with others.

As a functional leader, the supervisor continues to monitor the intern and provides feedback and assistance as needed. Although, feedback should be minimal at this stage in the internship. The functional leader is also able to anticipate the needs of the intern (Santos et al., 2015), and vice-versa. The intern will take initiative to complete job tasks without being told and is confident enough in their skills to seek guidance from their supervisor when needed. The functional leader/supervisor steps back and allows the intern to work independently, while providing distant supervision, as well as feedback when needed. Support from the supervisor begins to resemble a colleague as the intern begins to perform as an independent and competent recreational therapist. Weekly one to one supervision meetings should continue to take place. However, at this stage, the focus

of these meetings is on continued professional development after the conclusion of the internship.

At this time, the authentic and functional leader serves as a professional mentor who assists in guiding and educating the intern to understand the importance of continuing education, professional involvement, and contributing to the advancement of the profession. Specifically, the importance of becoming an active member and/or leader within local and national professional organizations should be discussed and demonstrated by the supervisor. This last point is particularly important because promoting a positive view of the profession contributes to a positive professional culture (Chan et al., 2005).

Figure 6.1

Recreational Therapy Clinical Supervision Model

Authentic Leader
Self-awareness.
Honesty.
Integrity.
Words match behaviors.
Clearly states
expectations.
Communicates often.
Has realistic
expectations of the
intern.

Authentic Leader
Provides supportive
learning environment.
Acts authentically
toward other staff.
Demonstrates
knowledge and
reliability.
Shares only relevant
information with intern
about staff and clients
they will work with.

Authentic Leader
Maintains authentic
behaviors and supportive
environment. Support
starts to transition from
supervisor to colleague.
Supervisor and intern
demonstrate mutual
trust and respect.

Stranger

(Transactional)

Acquaintance

Maturity

(Transformational)

Functional Leader
Provides orientation to
job, allows intern to
observe supervisor's job
tasks, provides
supervision to intern
during interactions with
clients. Observes for
maladaptation and
psychosocial distress
to intern. Provides 1:1
feedback.

Functional Leader
Observes completion of
newly learned job tasks.
(i.e., assessments and 1:1
and group interventions).
Intervenes only when
necessary.
Reviews documentation.
Provides 1:1 feedback at
least 1x per week based
on observations and
reports from staff and
clients.

Functional Leader
Anticipates the intern's
needs. Provides
opportunities for
independent practice.
Provides feedback based
on intern's verbal
reports, documentation
skills, evaluations from
other staff, and client
outcomes.

Discussion and Recommendations

The proposed model for CS in RT is the first step in designing a model to describe CS in RT. The application of leadership theories within this model was important in understanding the impact of leadership and followership behaviors on the quality of the supervisor-intern relationship. More importantly, this model contributes to understanding the role that leadership plays in competency development during the RT student internship. Based on the most recent findings from the Bright, et al. (2020) study, it is recommended that clinical supervisors in RT complete some type of training prior to supervising their first intern. A training could help them feel more prepared as a supervisor, educate them on how to structure an effective internship. The model presented in this article could be used as a guide for supervisors to provide effective mentorship and develop positive transformational relationships with their intern. However, research is needed to properly test the model and validate its application to relationship and competency development during the RT internship proves.

Several additional recommendations result from the previous research on CS in RT. As presented in Table 6.1, there is consistency among professionals in the field that CS needs more attention, as it is an important and necessary piece of professional preparation. All investigators agreed that additional research is needed to identify the benefits of CS, as well as the current status of CS in the field today. As it relates to internships, more data is needed to understand the prominent leadership and followership behaviors, and how those behaviors impact relationship and competency development. The most recent edition of *Professional Issues in Therapeutic Recreation: On*

Competence and Outcomes (Stumbo et al., 2017) discusses what is termed "fieldwork

education" through a cognitive model called the Integrative Learning Framework (ILF).

However, this chapter seems focuses more on the teaching role of CS, and less on a

counselor or mentor role (i.e., leadership). Both teaching and mentoring student interns

seems important to the clinical supervisory process. The model presented in this study

can be used to supplement the ILF.

Table 6.1

Recommendations for Clinical Supervision in Recreational Therapy

Author(s)/Year	Type of publication	Recommendations
Gruver & Austin (1990)	Research	• Instructional strategies for CS education should include case studies, role playing, and guest speakers. • Model CS practices after the successes of other professions.
Murray & Shank (1994)	Review	• Seek CS guidance from co-workers • Develop a standard of practice for CS
Bedini & Anderson (2003)	Research	• Mentor education should be taught at the bachelor's level • Mentoring programs should be set up by the facility with a focus on cultural diversity and goodness of fit
Austin (2004)	Book Chapter	• CS should be kept separate from administrative supervision • The clinical supervisor should acquire training (from their place of employment, a professional organization, or through continuing education) prior to supervising others

		• CS should be provided to practitioners at all stages of professional development
Jones & Anderson (2004)	Research	• CS should be provided at all stages of professional development • CS in RT should be recognized as a competency • Training on CS should be a part of RT curriculum, job tasks, required by NCTRC for certification, and for educational accreditation
Hutchins (2005)	Research	• Develop and implement internship supervisor standards • Develop an additional training and set of competencies for clinical supervisors
Jones & Harvey (2007)	Review	• RTs should seek training before providing CS • CS standards should be created by ATRA and accrediting bodies
Austin (2013)	Opinion	• Peer to peer CS should be encouraged
Austin, McCormick, & Van Puymbroeck (2016)	Book Chapter	• CS should be separate from management • Clinicians at all levels will benefit from CS. • Novice RTs should always be provided with CS
Bright (2020)	Research	• Internship supervisors should complete a clinical supervision training prior to supervising interns • CS training should incorporate leadership theory • ATRA could provide the training • CARTE could require it and offer CEUs

Note. Studies are listed chronologically. CS = Clinical Supervision, RT = Recreational

Therapy, ATRA = American Therapeutic Recreation Association, CARTE = Committee

on the Accreditation of Recreational Therapy Education.

Conclusion

This article presented a model of CS that can be applied to the supervision that

occurs during the RT internship. More specifically, this model speaks to the importance

of relationship development between supervisor and intern as they progress through the

internship. Recommendations for CS in RT were presented, based on previous research

and available literature in the field. Additional research is needed to validate use of the

proposed model, as well as the recommendations made for CS and RT internships.

Chapter 7

Results

Quantitative Results

Recruitment efforts yielded 48 intern-supervisor dyads (i.e., intern-supervisor pairs). However, only 24 of those dyads completed all three of the online surveys (i.e., Demographic survey, LMX-7, and RT Competency Assessment), resulting in a 50% completion rate. Therefore, the data from only those 24 dyads were used for the quantitative portion of this study. While each of the three online surveys individually yielded high completion rates, it was the need for paired samples that resulted in the 24 usable intern-supervisor dyads. Additional information may be gained from analyzing the LMX-7 and the RT Competency Assessment data individually, which will be addressed in later studies.

Quantitative Data Cleaning

First, the demographic survey was reviewed to check for missing data and to ensure that all completed responses had the accompanying informed consent. A total of 46 individual clinical supervisors and 46 interns completed the demographic survey. The LMX-7 data set was reviewed next, which yielded 39 individual intern responses, 38 individual supervisor responses, and 31 completed pairs. Completed responses from the RT Competency Assessment yielded a total of 34 interns and 35 clinical supervisors.

The overall number of completed pairs for this study were determined by comparing the completed survey responses between the demographic survey, the LMX-7, and the RT Competency Assessment. If a participant response was missing from one

member of the dyad, then the other member's responses were omitted. This yielded a

final count of 24 completed pairs, for a total of 48 study participants. Table 7.1 displays

the individual completion rates for each of the three quantitative measures among interns

and clinical supervisors.

Table 7.1

Survey Completion Rates

Survey	Sent	Completed	Completion Rate
Demographics/Informed Consent			
Intern	48	46	96%
Supervisor	48	46	96%
LMX-7			
Intern	48	38	79%
Supervisor	48	38	79%
Completed Pairs	48	31	65%
RT Competency Assessment			
Intern	48	33	69%
Supervisor	48	37	79%
Completed Pairs	48	26	50%

Missing Data and Outliers

Prior to the analysis of any data, all surveys were checked for missing responses.

It was discovered that one participant, a clinical supervisor, did not complete the

Demographic Survey, which also contained the informed consent. Attempts to make

contact with this individual were unsuccessful, resulting in the elimination of one paired

sample due to the missing demographic data and informed consent. Additionally, upon

careful review of the RT Competency Assessment data, it was discovered that three

modalities were omitted, in error, from the supervisor version of the RT Competency

Assessment (e.g., Athletics/sports, Behavior Management Training, and Reality orientation experiences). In order to make a true, paired comparison of competency assessment scores intern responses for these three modalities were subsequently omitted from the final data set.

There were no missing data imputations in the Demographic survey or the LMX-7. Participants either completed these two surveys in full or did not complete them at all. Within the RT Competency Assessment, participant responses were omitted if they were incomplete or if the assigned participant number was not entered accurately. There were five participants with missing responses in the intern competency assessment, and four missing responses in the clinical supervisor's competency assessment survey. An additional response was deleted from the supervisor's competency assessment, as the incorrect participant number was reported at the beginning of the survey. The response stated "CS-1234" which was the example used in the survey's instructions. Because of this occurrence, it was not possible to match these responses with their subsequent intern, so they were omitted.

Calculations for missing data imputations could not be used for the RT Competency Assessment because all of the incomplete responses consisted of entire sections being left blank. There are eight sections in the RT Competency Assessment, each focusing on a different area of competency, therefore limiting the ability to predict responses across sections. To provide further evidence that it was not appropriate to use calculations for any missing data imputations, the following is a breakdown of how many sections were completed versus incomplete by each of the above-mentioned participants.

Among the clinical supervisors, two opened the survey but provided zero responses, one

completed 2/8 sections, and one completed 3/8 sections. Among the interns, two

completed 1/8 sections, one completed 2/8 sections, one completed 3/8 sections, and one

completed 4/8 sections.

Among the final 24 pairs who completed all three surveys, there were only two

missing data points, which was the grade point average (GPA) for two interns. The data

from these two participants were kept in the final data set because this was an optional

question asked at the end of the Demographic survey and this information was not

deemed critical in answering the research questions.

Clinical Supervisor Demographics

Among the completed pairs, the age of Clinical Supervisors ranged from 24-60

years of age, with a mean of 36 years and a standard deviation of 9.89 years. The number

of years each supervisor had their CTRS credential ranged from 2-36 years, with a mean

of 11.5 years and a standard deviation of 9.46 years. Clinical Supervisors reported being

at their current facility between 2-35 years, with a mean of 7.67 years, and a standard

deviation of 7.73 years. The top three most common populations served were adults,

young adults, and older adults. The top three service settings for clinical supervisors were

Hospitals, Long Term Care, and Behavioral/Mental Health facilities. The most common

age groups that the clinical supervisors worked with were Adults, Older Adults, and then

Young Adults, respectively (see Table 7.2). The most common education level was a

bachelor's degree, and the majority of these respondents had a degree in RT/TR. When

asked whether or not their program was accredited at the time of their graduation 10

responded that their program was CARTE accredited, 10 responded that they did not

know, and three responded that their program was accredited by COAPRT at the time of

their graduation. However, this question did not specify whether the COAPRT

accreditation was the TR option. All supervisor demographics can be found in Table 7.2.

Table 7.2

Clinical Supervisor Demographics

Demographic	Range/Frequency	Mean	Standard Deviation
Age	24-60	36	9.89
Gender			
Female	20 (83.3%)		
Male	4 (16.7%)		
Years as a CTRS	2-36	11.58	9.46
Years at Current Facility	2-35	7.67	7.73
Population Served			
Adults	20 (83.3%)		
Older Adults	13 (54.2%)		
Young Adults	10 (41.7%)		
Adolescents	4 (16.7%)		
Children			
Education Level			
Bachelor's	18 (75%)		
Master's	4 (16.7%)		
Doctorate	2 (8.3%)		
Degrees in Recreational Therapy			
Bachelor of Science	18 (75%)		
Bachelor of Arts	3 (12.5%)		
Bachelor's and Master's	3 (12.5%)		
Doctorate	0 (0%)		
Program Accreditation (from where the supervisor graduated)			
CARTE [a]	10 (41.7%)		
I don't know	10 (41.7%)		

COAPRT [b]	3 (12.5%)
Has CARTE now [c]	1 (4.2%)
Type of Facility	
Hospital	7
Long Term Care	6
Behavioral/Mental Health	6
Community	3
Inpatient Rehabilitation	3
Residential/Transitional	3
Skilled Nursing Facility	3
Adaptive Recreation	2
Parks and Recreation	2
Acute Care	1
Disability Support	1
Private Practice	1
School/Education	1
Outpatient Rehab/Day Treatment	0

[a] CARTE = Commission on the Accreditation of Recreational Therapy Education.

[b] COAPRT = Council on Accreditation of Parks, Recreation, Tourism and Related

Professions. [c] University did not have CARTE at the time of their graduation but they

have it now.

Note. Population Served frequency represents overlapping responses due to Clinical

Supervisors reporting more than one type of population. Type of Facility frequencies

represent overlapping responses due to Clinical Supervisors' reporting multiple facility

types in the demographic survey.

Among the clinical supervisor's there was representation from 17 universities and

colleges across the United States and Canada. This demonstrates a wide variety of

educational backgrounds among the clinical supervisors. A breakdown of each clinical

supervisor's undergraduate university or college is represented in Table 7.3.

Table 7.3

Clinical Supervisor's Undergraduate University

University	Frequency	%
Slippery Rock University	5	20.8
Temple University	2	8.3
University of Wisconsin, La Crosse	2	8.3
York College	2	8.3
Brigham Young University	1	4.2
California State University, Chico	1	4.2
California State University, Long Beach	1	4.2
Dalhousie	1	4.2
East Stroudsburg	1	4.2
Florida International University	1	4.2
Lean University	1	4.2
Northeastern University	1	4.2
San Jose State University	1	4.2
Springfield College	1	4.2
University of Minnesota, Twin Cities	1	4.2
University of New Hampshire	1	4.2
Western Carolina University	1	4.2

Note. Colleges are listed in order of frequency, and then alphabetical order.

Clinical Supervisors were asked if they use the ATRA Standards of Practice

(ATRA-SOP), in which 16 (66%) reported yes and eight (33%) reported that they do not.

Among the 16 clinical supervisors who reported using the ATRA-SOP in practice, 15

(93%) of them utilized the Self-Assessment Guide, six (37%) utilized the Documentation

Audit, three (18%) utilized the Management Audit, and one (.06%) clinical supervisor

used the results of the self-assessment to write policies and procedures for their

department/facility.

Clinical Supervisors were also asked to report whether or not they received any

type of CS education or training, to which 13 reported "yes" (54.2%) and 11 reported

"no" (45.8%). The clinical supervisors who reported "yes" were subsequently asked to

report what type of CS education or training they received. The most common type of CS

education/training was from a session at a conference or workshop. Additional findings

in this area are depicted in Table 7.7.

Intern Demographics

The age of the RT interns included in the study ranged from 21-32 years, with a

mean of 24.13 years and a standard deviation of 2.93 years. There were 21 females

(87.5%) and 3 males (12.5%). Twenty-three (95.8%) of the interns reported their class

standing as Senior, while one (4.2%) reported that they were a graduate student at the

time of their internship. Eleven (45.8%) interns reported that their current program of

study has CARTE Accreditation, with two (8.3%) that were in the process of obtaining

CARTE accreditation at the time of the study. No students reported that their program of

study had COAPRT accreditation, and 11 (45.8%) reported that they did not know

whether their program of study was accredited or not, or by which accrediting body. It

should be noted that in the demographic survey, the question regarding COAPRT

accreditation was not specific to the TR option. Demographic information for the 24

interns in the study can be found in Table 7.4.

Table 7.4

Intern Demographics

Demographic	Range/Frequency	Mean	Standard Deviation
Age	21-32	24	2.93
Gender			
Female	21 (87.5%)		
Male	3 (12.5%)		
Class standing at time of internship			
Senior	23 (95.8%)		

Graduate Student	1 (4.2%)
Doctoral Student	0 (0%)
University Accreditation Status	
CARTE [a]	11 (45.8%)
COAPRT [b]	0 (0%)
CARTE in progress [c]	2 (8.3%)
I don't know	11 (45.8%)

[a] CARTE (Commission on the Accreditation of Recreational Therapy Education).

[b] COAPRT (Council on Accreditation of Parks, Recreation, Tourism and Related Professions). [c] University is not currently accredited, but is currently in the process of getting CARTE accreditation.

As depicted in Table 7.5, there was representation from 15 colleges and universities across the United States. The most common educational institution among interns was Slippery Rock University, followed by San Jose State University, Temple University, University of New Hampshire, University of Utah, and Winona State University, in equal proportion.

Table 7.5

Intern's University

University	Frequency	%
Slippery Rock University	5	20.8
San Jose State University	2	8.3
Temple University	2	8.3
University of New Hampshire	2	8.3
University of Utah	2	8.3
Winona University	2	8.3
Arizona State University	1	4.2
Brigham Young University	1	4.2
Central Michigan University	1	4.2
Florida International University	1	4.2
Georgia Southern University	1	4.2
Ithaca College	1	4.2

Southern Connecticut State University	1	4.2
State University College of Cortland	1	4.2
University of Wisconsin, La Crosse	1	4.2

Note. Colleges are listed in order of frequency and then alphabetically.

Interns were asked to report what type of course content they received prior to the start of their internship. Table 7.6 depicts the frequency and percent of each course content area. All 24 interns had received education on Foundations of Professional Practice, Individualized Patient/Client Assessment, Implementing Treatment/Programs, and Modalities and Facilitation Techniques. Planning Treatment/Programs was reported by 23 interns, Evaluating Treatment/Programs was reported by 22 interns, and Managing Recreational Therapy Practice was reported by 21 of the interns.

Table 7.6

Intern Education: RT Course Content Areas

Content Area	Frequency	%
Foundations of Professional Practice	24	100
Individualized Patient/Client Assessment	24	100
Implementing Treatment/Programs	24	100
Modalities and Facilitation Techniques	24	100
Planning Treatment/Programs	23	95.8
Evaluating Treatment/Programs	22	91.6
Managing Recreational Therapy Practice	21	87.5

Note. This table depicts intern reported education content that they received prior to starting their 560-hour internship.

Interns were also asked to report whether or not they received any type of CS education or training prior to starting their internship, to which seven reported "yes" (29.2%) and 17 reported "no" (70.8%). Among the seven interns who reported "yes", there were only three forms of education/training reported. These include having one or more lectures as part of a class in an undergraduate program, one or more classes as part

of an undergraduate program, and one session at a conference or workshop. These

findings are depicted in Table 7.7.

Table 7.7

Clinical Supervision Education

Received CS [a] Education	Intern	Supervisor
Yes	7 (29.2%)	13 (54.1%)
No	17 (70.8%)	11 (45.8%)

Type of CS Education	Intern	Supervisor
One or more undergraduate lectures	5	3
One or more undergraduate classes	4	1
One or more graduate lectures	n/a	1
One or more graduate classes	n/a	0
Conference session or workshop	2	8
Attended a half day training	n/a	2
Attended a full day training	n/a	2

Note. These numbers represent overlapping responses due to interns reporting more than

one mode of education or training in clinical supervision.

[a] CS (clinical supervision)

More supervisors (n=13) than interns (n=7) reported that they had received some

type of education on CS. The most common type of CS education reported among

supervisors was from one or more conference sessions or workshops. The most common

form of CS education among interns was a lecture or a course as part of their

undergraduate program. It should also be noted that no interns reported receiving a class

or lecture as part of a graduate program.

Quantitative Results

This study began with three research questions. The first two research questions

addressed the quantitative portion of the study and are listed below, while the third

question addressed the qualitative portion. The following section describes the

quantitative findings related to research questions one and two.

>   RQ1: What is the association between relationship quality and interns perceived
>
>   competency development?
>
>   RQ2: What is the relationship between interns perceived competency
>
>   development and the supervisors perceived competency level?

Relationship Quality Scores

Quality of the intern and supervisor relationship was measured by the LMX-7.

The LMX-7 means, ranges, and standard deviations are reported in Table 7.8. LMX-7

scores for the interns had a range of 23-35 with a mean of 31.75 and a standard deviation

of 3.48. The supervisor scores ranged from 10-35 with a mean of 29.13 and a standard

deviation of 6.17. The LMX agreement (i.e., the difference between intern and supervisor

LMX-7 responses) ranged from 0-25, with a mean difference of 4.71 and a standard

deviation of 5.46. Among the 24 completed pairs, two intern-supervisor pairs rated each

other exactly the same on the LMX-7. In 15 of the 24 pairs, the intern rated their

supervisor higher than the supervisor rated the intern. In seven of the pairs, the intern

rated their supervisor lower than the supervisor rated the intern.

Overall, the intern's average LMX-7 score, based on their perceived relationship

quality with their supervisor, fell into the *Very High* category (George Graen & Uhl-Bien,

1995). The supervisor's average LMX-7 score, based on the supervisor's perceived

relationship quality with their intern, fell into the *High* category of relationship quality.

The averages for both the intern and supervisor LMX-7 scores, as well as the low

incidence of disagreement on LMX-7 scores, indicates a positive relationship, on

average, between interns and clinical supervisors.

Table 7.8

LMX-7 Scores

Response Type	Range	Mean	Standard Deviation
Intern	23-35	31.75	3.48
Supervisor	10-35	29.13	6.17
LMX Agreement	0-25	4.71	5.46

Note. 7-14 (Very Low), 15-19 (Low); 20-24 (Average), 25-29 (High), and 30-35 (Very

High).

Competency Assessment Scores

Data from the RT Competency Assessment yielded an intern pre and post

competency score, as well as a supervisor competency score. The intern pre and post

competency scores were used to calculate the percentage of competency change from the

beginning of the internship to the end. Table 7.9 displays the overall competency

assessment scores of both interns and clinical supervisors, as well as the change scores

and the individual scores for each section of the RT Competency Assessment.

Clinical Supervisors. Mean scores were used to calculate the overall percentage

of clinical supervisor perceived competency, which was 67%. Competency percentages

were also calculated for each subsection of the RT Competency Assessment. Based on

those calculations, the competencies among clinical supervisors ranking from highest to

lowest were Foundations of Professional Practice (77%), Implementing

Treatment/Programs (76%), Planning Treatment/Programs (72%), Managing

Recreational Therapy Practice (70%), Individualized Patient/Client Assessment (68%),

Evaluating Treatment/Programs (66%), Modalities (64%), and Facilitation

Techniques/Theories (57%).

Interns. Mean scores were also used to calculate the pre, post, and change

percentages for RT interns perceived competency in RT, which are listed in Table 7.9.

On average, interns increased their overall perceived competency from 56% to 69%.

Additionally, interns demonstrated increased competency in all eight subsections of the

RT Competency assessment. Those individual competencies are ranked from highest to

lowest based on percentage of change; Implementing Treatment/Programs (32%),

Managing Recreational Therapy Practice (29%), Patient/Client Assessment (29%),

Planning Treatment/Programs (28%), Evaluating Treatment/Programs (26%),

Foundations of Professional Practice (25%), Modalities (15%), Facilitation

Techniques/Theories (7%). As noted in Table 7.9, Modalities and Facilitation

Techniques/Theories are the two competency areas in which some interns reported a

decrease in their scores from the beginning to the end of the internship. These are also the

two subsections with the lowest percent change. The top three competency areas in which

interns reported the most improvement was Implementing Treatment Programs,

Managing Recreational Therapy Practice, and Individualized Patient/Client Assessment.

Table 7.9

RT Competency Assessment Scores

Response Type	Range	Mean	Standard Deviation	%
Pre-Intern Competency	**354-840**	**545.08**	**116.63**	**56.19**

Foundations	56-125	92.50	15.94	63.79
Assessment	30-102	65.17	15.02	56.66
Planning	30-90	59.21	13.69	59.21
Implementation	43-105	68.67	14.35	59.71
Modalities	58-177	106.71	29.43	53.35
Theories	33-114	65.13	20.09	48.24
Evaluation	20-46	30.71	6.83	55.83
Managing RT Practice	28-92	57.00	13.10	54.28
Post-Intern Competency	**498-951**	**673.00**	**98.31**	**69.00**
Foundations	100-145	116.00	10.89	80.00
Assessment	63-114	84.17	12.70	73.19
Planning	50-100	76.12	11.19	76.12
Implementation	68-115	91.12	10.55	79.24
Modalities	88-197	123.00	26.01	61.50
Theories	35-122	69.79	22.61	51.69
Evaluation	24-55	38.96	7.10	70.83
Managing RT Practice	52-104	73.75	11.83	70.23
Intern Competency Change	**22-233**	**127.91**	**55.49**	**23.46**
Foundations	5-67	23.58	12.33	25.49
Assessment	6-49	19.00	10.09	29.15
Planning	1-44	16.91	8.95	28.55
Implementation	7-45	22.45	8.99	32.70
Modalities	-26-43	16.29	18.72	15.26
Theories	-13-21	4.66	9.44	7.15
Evaluation	1-18	8.25	4.35	26.86
Managing RT Practice	5-32	16.75	6.91	29.38
Supervisor Competency Assessment Total	**352-833**	**666.12**	**113.97**	**67.00**
Foundations	63-142	112.33	18.00	77.46
Assessment	52-95	78.58	13.50	68.33
Planning	43-96	72.33	12.97	72.33
Implementation	48-111	87.54	14.33	76.12
Modalities	65-177	128.50	26.13	64.25
Theories	30-135	76.71	24.04	57
Evaluation	18-50	36.38	7.52	66
Managing RT Practice	33-90	73.75	12.98	70

Note. The following abbreviations are used in this table in order to save space within the

table; Foundations = Foundations of Professional Practice, Assessment = Individualized

Patient/Client Assessment, Planning = Planning Treatment/Programs, Implementation =

Implementing Treatment/Programs, Modalities = Modalities, Fac Tech/Theories =

Facilitation Techniques/Theories, Evaluation = Evaluating Treatment/Programs,

Managing RT Practice = Managing Recreational Therapy Practice.

Note. Intern Competency Change was calculated using the intern RT Competency

Assessment pre and post scores.

Tests for Normal Distribution

Prior to data analysis IBM SPSS Statistics (Version 26), a test for normal

distribution was completed for the dependent variable intern competency assessment

change scores, and the independent variables LMX-7 difference and supervisor

competency assessment scores. The intern competency change score had a Shapiro-Wilk

significance score of ($p=.574$), while the clinical supervisor competency assessment total

had a Shapiro-Wilk score of ($p=.231$) indicating that the data within these two variables

is normally distributed, as evidenced by the absence of significance. The LMX difference

score had a Shapiro-Wilk significance score of ($p=.000$), indicating that it is not normally

distributed, and the histogram was positively skewed (see Figure 7.1). However, during

the data analysis phase, it was discovered that the use of difference scores (i.e., LMX

agreement) between intern and supervisor LMX-7 scores is not an accurate measure

(Edwards, 1995, M. Uhl-Bien, personal communication, August 4, 2019) and the

individual LMX-7 scores should be used in statistical analysis. Therefore, the intern

LMX-7 scores (i.e., the intern's rating of their supervisor's leadership) and the supervisor

LMX-7 scores (i.e., the supervisor's followership rating of their intern) were both treated

as independent variables. Both yielded a significant Shapiro Wilk score (intern LMX-7

p=.002, supervisor LMX-7 p=.001), indicating that both are not normally distributed.

Both were negatively skewed (see Figures 7.2 and 7.3). Based on this information, non-parametric testing was used in place of tests that require the data to be normally distributed (i.e., Spearman's correlation instead of Pearson's correlation). Regression models were used because normal distribution of independent variables is not one of the required assumptions for regression models (Tabachnick & Fidell, 2013).

Additional normality tests were conducted for intern pre and post competency assessment totals, with the intention of using these two scores in an independent samples t-test. The intern pre and post competency assessment scores both yielded non-significant Shapiro-Wilk scores (p=.80 and p=.076, respectively), indicating that the data is normally distributed. Additionally, this researcher also intended to use a paired samples t-test to compare the individual competency change scores among the eight subsections of the RT Competency Assessment. Normality tests were also completed for each of the subsection variables. Results indicated that among the pre-competency assessment scores, all eight sections were normally distributed. Among the post-competency scores, six out of the eight subsections were normally distributed. Intern post-Foundations and intern post-Assessment had significant Shapiro Wilk scores of p=.009 and p=.038, respectively. Upon visually examining the histogram for intern post-Foundations scores, the data appeared to have only a slight positive skew (see Figure 7.4). Subsequently this variable was considered to have normal distribution. Upon visual examination of the histogram for intern pre-Assessment scores, the positive skew was more pronounced (see Figure 7.5). Thus, the intern post-Assessment variable is considered to be non-normally

distributed. See Table 7.10 for a listing for the Shapiro Wilk scores for each section of the

intern pre and pos-competency. Additionally, the histograms for the non-normally

distributed variables, as identified in their Shapiro Wilk significance score, are displayed

in Figures 7.1-7.5.

Table 7.10

Shapiro Wilk Scores for Independent and Dependent Variables

Variable	Statistic	df	Sig
Intern LMX-7	.834	22	**.002***
Supervisor LMX-7	.831	22	**.002***
LMX-7 Agreement	.731	22	**.000***
Supervisor Competency Total	.938	22	.182
Intern GPA	.932	22	.135
Intern CA Change	.965	22	.597
Pre-Intern Competency Total	.931	22	.131
Foundations	.973	22	.774
Assessment	.949	22	.305
Planning	.960	22	.495
Implementation	.920	22	.076
Modalities	.927	22	.108
Theories	.944	22	.236
Evaluation	.959	22	.469
Managing RT Practice	.978	22	.891
Post Intern Competency Total	.936	22	.164
Foundations	.874	22	**.009***
Assessment	.905	22	**.038***
Planning	.940	22	.201
Implementation	.938	22	.180
Modalities	.930	22	.124
Theories	.968	22	.670
Evaluation	.956	22	.407
Managing RT Practice	.965	22	.588

Note. IV = Independent Variable; DV = Dependent Variable, **$p \leq .01$; *$p \leq .05$, the

following abbreviations are used in this table in order to save space within the table;

Foundations = Foundations of Professional Practice, Assessment = Individualized

Patient/Client Assessment, Planning = Planning Treatment/Programs, Implementation =

Implementing Treatment/Programs, Modalities = Modalities, Fac Tech/Theories =

Facilitation Techniques/Theories, Evaluation = Evaluating Treatment/Programs,

Managing RT Practice = Managing Recreational Therapy Practice.

Figure 7.1

LMX-7 Difference Score
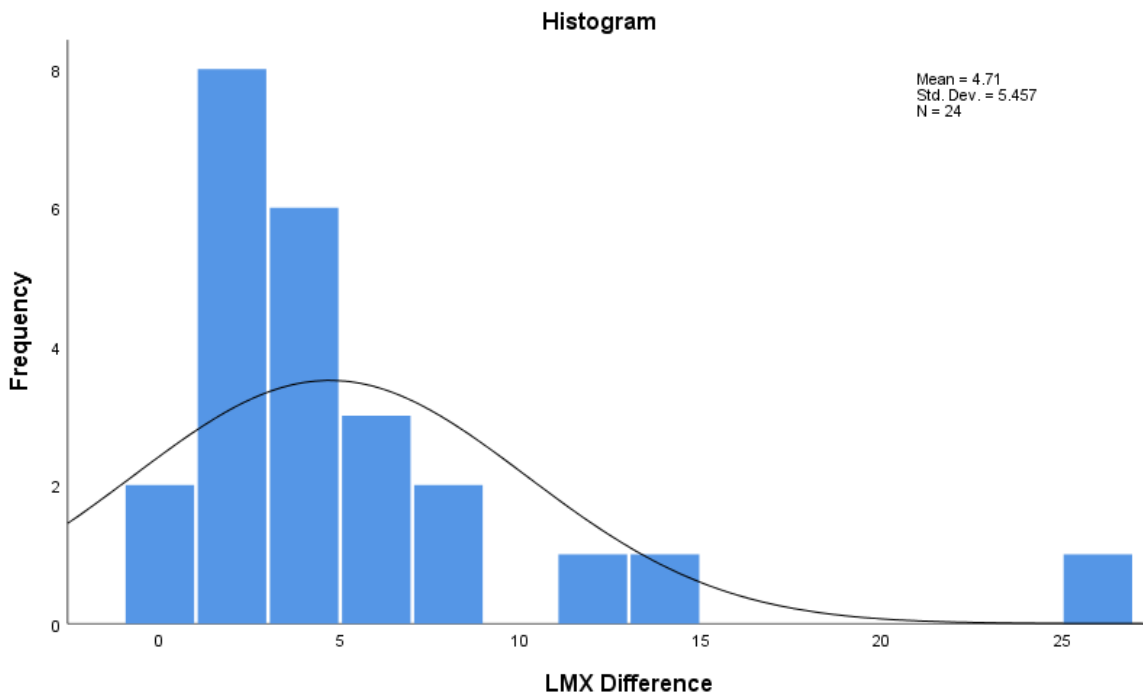
Figure 7.2

Intern LMX-7 Scores
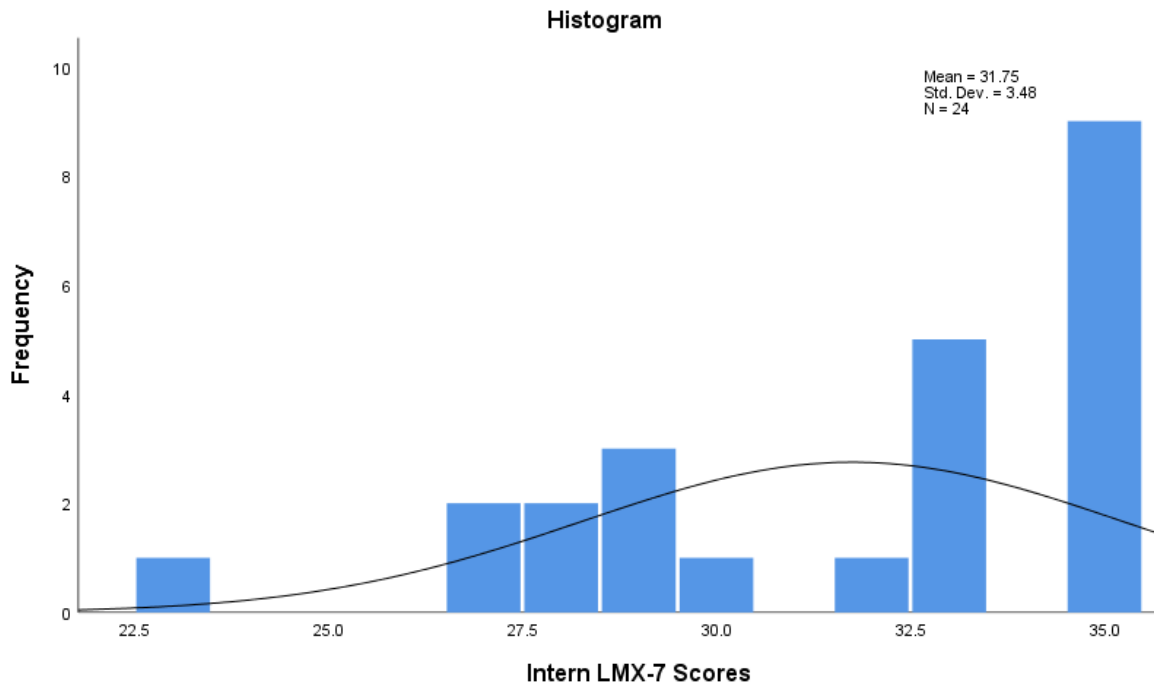
Figure 7.3

Clinical Supervisor LMX-7 Scores
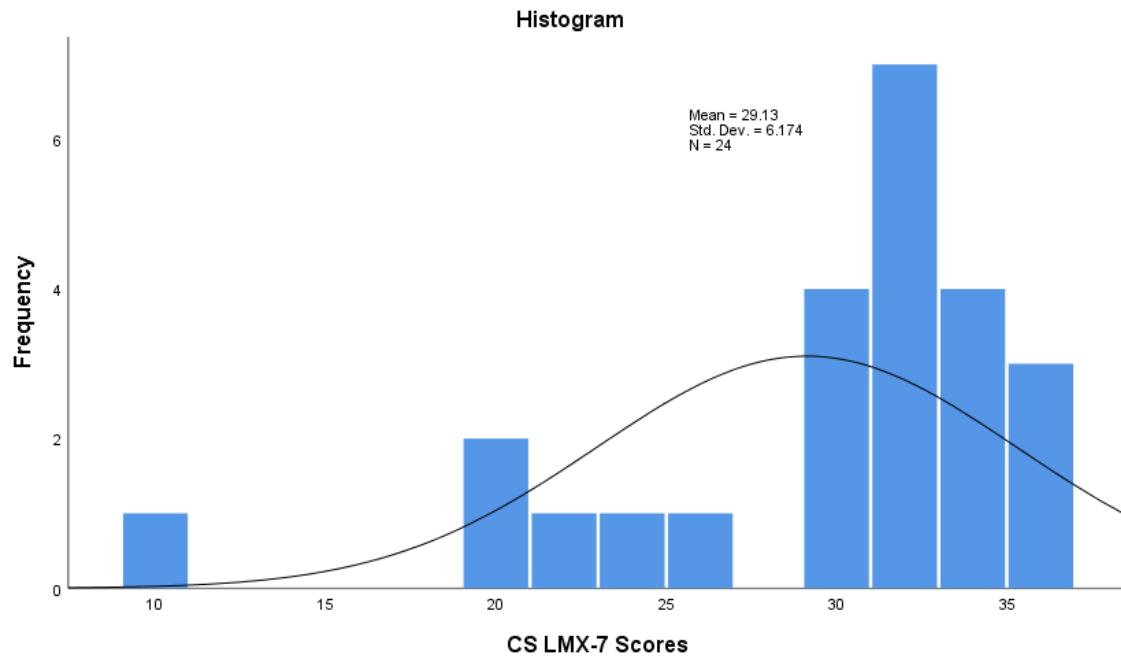
Figure 7.4

Intern Post-Foundations of RT Competency Assessment
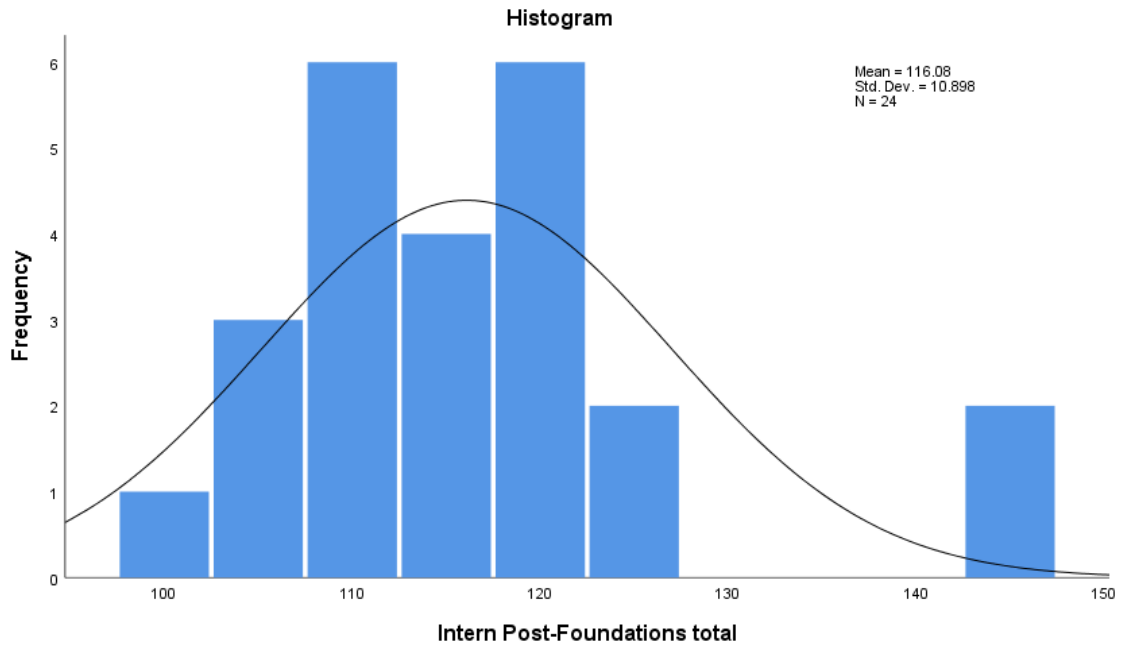
Figure 7.5

Intern Post-Assessment of RT Competency Assessment
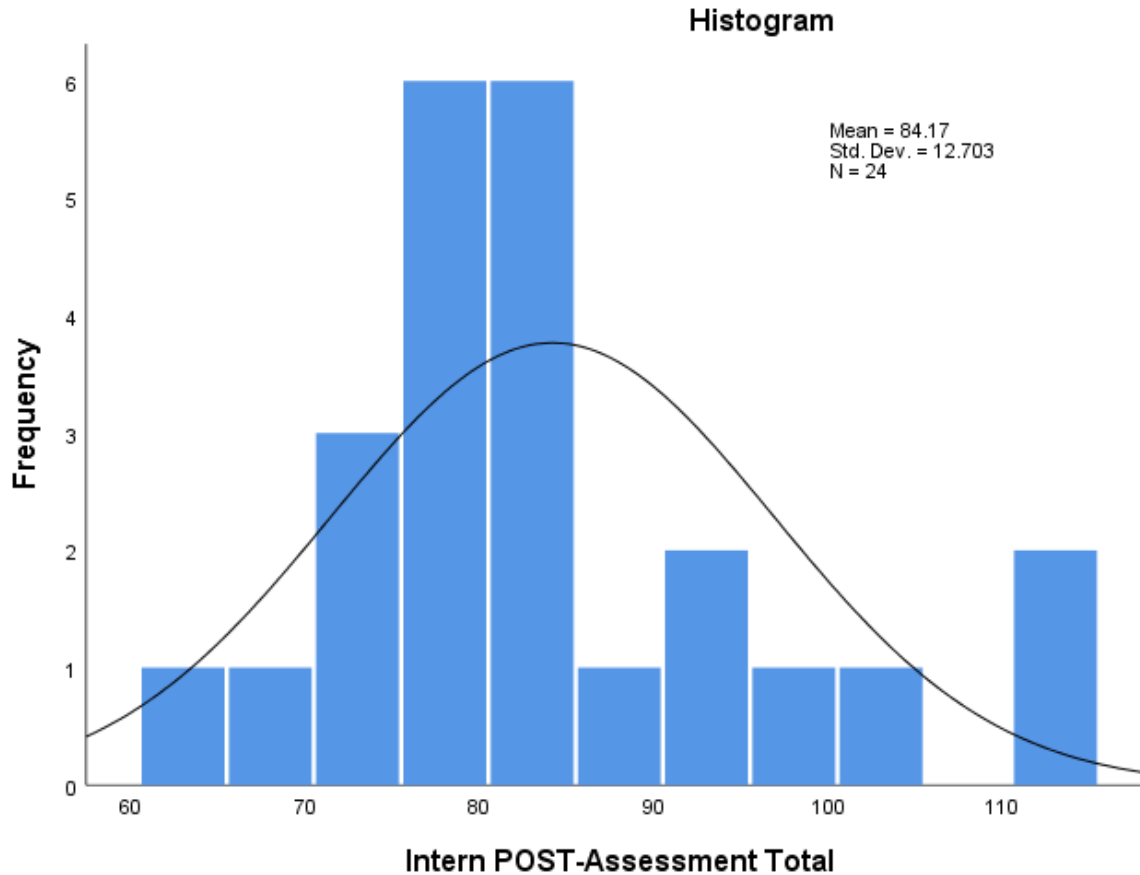
Spearman's Correlation

Due to some of the main variables in this study being non-normally distributed (e.g., LMX-7 scores), Spearman's correlation was used to evaluate the strength of the relationship between the independent and dependent variables. Related to research question one, the variable that showed significant correlation with intern post-competency scores was the intern LMX-7 score ($r = .539$, p $= .007$). This correlation indicates that there is a relationship between the intern's perceived competency at the end of their internship and how they felt about their supervisor's leadership, and how those

feelings affected the quality of their relationship. There was no correlation between intern

competency change and any of the LMX-7 scores (intern LMX-7 $r = -.184$, p = .389,

supervisor LMX-7 $r = -.165$, p = .441), and the LMX difference ($r = -.047$, p = .829).

Related to research question two, intern post competency scores showed significant

correlation with pre-competency score ($r = .819$, p =.000). Additionally, there was a

negative correlation between intern competency change score and intern pre-competency

score ($r = -.585$, p = .003). This negative correlation indicates that interns with a lower

perceived competency at the beginning of the internship showed the greatest

improvement in their perceived competency at the end of their internship. Table 7.11

highlights the relevant correlations discussed in this section.

Table 7.11

Spearman's Correlation Results

Variable	Intern CA Change	Intern Post-CA	Intern LMX-7
CS-Competency	-.190	.163	.249
Intern LMX-7	-.184	.539**	
Intern GPA	-.045	.066	
Intern Pre-Competency	-.585**	.819**	.596**
Intern Competency Change		-.112	-.184
Foundations	.786**	-.104	-.009
Assessment	.814**	-.072	.074
Planning	.820**	-.128	-.020
Implementation	.724**	-.258	-.206
Modalities	.658**	.021	-.381
Fac. Tech/Theories	.443*	.322	-.149
Evaluation	.728**	.084	.210
MGT of RT	.749**	-.095	-.119
Intern Post- Competency	-.112		.539**
Foundations	-.032	.675**	.550**
Assessment	-.045	.799**	.741**
Planning	-.210	.648**	.385
Implementation	-.285	.698**	.399

Modalities	-.015	**.875****	.351
Fac. Tech/Theories	-.071	**.819****	**.441***
Evaluation	.058	**.737****	**.685****
MGT of RT	-.045	**.838****	**.583****

As reported in Table 7.12, there is a strong negative correlation between LMX difference and supervisor LMX-7 scores ($r = -.648$, p=.001). This indicates that as the supervisor's LMX-7 score (i.e., supervisor's perception of the quality of their relationship with their intern) decreased, the difference in LMX-7 scores between supervisors and interns increased. Essentially, supervisors tended to rate their relationship with their intern lower than interns rated their relationship with their supervisor. There was also a strong positive correlation between intern pre and post-competency scores ($r = .819$, p=.000), indicating that interns with higher perceived competency at the beginning of their internship also ranked themselves highly at the end of their internship. Both the intern pre and post competency scores had moderate positive correlations with intern LMX-7 scores (pre $r = .596$, p=.002; post $r = .539$, p=.007). One indication is that as the intern's LMX-7 rating of their relationship with their supervisor increased so did their post competency score (i.e., perceived competency level at the end of the internship). There was no correlation indicated between clinical supervisor competency scores and intern pre and post competency scores (pre $r = .226$, p= .289; post $r = .163$, p=.446), nor with the intern competency change score ($r = -.190$, p=.374).

Table 7.12

Correlations Between LMX and Total Competency Assessment Scores

	S	I	D	CS CA	PRE	POST
Supervisor LMX-7 (S)						
Intern LMX-7 (I)	.217					

LMX difference (D)	**-.648****	-.137				
CS [a] CA [b]	**.417***	.249	**-.463***			
Intern PRE CA	.214	**.596****	-.085	.226		
Intern POST CA	.159	**.539****	-.223	.163	**.819****	
Intern CA Change	-.165	-.184	-.047	-.190	**-.585****	-.112

Note: **p ≤ .01; *p≤.05, [a] Clinical Supervisor, [b] Competency Assessment.

Standard Multiple Regression

Three standard multiple regression models were used to predict the effects on intern competency development. Due to the small sample size, this study used a 90% confidence interval to interpret significance for each of the models discussed below. Three out of the five independent variables used in model one did not yield a strong or statistically significant correlation coefficient. These included clinical supervisor competency assessment scores, supervisor LMX-7 ratings (of the quality of the relationship with their intern), and intern GPA. These independent variables were used in the first model despite an insignificant correlation in order to fully test the hypotheses and research question of this study.

*M***odel One**

To answer research questions one and two, the first regression model included intern competency change score as the dependent variable and five independent variables, including intern pre-competency total, clinical supervisor competency total, clinical supervisor LMX-7, intern LMX-7, and intern GPA. This model was used to test which of these variables had the greatest effect on intern perceived competency development. Results indicated that these five variables accounted for approximately 45% of the

variance seen in the intern competency change scores (R^2=.457, $F(5,16)$ = 2.68, p=.060), which indicates that the model is significant when using a 90% confidence interval.

Among the independent variables, the intern pre-competency score (β = -.797, p=.003) and the intern LMX-7 (β = .472, p=.062) yielded significant results. Intern GPA (β = -.181, p=.393), clinical supervisor LMX-7 (β = -.067, p=.753), and clinical supervisor competency (β = -.154, p=.490) did not yield significant results. This suggests that intern's perceived competency at the beginning of the internship and intern's perceived relationship quality with their supervisor has a greater effect on their competency development. This also suggests that intern GPA, clinical supervisor's LMX-7 rating of their student, and the clinical supervisors perceived competency in RT have little to no effect on intern's perceived competency development (see Table 7.13 for a list of these results).

Intern pre-competency was the largest predictor of perceived change in intern competency (β = -.797, p=.003). Specifically, interns who rated themselves lower in the pre-competency score were more likely to have a higher competency change score. The second largest predictor of competency change was the intern LMX-7 rating (β = .472, p=.062). Overall, these results suggest that interns who had a lower perceived competency rating at the beginning of their internship increased their perceived competency the most over the course of the internship. Interns with lower pre-competency scores had more room for growth over the course of the internship. This result also suggests that the interns who perceived a higher quality relationship with their clinical supervisor reported higher perceived change in competency. Essentially, this

finding suggest that intern's competency increased when interns felt they had a better relationship with their supervisor.

Model Two

Based on the results of the first model, a second standard multiple regression model was tested using only the two independent variables that were significant (i.e., Intern pre-competency and Intern LMX-7). The purpose of running this second model was to yield the most parsimonious effects. This second model used the intern competency change score as the dependent variable and intern pre-competency and intern LMX-7 as the two independent variables. Results of this model indicate that the two independent variables account for approximately 38% of the variance seen in intern competency change (R^2=.338, F(2,21)= 6.664, p=006). Additionally, intern pre-competency remained a significant factor in predicting intern competency change (β = -.738, p=.002), as well as intern LMX-7 (β = -.364, p=.086). The size and direction of the relationships between these two independent variables supports the findings of the first model. While both variables were significant at the .10 level, intern pre-competency was still the strongest predictor of intern competency change. See Table 7.13 for a list of these results.

Model Three

Since the intern pre-competency score yielded the highest significance score in the first two models (p=.004 and p=.002), a third standard multiple regression model was tested using intern competency change as the dependent variable and the individual eight subsections of the intern's pre-competency score as the independent variables.

Specifically, the pre scores for Foundations of Professional Practice, Patient/Client

Assessment, Planning Treatment/Programs, Implementing Treatment/Programs,

Modalities, Facilitation Techniques/Theories, Evaluating Treatment/Programs, and

Managing Recreational Therapy Practice were inserted into the model as independent

variables. Results of the regression model indicated that each of the eight sections of the

competency measure accounted for approximately 65% of the variance seen in intern

perceived competency change (R^2= .654, F(8,15)= 3.551, p=.017). Indicating that the

model is significant at the .05 level. Three of the independent variables (i.e., subsections

of the RT competency assessment) were significant predictors of overall competency

change at the .05 level. These predictors include intern pre-Patient/Client Assessment (β=

-1.328, p= .027), intern pre-Modalities (β= -.837, p= .043), and intern pre-Theories (β=

1.237, p= .014). A list of all results can be found in Table 7.13. The size and direction of

the relationships indicate that higher scores for the intern's pre-Facilitation

Techniques/Theories at the beginning of the internship, the higher the change in intern

perceived competency. Additionally, the lower an intern rated their pre-Modality and pre-

Patient/Client Assessment scores, the higher they rated their perceived change in

competency.

Table 7.13

Regression Models with Intern Competency Change as Dependent Variable

	R Square	F	Sig.	β	Part [d]	Sig.
Model 1	.457	2.688	.060			
Intern GPA [a]				-.181	-.214	.393
Intern LMX-7				.472	.448	.062
CS [b]-LMX-7				-.067	-.080	.753
CS-CA				-.154	-.214	.490

Pre-Intern CA [c]				-.379	-.617	.004**
Model 2	.388	6.664	.006**			
Pre-Intern CA				-.738	-.623	.002**
Intern LMX-7				.364	.366	.086
Model 3	.654	3.551	.017*			
Pre-Foundations				-.054	-.037	.887
Pre-Assessment				-1.328	-.534	.027*
Pre-Planning				-.424	-.204	.433
Pre-Implementation				.072	.041	.874
Pre-Modalities				-.837	-.496	.043*
Pre-Facilitation Techniques/Theories				1.237	.581	.014*
Pre-Evaluation				.412	.309	.227
Pre-Managing RT Practice				.379	.274	.287

Note: **$p \leq .01$; *$p \leq .05$, [a] Grade Point Average, [b] Clinical Supervisor, [c] Competency

Assessment. [d] Part and partial correlations

Note. The following abbreviations are used in this table in order to save space within the

table; Foundations = Foundations of Professional Practice, Assessment = Individualized

Patient/Client Assessment, Planning = Planning Treatment/Programs, Implementation =

Implementing Treatment/Programs, Modalities = Modalities, Fac Tech/Theories =

Facilitation Techniques/Theories, Evaluation = Evaluating Treatment/Programs,

Managing RT Practice = Managing Recreational Therapy Practice.

Paired Samples T-Test

A paired samples *t*-test was used to compare the means of the intern pre and post

competency scores, as well as to compare the means for the eight subsections of the RT

competency assessment survey. This resulted in a total of nine t-tests. Table 7.14 displays

the pre and post means of each of these tests, the percentage of change between those two

mean scores, and the significance level for each. Results of the paired samples t-test

indicate that there is a significant difference between the mean scores of the intern pre

and post competency assessment (p=.000). There is also a significant difference between

the pre and post mean scores in each of the eight subsections (p=.000), with exception for

intern pre and post Modalities (p=.024) (see Table 7.14 for results).

Table 7.14

Intern Pre-Post RT Competency Assessment Scores

Competency Subsection	Pre	Post	% Change	Standard Deviation	t	df	Sig.
Foundations	92.50	116.08	25.49	12.33	9.36	23	.000
Assessment	65.17	84.17	29.15	10.09	9.22	23	.000
Planning	59.21	76.13	28.55	8.95	9.25	23	.000
Implementation	68.67	91.13	32.70	8.99	12.23	23	.000
Modalities	106.71	123.00	15.26	18.71	4.26	23	.000
Facilitation Techniques/Theories	65.13	69.79	7.15	9.44	2.42	23	.024
Evaluation	30.71	38.96	26.86	4.35	9.27	23	.000
Managing RT Practice	57.00	73.75	29.38	6.91	11.87	23	.000
Competency Total	545.08	673.00	23.46	55.49	11.29	23	.000

Note. The following abbreviations are used in this table in order to save space within the

table; Foundations = Foundations of Professional Practice, Assessment = Individualized

Patient/Client Assessment, Planning = Planning Treatment/Programs, Implementation =

Implementing Treatment/Programs, Modalities = Modalities, Fac Tech/Theories =

Facilitation Techniques/Theories, Evaluation = Evaluating Treatment/Programs,

Managing RT Practice = Managing Recreational Therapy Practice.

Qualitative Results

Qualitative recruitment efforts yielded a total of 20 follow up interviews, with 10

interns and 10 clinical supervisors. Among the supervisors and interns who completed

interviews three of them were completed pairs, meaning that both the intern and the

supervisor from the same site participated in the follow up interview. Each interview

lasted approximately 30 minutes to one hour and 17 minutes. All participants were asked

the same core set of guided interview questions. The interview was semi-structured,

based on the interview guide found in Appendix D. While both interns and supervisors

were interviewed in the qualitative portion of this study, only the intern qualitative data

was needed to answer the qualitative research questions. The range of LMX-7 scores for

the 10 interns was 27-35, which ranges from *Average* to *Very High* on the LMX-7 scale.

The research question driving the qualitative research methods and results of this

dissertation was *what is the experience of recreational therapy intern's competency*

development as related to the intern's perception of their supervisor's leadership

behaviors and competency in recreational therapy? Five themes emerged as a result of

the qualitative coding process. The five themes included *open, honest, and authentic*

communication; scaffolded learning; modeling skills and recognizing deficits;

professional mentoring; and personality traits and leadership. While direct quotes from

research participants are included to support the definition of each theme, the

demographic details of each participant (e.g., age, population, setting,) are not included in

these results to ensure complete anonymity of the research participants (Morse, 2008).

While the design of the study required participants to be paired (i.e., intern and their

clinical supervisor), their individual quantitative scores and qualitative reports remained

confidential. There was concern that the clinical supervisors could identify the

information provided from their intern, and vice versa. The exclusion of any identifiers

related to the qualitative participant data was the only way to ensure confidentiality.

However, demographic information for all study participants can be found within the

quantitative results. The following sections will provide descriptions of the themes with

direct quotes from participants to further contextualize and provide evidence of their

experiences. To further protect the original of each quote all gender-identifying pronouns

were changed to [CS], when referring to the clinical supervisor.

Open, Honest, and Authentic Communication

Each intern reported that their [CS] provided them with feedback that helped to

improve their skills and develop competency. Interns related that this feedback was open

and honest, and authentic. For some interns, communication was direct and immediate

(i.e., when working with the client or directly afterwards) and for others, it occurred

during a daily check-in or a weekly meeting. Regardless of when it occurred, the purpose

of providing feedback was so the intern could improve their skills, as well as reinforce

and/or highlight the areas in which the intern performed well.

Direct and immediate feedback occurred either when working directly with clients

or directly after a professional task, such as an intervention or an assessment. Some

supervisors were more diligent and intentional about providing feedback than others. The

style of their feedback also varied. However, receiving authentic and honest feedback

was a theme among all interns as something that was impactful to their competency

development. One intern stated, "Without [CS] being honest, I don't think I would have

learned half the things that I learned." Furthermore, all interns reported that they

welcomed this feedback. Some actually seemed to thrive on it. Interns also felt that this

open style of communication allowed them to feel more comfortable when asking

questions of their clinical supervisor. The following quote highlights, specifically, the value that one intern placed on receiving authentic and honest feedback.

> Being honest with us. I mean, completely open and honest with us, you know. And [CS] didn't baby us or beat around the corner. When we did something wrong or if we didn't do something so well, [CS] wouldn't tell us, 'Oh, it's going to be okay. It'll be okay for the next time.' [CS] would say, 'okay what did you do wrong and how are you gonna fix it?'

Based on intern reports, it was apparent that the purpose of providing feedback was so the intern could improve their skills, as well as reinforce and/or highlight the areas in which the intern was performing well. Giving and receiving feedback is a traditional exchange between a supervisor and an intern in any setting, and this next quote speaks directly to that type of feedback.

> I got a lot of feedback from my supervisor... like, [CS] would sit in, and after each session I would do by myself, or even if we did it together, [CS] would give me feedback each time. And then [CS], the next time would be like 'oh you improved on this' or 'here's something to keep working on.'

Another perspective to consider when discussing feedback is that of the clients with whom the intern and supervisor are providing treatment. When providing direct and immediate feedback, whether intended to correct or give praise, it was important for the clinical supervisor to explain to the clients what was happening. This next quote provides an example of how one clinical supervisor approached that dynamic.

[CS] would stop mid-intervention with clients and like explained to them that

[CS] needed to explain [to me] ... First, [CS] would tell them what's happening….

and then [CS] would explain to me what I needed to do… sometimes it was

positive reinforcement, like, 'That was great.' … 'That was a really great

question.' or 'That was a really good observation that you just had.'

Scaffolded Learning

Several interns reported that their supervisors used a systematic approach that led

to their competency development and independence as a clinician. Many interns received

an orientation at the beginning of their internship, similar to that of a new employee. In

some cases, an initial orientation was required by the organization. As the intern's skills

progressed, the clinical supervisors gradually relinquished responsibilities to the intern.

The responsibilities given to the intern depended on which competencies the intern

demonstrated. As the intern demonstrated more competency, more responsibility was

given, and this process continued until the end of the internship.

In some cases, an initial orientation was required by organizations. In other cases,

the clinical supervisor took the liberty of creating an internship manual. Some used it for

orientation only and others used it throughout the entirety of the internship to check off

competencies as they were met or addressed. When a manual or checklist was used, the

purpose was to ensure that certain competencies were at least addressed, if not mastered.

One intern related, "...we had this list of competencies from [organization] that they want

their interns to learn, I guess… So, when I met with [CS] we walked through each thing

on the list and checked it off." Some orientations included a tour of the facility, which

helped the intern become familiar and comfortable with their environment, serving as a

knowledge foundation for the student, "…[CS] told me… the do's and the don'ts, and the

where's and where to go and where not to go, as far as the hospital." For other interns,

their orientation consisted of them reading about the clients in which they would be

working, including the client's diagnoses, "[they] provided me information on the

residents there that I wasn't aware of. Things to be sensitive of before I implement an

intervention." Regardless of how organized or detailed the orientation was, the

orientation seemed to lay the foundation for competency development.

Following the initial stage of the internship, interns progressed at different rates

and in different ways. They continued to do things alongside their clinical supervisor,

observing and asking questions. As their time in the internship progressed so did their

responsibilities. Regardless of their individual timelines, one thing was apparent, the path

to independence was dependent on the clinical supervisor recognizing the intern's skill

progression and being willing to step back and gradually allow the intern to perform

independently. This first quote demonstrates that process.

> The longer I was in the internship, the more I see patients and the less [CS] sees
>
> patients. So, it was really me as the rec therapist for the day… [CS] kind of
>
> stepped back and let me do everything.

This progression in responsibility was a welcomed challenge, which helped the

interns to emerge as independent clinicians. In response to a question about how their

clinical supervisor influenced their competency development, one intern replied, "…[CS]

challenging me… obviously throughout the internship you grow competency and your

expectation is… you know more. And like, okay, 'I'm not going to assist you as much'…

I loved how [CS] did that. I like being challenged." And another intern stated,

> [CS] started to push me out on my own. Like, "you're coming up with an
>
> intervention today" or "you're going to do the assessment today." … By the end
>
> of the internship, [CS] was like, "Oh these [goals] are good" "There's no
>
> mistakes, these are good" "Go ahead and think of an intervention that you want to
>
> do and you're going to facilitate it by yourself as well."

Once interns were given the green light to perform job tasks independently, they

saw this as being given freedom and not having to constantly check in with their clinical

supervisor for each decision or action. One intern reported the following in regards to this

sense of autonomy.

> I had a lot of freedom. I didn't really have to report to [CS] where I was at all
>
> times. I could go talk to residents, go do my assessments and I just would come
>
> back and kind of be like, oh, this is what I did for the day, you know.

Interns also progressed in learning the assessment, planning, implementation,

evaluation, and documentation (APIED) process in RT. This next quote from an intern

describes how they were introduced to the assessment process and then gradually took

over more and more responsibility.

> Say for an assessment, [CS] would like, show me the form and explain how [CS]
>
> does it. And then I would watch [CS] do it. And then I would watch [CS] put it in
>
> the computer. And then maybe the next time I would, we would do the same
>
> thing. And then I would put it in the computer. And then the next time maybe

[CS] would sit with me, and we would both ask the questions… so [CS] made

sure that I felt comfortable doing them and that I was doing them okay. And then

eventually it was just me. So, [CS] like really did it step by step.

This next quote is from another intern who reported a similar experience with

gradual development of assessment skills that ultimately led to their independence.

[CS] was… in the room, obviously… if I ever [had] a question… but… after that

you kind of just… you're on your own and… you can totally do it… At first, [CS]

would, um, kinda like sneakily leave me alone. [CS] would be like 'Oh… I'll be

in the room in one second… you go ahead' … stuff like that. But then it turned

into… 'you're going to see this person'

Modeling Skills and Recognizing Deficits

Another way in which interns reported the development of knowledge, skills, and

abilities was by watching their supervisor perform specific tasks, such as assessments,

planning, implementing interventions use of terminology in documentation, and client

interactions (i.e., building rapport). Areas in which clinical supervisors demonstrated or

communicated to their interns that they had deficits included advocacy, regulatory

knowledge, and management skills. Skills and deficits were included together into one

theme because they seemed to be in concert with one another. The clinical supervisor

either demonstrated skill for the intern or they demonstrated or verbalized a lack of skill

in a particular area. Additionally, the clinical supervisors who acknowledged their

deficits also modeled professional behavior, specifically, self-awareness and humility.

For clinical supervisors who did not openly acknowledge their deficits, their intern

recognized that lack of acknowledgement. This lack of self-recognition caused the intern

to question whether or not this was professional behavior, and/or if it was behavior that

the intern wanted to exhibit.

Interns found particular value in watching their supervisor interact with clients, as

they were previously unsure of an appropriate level or style of interaction. Other interns

discussed watching their clinical supervisor complete various levels of the (APIED)

process. The following examples address assessments, specifically. It is interesting to

note that these examples reflect how the clinical supervisor performed the assessment,

connecting with the client and building rapport, rather than the content of the assessment

itself. One intern stated, "our very first day we watched [CS] do an assessment and I

noticed [CS] was very, very personable with them". Another intern reported that "[CS]

patience… and even… doing… assessments… just being like real personable… help me

to see kind of a different style of approach." While a third intern reflected on the clinical

supervisors' conversational skills during the initial assessment.

> [CS's] intake interviews were very, very good… [CS] could literally talk for… 60
>
> minutes… elaborate on literally what they had for dinner and… make a
>
> connection through that. [CS] is… really personable so I feel like [their] intake
>
> interviews were… what I learned.

In another example, one intern spoke directly to advocacy skills when reflecting

on observing their supervisor advocate for RT during a budget meeting.

> I think we sat in one or two [budget] meetings… And to see… like, number one,
>
> how to interact with your boss and how do you talk about a budget. How do you

stand your ground and be like, 'alright, well, you know, this is why this is?... You

know what I mean? Like, advocating for this program.

Based on intern reports it was clear that the interns learned a great deal from

observing their clinical supervisor. What they learned was influenced by the knowledge

their clinical supervisor possessed. Interns also recognized areas of knowledge or skill

deficit in their clinical supervisor. This recognition of deficits was not meant to be critical

or demeaning. In fact, interns saw these deficit areas as an opportunity for growth within

themselves, as well as their supervisors. One intern described the meek personality of

their clinical supervisor as a barrier to their opportunities for advocacy. The intern stated,

"[CS] is… a little bit quiet… soft spoken, I guess. So… in team meetings… afterwards

[CS] had told me [their] thoughts, but [CS] didn't… share them with the team. But [CS]

also told me [CS] knows that about [themselves]." The lack of advocacy skills was

observed by another intern who reportedly provided encouragement to their clinical

supervisor to request permission to start a new program.

We have to get approval most of the time. And [CS], sometimes, [they] always

felt like, I guess from previous experience, [CS] always felt like [they] would get

shut down by… the director or [their] supervisor. So, I kind of had to… push [CS]

to just go for it.

Some clinical supervisors were openly cognizant of their deficit areas as well and

were honest with their interns about this reality. Clinical supervisors who recognized

their deficits either provided opportunities for their intern to learn from or observe

another staff member, or they provided resources for the intern to seek the knowledge

independently. Intern's reported being appreciative of these opportunities, rather than not

getting the chance to gain additional knowledge. One intern related a conversation with

their clinical supervisor regarding NCTRC exam content in which the clinical supervisor

could not provide.

> [CS] was pretty clear in 'there are things that I cannot teach you, so you should go
>
> to my supervisor and learn these things'... [CS] told me that I should schedule an
>
> appointment with [their] supervisor… Because of the fact that [their] supervisor
>
> was going to be able to give me a lot more knowledge when it comes to CARF
>
> and Joint Commission, and how they budget everything, and how [their]
>
> supervisor] runs the Rec Therapy program and that there was going to be a lot that
>
> could help me in the future and can help me on the [NCTRC] exam.

In other cases, there was a lack of humility, which the interns also noticed. For

example, there were instances where a clinical supervisor seemed overly confident in

their knowledge or unwilling to change their opinion. One intern reported their

experience as an opportunity for self-reflection regarding the kind of professional they

wanted to be.

> … [CS] is not afraid to share [their] opinion and kind of be stern about it…. If
>
> [CS] sees things [CS] doesn't like or… if there's a TR that did something that [CS]
>
> didn't agree with… [CS] would definitely… talk to me about it… which was kind
>
> of confusing because… [CS] talking about this TR, but… I'm friends with [them]
>
> … It challenged me because it allowed me to see like, okay… Do I agree with this
>
> or do I want to practice this?

Professional Mentoring

Interns also reported that mentorship contributed to their competency development. This theme, while possessing some similarity with the *open, honest, and authentic communication* theme, identified mentorship provided by clinical supervisors that was not always related to the intern receiving feedback on their performance. Mentorship strategies used by clinical supervisors ranged from strictly professional advice to sharing personal information or listening to the intern vent about their frustrations. Some clinical supervisors involved their intern in every aspect of their job and guided them through this experience. One intern reported, "Right from the start [CS] helped me to get involved, personally, and… was very encouraging. And [CS] explained everything that [CS] was doing. Like, [CS] never just had me just sit and watch, [CS] explained everything." While another intern stated, "not only is [CS] like a supervisor, but [CS] was also like a mentor to me. Like, every single day [CS] wanted me to learn something new, every day. And [CS] was very inclusive with me." Interns seemed to appreciate being immersed in the process and treated as if they were a part of the team. This was evident in one intern's report regarding client care;

> They would send emails to [CS] about… a specific client that we're working with
> together, and [CS] would tag me in the email and tell me to just continue the
> conversation like anything else… So, I would be included in all the conversations
> that had to do with clients.

Another intern stated, in regards to feeling like they were included.

It wasn't like [CS] was a supervisor and I was the student. It was more of… [CS] treated me like an equal. And I really liked that because [CS] liked my input or my ideas and [CS] gave me like little projects to work on.

Other forms of mentorship involved pushing the student outside of their comfort zone, when necessary. In one instance, the intern was reluctant to send a second email to a therapist representing another discipline, for the purpose of scheduling a co-treat session for a particular client. The intern stated, "I'm… not the kind of person that wants to confront someone. So… I wouldn't… want to chase after you." In this instance, the clinical supervisor made the intern reach out a second time because it was the correct and professional thing to do.

Additionally, making independent decisions and having confidence in their decision-making is another area where some intern's struggled. One intern recalled that they would ask their clinical supervisor questions and their clinical supervisor replied "I don't know, what do you think? … come on… push yourself… you know the answer to the question you just asked me." Forcing them to rely on their own knowledge and resources, and to make decisions, allowed them the opportunity to learn from failure. One intern recounted an interaction with their clinical supervisor where they were forced to make a decision on their own;

[CS] really pushed us to learn and [CS] really pushed us to figure things out. There were a lot of times that I would come to [CS] with an idea for something and I'd say, 'is this a good idea?' And [CS] would say, 'I don't know. Is it?' …

'No. No. Tell me is it a good idea?' [CS] says, 'I don't know. Figure it out. Is it a good idea? Run an activity and see if it's a good idea.'

In instances where the intern did not have the knowledge or skills in a particular area, their clinical supervisor readily shared resources with the intern that promoted them finding the answer on their own. For example, one intern reported that "even throughout the evenings or the weekends [CS] would send me a bunch of… links or information, or text me, like, "do you have any questions?"

Interns also reported feeling closer to their supervisor when they were able to get to know each other on a personal level. One intern reported that "… it felt like [CS] was my colleague, but it felt also like a peer." This sense of personal connection and investment in the intern's future seemed to promote a professional and respectful relationship between the clinical supervisor and intern. As one intern reported, "… obviously we talked about… patients and stuff, but we'd also… get to know each other too, which is really nice. So, I feel like knowing [CS] on a personal level, as well as a professional level, was… really important." And another intern talked about the impact that having a good relationship can have on the communication that occurs between intern and clinical supervisor, "Having the relationship outside of just work, I think that that opens up a lot of communication between supervisors and their interns. Like, I definitely felt comfortable asking [CS] questions." In another example, one intern recounts a conversation with their clinical supervisor regarding the stress of trying to work during their internship.

There were days that I, I felt overworked, overstressed working full time in my

restaurant at the same time was working full time at the internship. So that was

really hard and really stressful. And, you know, come to work the next day and,

'Oh, I'm so tired of this.' … 'I was up 'til one o'clock in the morning after work,

writing the session.' ... 'Okay. Welcome to being an adult.' ... I don't think [CS]

ever used those words, but it really made me realize like, this is what I gotta do,

and I, you know I just got to keep pushing through it and not complain about it.

So, [CS] really kind of taught me how to handle things a lot better.

Personality Traits and Leadership

Leadership behaviors varied from supportive, functional leadership, and distracted

or absent leadership. The clinical supervisor's personality seemed to guide their

leadership style, and the leadership style of the clinical supervisor seemed to have an

effect on the quality of the relationship between intern and supervisor. The quality of

their relationship appeared to reflect either how comfortable the intern felt when

interacting with their supervisor or how much respect they had for them.

Interns reported various personality types and leadership styles among their

clinical supervisors. In some cases, the intern felt that their personality style matched that

of their clinical supervisor, "I think we were good mix because we're both kind of like

shy and soft spoken at first, and it takes time to build up. So, it wasn't like, it wasn't ever

uncomfortable because we were both kind of that same way until we got used to each

other." While other times the intern felt that they had different personalities but were still

able to work together or that the clinical supervisor adjusted their leadership style to

match the intern's personality, "[CS]'s leadership style worked really well with me and

my personality. And I think [CS] also kind of adapted [themselves] to me a little bit… I

think [CS] is really good at reading people." While another intern reported a unique

approach by their clinical supervisor in the beginning stages of the internship;

> When I first got here... [CS] bought me a book about … it was a self-
>
> assessment… take a quiz online and then it tells you like your top five strengths.
>
> Your personality strengths…. After I told [CS] my personality traits, [CS] was
>
> like, "Okay, I know how to work with you as a… supervisor." ... after that it kind
>
> of broke the ice between me and my supervisor.
>
> As mentioned above, decision-making was a source of stress for some interns.

One intern reported having a more positive outlook on work environments and feeling

more comfortable making decisions knowing their clinical supervisor would openly

support their decision if it was questioned by others.

> [CS] even said… "if you kick somebody out of the group… or… if you do
>
> something and it's questioned by like upper management… I will defend you…"
>
> [CS] wasn't gonna throw you under the bus. Like, [CS] would jump in front of the
>
> bus before anything… to see that, like, it can be like that and be a family and like
>
> a team and tight knit, like really changed my outlook on work.
>
> Other types of support were echoed by other interns as well. This next intern

highlights how their clinical supervisor helped to increase their self-confidence by

providing the right balance between support and challenge;

[CS] was really supportive too… in my confidence. I think I questioned myself a

lot… [CS] was really, really good at, you know… reassuring me… [CS] was

good at putting that challenge out there and helping me reach it without holding

my hand.

For the most part, the approaches used by clinical supervisors were advantageous

to the intern's knowledge and skill development. There were some instances where the

clinical supervisor's approach left the intern questioning their clinical supervisor's

professional behavior. For example, one intern related;

There was kind of like a lack of humility I think, from [CS]. And like, I think

sometimes [CS] just maybe thought… "I'm right" … "you're wrong." And it was

kind of, seemed like a know it all. And maybe sometimes didn't want to like talk

to other TRs if [CS] didn't like really like them.

At different times during the internship the clinical supervisor served as a

supervisor or a leader to their intern, depending on what was needed at the time.

However, in some cases, interns felt that their clinical supervisor was not available when

needed or was oblivious to the struggles the intern experienced when interacting with

other staff at the facility. One intern described their supervisor's leadership style as

Laissez Fair and recounted frustrations felt as a result of another staff member not doing

their share of the work in the department;

I think that's just who [CS] is. [CS] is a relaxed person…. [CS] didn't stand up for

certain things unless [they] … absolutely had to. And I think that's also why I had

to stand up a lot for myself… when it comes to… the stuff that [CS] should have

been doing… you know, the aides, who I didn't feel were competent or doing

their job… I shouldn't have had to pick up that slack. You know, I shouldn't have

had to deal with a lot, especially as an intern, even as a worker. But like, as an

intern, I should have had somebody behind me saying 'stop putting all of your…

work on my intern' which eventually [CS] did, but it had to be brought to [their]

attention…

Data Mixing

The purpose of this study was to address the overarching mixed methods research

question: *what are the prominent leadership behaviors and competencies among clinical*

supervisors in Recreational Therapy and how do those behaviors and competencies

impact competency development in Recreational Therapy interns? In order to answer this

question, the quantitative and qualitative results are discussed below. A joint display

model (see Table 7.15) was used to assist in communicating where the quantitative and

qualitative results converged and where they were diverged. In this explanatory

sequential mixed methods study, the qualitative results were used to give a deeper

meaning and understanding to the quantitative (i.e., statistical) results.

Convergent Results

Similarities between the quantitative and qualitative results were revealed through

the data mixing process. Average intern LMX-7 scores were 31.75 out of 35 total

possible points indicating very high-quality relationships between intern and clinical

supervisor. To help explain this result, during the qualitative stage, interns often reported

that their supervisors had an agreeable personality, effective leadership behaviors, had

open, honest, and authentic communication, and provided professional mentorship. These qualitative results help describe how these qualities and supervisory practices contributed to interns having a positive regard for their clinical supervisor. It is possible that the positive interactions that most interns experienced led to them viewing their relationship with their supervisor as high quality. It is possible that when a clinical supervisor demonstrated a commitment to their intern's professional development and future success the intern was more likely to perceive a high-quality relationship with their clinical supervisor.

Additional quantitative analysis revealed that higher intern LMX-7 scores were associated with greater perceived competency increase at the end of the internship. Related to this, the reports from interns during the qualitative phase indicate that when interns perceived their clinical supervisor as a good leader with an agreeable personality, they also perceived learning to be easier and/or they were able to learn more.

Statistical analysis of the intern competency assessment pre and post scores demonstrated an increase in the interns' overall perceived competency score at the end of the internship (i.e., 23.46% increase). Qualitative reports from interns indicate that this increase in competency could have been a result of the scaffolded learning approach implemented by supervisors. Once the intern demonstrated enough competence in one area the supervisor added to their responsibility or gave them more difficult tasks. Essentially, the quantitative results of the RT Competency Assessment show that intern competency increased, and the qualitative result describes the details of how their competency increased over the course of the internship.

Quantitative results indicate the interns perceived their competency to increase the greatest in implementation, management, and assessment skills. Likewise, interns discussed watching their clinical supervisors conduct assessments and interact with clients during treatment interventions. This speaks to the modeling skills and recognizing deficits theme that emerged during the qualitative stage. Essentially, interns reported that observing their clinical supervisors' complete assessments and implement treatment interventions contributed to their competency development, which supports the quantitative finding in the intern competency change scores.

Quantitative data showed that interns had the lowest competency improvement in the Facilitation Techniques/Theories subsection. Qualitative findings support this result because interns did not report exposure to any theories, specifically, during the follow up interviews.

Quantitative findings among the intern competency assessment and the clinical supervisor competency assessment were both similar and different. First, two out of the top three competency changes among interns demonstrated improvement in Implementation (32.70% increase) and Assessment (29.15% increase). Likewise, qualitative reports from interns within the Modeling Skills and Recognizing Deficits phase revealed that interns learned from watching their clinical supervisors perform tasks, such as client assessments and interactions with clients during treatment (i.e., implementation). Second, two out of the top three supervisor competencies in the quantitative data were Implementation (76.12%), and Planning (72.33%). This gives further support to the qualitative finding that interns increased their competency in

implementation by observing their clinical supervisor while they were implementing treatment plans with clients.

Divergent results

Statistical analysis demonstrated that clinical supervisor competency was not a strong factor in intern competency development. However, within the Modeling Skills and Recognizing Deficits theme, several interns discussed observing their clinical supervisor demonstrate specific skills. Interns indicated that having the ability to observe their clinical supervisor, specifically during client interactions, was something that helped them develop competency in these areas.

Quantitative results demonstrate that Managing Recreational Therapy Practice was the second highest increase among intern competency assessment subsection scores (29.38%). However, management was not a common theme that was discussed amongst interns during the individual follow up interviews.

An additional divergent finding was the quantitative result that showed intern pre-competency assessment as a strong predictor for intern competency change at the end of the internship. During follow up interviews, interns did not discuss their preexisting knowledge, skills, and abilities at the beginning of their internship as something that they felt impacted their competency development. In the Modeling Skills and Recognizing Deficits theme, it was their supervisor's competency that interns reported as having an impact on their own competency development.

Table 7.15

Model of Quantitative and Qualitative Results

QUAN finding: Intern (M=31.75/35) and supervisor (M=29.13/35) LMX-7 scores fell into the Very High range on the LMX-7 rating scale, suggesting high quality relationships among most dyads.

QUAL finding: Professional Mentoring

Convergent Interpretation: Professional Mentoring was a common theme reported among interns. The more an intern felt that their supervisor was invested in their future, the better the intern viewed their relationship, and therefore the intern rated their supervisor higher on the LMX-7.

QUAN finding: Intern (M=31.75/35) and supervisor (M=29.13/35) LMX-7 scores fell into the Very High range on the LMX-7 rating scale, suggesting high quality relationships among most dyads.

QUAL finding: Personality Traits and Leadership

Convergent Interpretation: Higher intern LMX-7 ratings means that interns felt they had a high-quality relationship with their supervisor. Likewise, interns reported positive leadership traits among their supervisors.

QUAN finding: Intern LMX-7 scores were a predictive variable in intern Competency Change (β=.364, p=.086)

QUAL finding: Open, Honest, and Authentic Communication

Convergent Interpretation: Intern competency increased due in part to the intern having a high-quality relationship with their supervisor. Qualitative findings indicated that authenticity and open communication between intern and supervisors promoted the development of a positive relationship.

QUAN finding: Intern Competency Change (23.46% increase)

QUAL finding: Scaffolded Learning

Convergent Interpretation: Interns demonstrated an increase in perceived competency assessment, overall, as well as within the eight subsections of the RT Competency Assessment. The Scaffolded Learning theme from the qualitative data suggests that intern competency change was due to their supervisor methodically introducing skills to the intern and then building on those skills once the intern demonstrated mastery.

QUAN finding: Intern competency change yielded 7.15% increase in the Facilitation Techniques/Theories subsections. This was the lowest change

QUAL finding: Introduction to or exposure to theories was not reported by any of the interns

of all the competency assessment
subsections.

Convergent Interpretation: Quantitative data suggests that students begin their
internship with limited knowledge of relevant practice theories, as well as not being
exposed to theories much during their internship. This finding was supported by the
lack of related exposure to theories and facilitation techniques during follow up
interviews with interns. Interns did not specifically state that theories were lacking in
their education, it simply was not something that interns related when they discussed
what they learned from their clinical supervisor.

QUAN finding: Two of the top three intern competency changes were Implementation (32.70) and Assessment (29.15) | **QUAL finding**: Modeling Skills and Recognizing Deficits

Convergent Interpretation: Quantitative findings revealed that interns perceived their
greatest competency increase in the areas of implementation, management, and
assessment. Likewise, interns reported during the qualitative phase that they learned by
observing their supervisor complete client assessments, as well as when the supervisor
interacted with the client during treatment.

QUAN finding: Two of the top three supervisor competencies were Implementation (76.12), and Planning (72.33) | **QUAL finding**: Modeling Skills and Recognizing Deficits

Convergent Interpretation: Quantitative findings show that supervisors had the highest
competency in foundational knowledge, implementation and planning. Qualitative
reports from interns show that observing their supervisor implement treatment plans
contributed to their competency development.

QUAN finding: Pre competency assessment scores were a predictor of intern competency change (slope=-.738, p=.002) | **QUAL finding**: Modeling Skills and Recognizing Deficits

Divergent Interpretation: Students who began their internship with lower perceived
competency had the greatest improvement at the end of the internship. Qualitative
reports from interns did not discuss their own knowledge, or lack thereof. Intern
reports focused on their supervisor's competence as one of the things that impacted
their competency development.

QUAN finding: Supervisor competency assessment scores were not a predictor of intern competency change in the regression model (slope=-.154, p=.490)	**QUAL finding**: Modeling Skills and Recognizing Deficits

Divergent Interpretation: Despite the clinical supervisor's perceived competency not being a predictive factor in intern competency change, interns still reported learning a great deal from observing their supervisor and talking with their supervisor about specific skills.

QUAN finding: Managing Recreational Therapy Practice was the second highest competency change among interns (29.38% increase).	**QUAL finding**: When interns reported observing skills in their supervisor, Managing RT Practice was not a common theme

Divergent Interpretation: While interns reported an increase in perceived competency in the Management of Recreational Therapy Practice sub-category, they did not report having exposure to management, specifically, during their follow up interview.

<center>**Chapter 8**</center>

<center>**Discussion**</center>

The purpose of this study was to understand the association between the leadership behaviors and competencies among clinical supervisors, the relationship quality between supervisors and interns, and how those impact competency development among RT interns. The rationale for completing a study of this nature is the lack of available research on the topic of CS, as it relates specifically to the field of RT. Additionally, there are no standardized processes for training RT students or professionals on how to be a clinical supervisor to interns or novice professionals in the field. As leadership is often considered a component of providing CS, three leadership theories were included in this study in order to make a workable framework that would assist in understanding the results. The three leadership theories used in this study were the Leader-Member Exchange (LMX), Authentic Leadership, and Functional Leadership. These theories were chosen because of their application to CS, specifically in RT.

Methods Overview

This study used a mixed methods phenomenological framework to answer the overarching mixed methods research question, which was; *what are the prominent leadership behaviors and competencies among clinical supervisors in RT and how do those behaviors and competencies impact the competency development in RT interns?* To help answer this overarching question, three research questions were used to guide the study. The first two research questions focused on quantitative methods, while the third research question focused on qualitative methods.

The qualitative portion of the study consisted of individual follow up interviews, using a list of semi-structured interview questions. While both interns and supervisors were interviewed during this phase of the study, it was only the intern data that was needed to answer research question number three. As a result of reviewing the qualitative data, five themes emerged that helped to describe the lived experience of the interns during their 14-week internship and what factors influenced their competency development. The data from both the quantitative and qualitative portions of the study were then mixed together to provide a richer and well-rounded explanation of the phenomenon being studied.

Summary of Primary Findings

Quantitative, qualitative, and mixed methods results revealed several interesting findings related to each of the three research questions. The findings related to each research question are discussed below, as well as a section on the overarching mixed methods research question.

Research Question One

Research question one asked, *what is the association between relationship quality and interns perceived competency development?* Results from the first and second regression models indicated that the best predictor of intern competency development was the intern's pre competency assessment score. This result means that interns who rated themselves low in RT Competency Assessment before their internship reported greater increases in their competency as compared to interns who rated themselves with higher competency at the beginning of the internship. It is likely that the students with

lower perceived competency at the beginning of their internship had more room to

develop competency. The second-best predictor of intern competency development was

the intern LMX-7 ratings as an indicator of the quality of the relationship with their

supervisor. Based on these results, using a 90% confidence interval, the intern's

perception of their relationship quality with their supervisor (i.e., intern LMX-7 score)

had a moderate impact on their ability to develop competency. Intern LMX-7 scores

ranged from 23-35, with an average intern LMX-7 score of 31.75, indicating a very high-

quality relationship. Collectively, the interns with lower competencies entering internship

and with strong relationships with their supervisor exhibited higher competency

development over the course of their internship.

Research Question Two

Research question two asked, *what is the relationship between an intern's*

perceived competency development and the supervisors perceived competency?

Intern and supervisor competency totals were converted to percentages to allow for a

meaningful comparison of competency. The use of percentages was used for two reasons.

First, there is a varied number of possible points within each subsection of the RT

Competency Assessment, and second, there is not an established scale for this assessment

that indicates whether one's score is high, moderate, or of low competency. Using the

percentage calculations, data analysis revealed that intern post-competency total was 69%

and supervisor competency was 67%. In looking at percentages only, intern post

competency and supervisor competency were within two percentage points by the end of

the internship. The change in intern competency from pre to post was measured by

calculating the percentage of change. Results showed that interns increased their overall

competency by 23% (p = .000), representing a statistically significant increase in

competency, on average from the beginning of internship to the end of internship.

While it was hypothesized that supervisor competence would impact intern

competency development, statistical analysis revealed that there was no correlation

between clinical supervisor competency and intern competency change (r = -.190,

p=.374). There also was no correlation between clinical supervisor competency and

intern post-competency (r = .163, p=.446). Additionally, in the first regression model,

supervisor competency had no effect on intern competency development (β = -.154, p=

.490) so it was not included in subsequent analyses. These findings demonstrate that

supervisor competence was not statistically associated with the 23% average increase in

intern competence found in this study.

Research Question Three

The third research question asked, *what is the experience of RT intern competency*

development as related to the student's perception of their supervisor's leadership

behaviors and competency in RT? The third research question had the purpose of

describing the experience of the intern's competency development based on the intern's

perception of their supervisor's leadership behaviors and level of competence in RT. Five

themes emerged as the primary components that influenced intern competency

development, which were; *open, honest, and authentic communication; scaffolded*

learning; modeling skills and recognizing deficits; professional mentoring; and

personality traits and leadership.

Interns fondly related their experience of receiving *open, honest, and authentic communication* from their supervisor as something that impacted their competency development. Specifically, it was the feedback from their supervisor that helped the intern to know in which areas they were performing well and in which areas they needed to improve. *Scaffolded learning* occurred as the supervisor recognized their intern's skill development and increased competency in specific areas. When the intern's skill development was recognized, their supervisor gradually assigned them additional tasks and responsibilities. This approach allowed interns to learn how to complete tasks independently. The third theme, *modeling skills and recognizing deficits*, emerged because interns reported that they learned some of their skills and developed insights by observation. Several interns related specific moments during their internship where they learned a new approach or technique by observing their supervisor interact with another client during an assessment or intervention. The fourth theme of *professional mentoring* highlighted the unique relationship dynamics and mentorship approaches of each clinical supervisor. Beyond teaching interns specific RT competencies, supervisors also served as professional mentors to guide and support their intern through a period of life that usually elicits high levels of stress. The fifth and final theme that emerged was *personality traits and leadership*. Interns felt that their supervisor's *personality and leadership style* had an effect on their competency development. Some supervisors had inviting personalities, others had more intimidating personalities, while others changed their approach based on the needs of the intern. Supervisor personalities were accompanied by leadership styles

that resembled functional leadership, transformational leadership, and sometimes even absent or Laissez Fair.

Mixed Methods Question

The overarching mixed methods research question asked, *what are the prominent leadership behaviors and competencies among clinical supervisors in recreational therapy and how do those behaviors and competencies impact competency development in recreational therapy interns?* There were several quantitative and qualitative findings that converged and diverged from one another that helped to answer this question.

Convergent Findings. The mean scores for intern and supervisor LMX-7 scores revealed that, on average, interns and supervisors had high quality relationships. This finding was also supported by the two themes, *professional mentoring* and *personality traits and leadership*, that emerged in the qualitative analysis. These findings together suggest that two factors contributed to the development of high-quality relationships between interns and supervisors. The first factor was the positive leadership traits that interns recognized in their supervisor, and the second factor was interns feeling that their supervisor was invested in their future. Additionally, statistical analysis found that the intern LMX-7 scores were predictive of intern competency change. This finding was complemented by the qualitative theme *open, honest, and authentic communication*. When comparing both of these findings, it was evident that when interns felt their supervisor was honest and open in their communication style this promoted the development of high-quality relationships. These high-quality relationships therefore contributed to the increase seen in intern competency.

While the statistical analysis revealed that intern competency increased over the course of the internship, it was the qualitative analysis that revealed the manner in which the intern improved their competency. During interviews, interns described their supervisor's implementation of a *scaffolded learning* approach. This finding suggests that intern competency change was due, in part, to their supervisor methodically introducing new skills to the intern and then building on those skills once the intern demonstrated mastery.

Divergent Findings. Statistical analysis revealed that the best predictor of intern competency change was pre-internship scores and that supervisor competency had no influence on intern competency development. However, one of the themes that emerged during the follow up interviews was *modeling skills and recognizing deficits*, suggesting that interns developed competency by observing their supervisor complete tasks associated with their job. Specifically, Managing RT Practice was one of the top three areas of increased competency among interns, yet this was not a common theme reported by interns during follow up interviews.

Summary of Convergent and Divergent Findings. To answer the overall mixed methods research question; clinical supervisors demonstrated various leadership behaviors toward their intern and had the highest competency scores in Foundations of Professional Practice, Implementation, and Planning. The quantitative data suggested that supervisor competency did not contribute to the increase seen in intern competency. However, the qualitative data supports the opposite of this finding. Interns reported that they developed competency in three ways; 1) from observing their supervisor as they

modeled specific skills; 2) from their supervisor recognizing the intern's competency

development; and 3) by building upon that foundation by scaffolding additional tasks and

responsibilities. The quantitative data also suggested that interns had high-quality

relationships with their supervisors, and that these high-quality relationships contributed

to intern competency development. This finding was supported by qualitative reports

from interns that highlighted the open and honest communication from their supervisor,

as well as their mentorship throughout the internship.

Summary of Secondary Findings

Several results were discovered during the data analysis phase that were not part

of the primary research questions of this study. First, the pre-post and scores for each

subsection of the RT Competency Assessment revealed the specific areas of highest and

lowest competency among interns and supervisors. Statistical analysis revealed that

supervisors had the highest competency in the areas of Foundational Knowledge,

Implementation, and Planning, and Managing RT Practice. Similarly, Foundational

Knowledge, Implementation, and Planning were among the top three competency areas

for interns at the beginning of their internship. In looking at the competency change at the

end of the internship, interns demonstrated the greatest competency change in

Implementation, Assessment, and Planning, with Implementation and Planning being

among the top three supervisor competencies. Additionally, during the follow up

interviews, program implementation and client assessment were discussed by interns, as

they observed their supervisors complete these types of tasks. These findings indicate that

both supervisors and RT students in this sample received adequate preparation in their

curriculum in the areas of Foundational Knowledge, Implementation, Planning, and Assessment.

The two lowest areas of competency for supervisors was Modalities and Facilitation Techniques/Theories. For interns, these two competency areas were rated the lowest in their pre-competency score and their post-competency score, resulting in the lowest competency percentage increases in these two subsections. Likewise, the topic of facilitation techniques and theories was not a common theme discussed among interns. However, these results also indicate that RT students have the least exposure to theories in their curriculum preparation prior to internship, and that they receive the least amount of education or exposure to facilitation techniques/theories during their internship. Two possible explanations are that clinical supervisors either lack education and training in this area or they have limited opportunities to apply their knowledge of this topic in practice.

In looking at the competency change percentage scores, the top three areas in which interns increased their perceived competency in RT was Implementation, Managing RT Practice, and Assessment. This finding indicates that, on average, interns spend more time conducting assessments and implementing programs when compared to tasks in other competency areas, which was supported by the qualitative data. This also suggests that interns are exposed to the managerial practices that are often required of a CTRS. Additionally, since two of the top three increases in competency were not among the top three supervisor competencies it suggests that interns develop competency from sources other than their supervisor.

This study also revealed that respondents (both supervisors and interns) with a Master's or a Doctoral degree were more likely to have received some type of education or training in CS than those with a Bachelor's degrees only. The most common method among interns was undergraduate lectures or classes, and the most common method among supervisors was a conference session or workshop.

Connection to Previous Literature

Some of the findings from this current study support the findings from previous leadership studies, as well as the CS research in the RT field.

Leadership Literature

Previous LMX literature states that high quality relationships develop as a result of positive interpersonal interactions between leader and follower (Ilies, Nahrgang, & Morgeson, 2007). High quality relationships are also the result of followers having trust in their leader, and when followers feel motivated, empowered, and have a sense of job satisfaction (Martin et al., 2016). Findings in the current study support this literature, as interns' perspective of relationship quality (i.e., intern LMX-7 scores) was the second-best predictor of intern competency development. Specifically, higher relationship quality led to higher intern competency. Additionally, the factors that contributed to these high-quality relationships were the specific supervisor actions and behaviors described in each of the five themes that emerged in the qualitative portion of the study.

One of the five themes that emerged was *personality traits and leadership*. In addition to impacting competency development, *personality traits and leadership* also had an impact on supervisor-intern relationship quality. This finding is similar to

previous leadership research that found personality to be the greatest indicator of success for a manager or leader (Hogan et al., 2011).

Recreational Therapy Literature

There are several connections to be made between the CS literature and the current study. The first is a comparison to the Hutchins (2005) study, in which some of the competency areas identified as *extremely important* or *moderately important* also emerged as factors affecting intern competency development in the current study. For example, in the Hutchins (2005) study "Provides well-timed feedback to the student", "Provides specific and direct feedback to student", "Communicates effectively with student", and "Demonstrates genuineness, empathy, and caring" were all deemed *extremely important*. Similarly, the finding in the current study is that *open, honest, and authentic communication* and *personality and leadership style* influenced competency development among interns. In comparing the findings from both studies, interns and clinical supervisors believed leadership behavior and communication style to be important factors in the clinical supervisory and competency development process. Competencies rated as *extremely important* in Hutchins' study that are specific to a recreational therapist's role includes, "Implements interventions to meet client needs" (i.e., implementation) and "Utilizes various assessment methods" (i.e., assessment). While in the current study, quantitative and qualitative results revealed increased competency in these same areas, indicating that implementation and assessment are important competency areas for supervisors. This finding also indicates that interns receive adequate exposure to implementation and assessment skills during their

internship. Additional comparison to the Hutchins (2005) study shows that "Knowledge of major theories related to TR" was ranked as "moderately important". In the current study, the two lowest competencies among interns and clinical supervisors was Modalities and Facilitation Techniques/Theories, which was also not discussed by interns during the follow up interviews. The findings in both studies indicate the need for a greater focus on these topics at the academic level and at the practice level.

The current study found that approximately half of the clinical supervisors received any type of CS education or training. The most common method of CS education for supervisors was a conference session or workshop, with a small number receiving it via one or more undergraduate or graduate lectures or classes. This finding supports the Jones and Anderson (2004) study that found RTs who had received some type of CS education had done so via a workshop or conference. There is also support for the Gruver and Austin (1990) study that revealed inconsistent provision of CS education among RT/TR curriculums. Based on the findings from the current study, as well as from the two previous studies, a need remains to increase the provision of CS education at the academic level (whether bachelor's or master's), as well as the consistency in which these educational opportunities are offered.

In the Bedini and Anderson (2003) study, CTRSs who received mentorship were more often in middle management positions and had higher job satisfaction. While those who were not receiving mentorship were more likely to have intent to leave their current job. The greater mentorship literature supports the role of mentorship in the development of "professional identity" (Ragins, 2016), as well as the need for mentors to possess

specific competencies about their role, with ongoing evaluation of the effectiveness of

their mentorship practices (Heeneman & De Grave, 2019). The current study did not

evaluate mentorship specifically, however, *professional mentoring* emerged as a common

theme during the qualitative portion of the study as interns recounted interpersonal

interactions with their supervisor that resembled mentorship. Specifically, interns felt that

these mentorship behaviors meant that their supervisor was invested in their well-being,

as well as their future in the profession. This perspective from the intern contributed to a

higher quality relationship with their supervisor, which in turn promoted the intern's

competency development.

Findings from both studies demonstrate the importance of providing mentorship to both

practitioners (i.e., clinical supervisors) and interns.

In addition to the previous CS research in RT, several other experts in the field

(Austin, 2004; Austin, McCormick, & Van Puymbroeck, 2016; Jones & Harvey, 2007;

Murray & Shank, 1994) have published recommendations that are supported by the

findings in the current study. These previous recommendations are included in the

recommendations section of this chapter.

Connection to Frameworks

Viewing the results of the current study through the lens of the three leadership

theories chosen for this study offers a deeper understanding of the impact of leadership

behaviors on the relationship quality between supervisor and intern.

Leader-Member Exchange Theory

Two key components of the LMX theory are the antecedents (Nahrgang & Seo, 2016) and the Leadership Making model (Graen & Uhl-bien, 1991,1995). Antecedents are the actions, behaviors, and personality traits displayed by the supervisor or the intern that impact the quality and development of their relationship (Nahrgang & Seo, 2016). Several previous studies on antecedents revealed that initial interactions (Nahrgang, Morgeson, & Ilies, 2009), mutual trust (Liden, Wayne, & Stilwell, 1993; Nahrgang & Seo, 2016), leader delegation (Bauer & Green, 1996), and interpersonal interactions (Ilies, Nahrgang, & Morgeson, 2007) all contribute to the development of high-quality relationships between a leader and a follower. These findings are supported by the current study, as the statistical analysis revealed that, on average, interns and supervisors had developed high quality relationships over the course of the internship. Subsequent qualitative findings revealed that interns developed these high-quality relationships as a result of several factors, or antecedents. During their initial interactions, most interns received some type of orientation, which helped them to learn about the organization, as well as what was expected of them by their supervisor. This action set the foundation for the development of mutual trust, which occurred as a result of open and honest communication with each other. Later in the internship, as the intern demonstrated increased competency in certain areas, the supervisor delegated more and more tasks to the intern. Delegation of tasks and responsibilities also likely contributed to the development of mutual trust. And finally, most interns reported agreeable personality traits and positive leadership behaviors in their supervisor that resembled *professional*

mentoring. These types of positive interpersonal interactions likely contributed to the

high-quality LMX-7 scores found in this study.

Another interesting finding in the LMX literature is that leaders tend to interact

with or behave differently when interacting with different followers (Martin et al., 2016).

Additionally, one of the qualitative findings in this study revealed that supervisors

displayed various *personality traits and leadership* behaviors. Specifically, some interns

reported that their supervisor adjusted their behavior and approach to supervision based

on the intern's personality. Based on the results of the quantitative data, these leadership

behaviors were one of the factors that contributed to the high-quality relationships

between interns and supervisors.

In looking at the progression of these high-quality relationships, the three stages

of the Leadership Making model provide some insight into how these high-quality

relationships developed (Graen and Uhl-Bien, 1991,1995). Based on reports from interns,

their *stranger* stage consisted mostly of getting to know each other's personalities,

receiving an orientation about the organization and their supervisor's expectations, and

learning their role as an intern. As interns and supervisors engaged in more dialogue, they

became more comfortable with each other and their individual roles. Interns were able to

enter the acquaintance stage as a result of *open, honest, and authentic communication*

from their supervisor. Supervisors also implemented a *scaffolded learning* approach,

which gradually gave more responsibility to the intern whenever they demonstrated

competence. Once the dyad's relationship became transformational, they entered the

mature stage, consisting of mutual respect, trust, and loyalty, working toward a common

goal. While not all interns described reaching this stage with their supervisor, the majority of interns felt that they were viewed and treated as more of an equal than a subordinate. Interns felt that their supervisor recognized their competence and trusted them to carry out their assigned tasks.

Authentic Leadership

Leadership multipliers are discussed within the Authentic Leadership theory and are described as traits found in a leader that promotes positive responses from followers (Chan et al., 2005). The leadership multipliers are also comparable to the antecedents discussed within the LMX theory, that lead to high-quality relationships. Examples include self-awareness, unbiased processes, authentic behavior and relational authenticity (Ilies et al., 2005). Two themes emerged in the qualitative portion of the current study supporting the concept of Authentic Leadership including *modeling skills and recognizing deficits* and *open, honest, and authentic communication*. The recognition of skill deficit by supervisors suggests that they demonstrated self-awareness when interacting with their intern. This behavior also supports the idea of relational authenticity, which describes the development of trust through recognition of one's own good and bad qualities. Supervisors also engaged in open and honest communication with their interns, which promoted their image as an authentic leader in the eyes of their intern, contributing to the high-quality LMX-7 scores seen in the quantitative portion of the study.

Functional Leadership

The Theory of Functional Leadership highlights two important actions of a leader. The first is observation or monitoring (Santos, Caetano, & Tavares, 2015) and the second is taking action, when needed or warranted (Barnett & McCormick, 2016). In the current study, supervisors closely monitored their interns toward the beginning of the internship. Supervisors observed their interns when completing assessments or facilitating group programs or one on one interventions. If needed, the supervisor intervened to correct the intern's decision or action. Specifically, supervisors provided guidance and encouragement to the intern so they would learn how to respond in future, similar, situations. In some cases, the supervisor had to completely take over for the intern during an intervention that was not going as planned, or when client behavior became unmanageable. In either case, the supervisor followed up with the intern afterward to provide feedback on the areas they performed well and the areas in which must improve. As it relates to competency development, when the intern demonstrated skill proficiency, the supervisor awarded the intern with more responsibility and opportunities to complete additional tasks. As mentors, supervisors also observed their intern for signs of maladaptive behaviors and listened when their intern came to them with a problem. If the supervisor was concerned with an intern's language or behavior it was addressed appropriately.

Implications for Practice

Several recommendations were made for the RT profession in previous CS literature, which are also supported by the findings in the current study. The sections

below discuss the recommendations for internship supervisors, RT educators, and the profession as a whole.

Suggestions for Internship Supervisors

Based on the results of this study, as well as the recommendations by previous researchers in the field (Austin, 2004; Austin et al., 2016; Hutchins, 2005; Jones & Anderson, 2004; Jones & Harvey, 2007), it is recommended that internship supervisors complete some type of CS education or training prior to supervising an RT intern. A CS training would enhance the supervisor's skills as a leader and help them to be better prepared to provide guidance and mentorship to interns. Additionally, this training could provide supervisors with guidance on how to mentor interns who enter the internship at a higher competency level. These interns may benefit from advanced competencies beyond what is traditionally focused on during the internship.

It is also recommended that supervisors establish a standardized method for orienting and training their interns at the start of the internship. Some interns in this study attributed the beginning of their competency development to the orientation process at the beginning of their internship. An orientation helps the intern to learn the facility (i.e., layout and where to find certain units or resources), as well as the policies and procedures of the organization. Providing the intern with the tools they need to be successful during their internship can help interns to build trust in their supervisor, thus laying a foundation for a successful and positive relationship.

One method for providing an effective orientation to interns includes the development of a checklist that includes essential items necessary for the intern to be safe

and successful. This orientation checklist could be part of a larger internship manual that

also contains a list of competencies specific to the RT profession, as well as any

competencies required by the organization. Including a flexible timeline to help the

supervisor guide the student provides opportunities for adaptability and allows the

supervisor to stay tuned to the needs of their student as they progress through each

competency. RT specific competencies should be based on CARTE requirements, and the

methods for evaluating such competencies should be clear to the student. Interns would

also know what is expected of them, therefore minimizing tension that could develop as a

result of the supervisor not communicating these expectations to the intern. The CARTE

(2017) also recommends that clinical supervisors provide a job description that outlines

the expectations, responsibilities, and duties of the intern. An internship manual would

also provide a method for documenting when competencies are met, which competencies

the intern still needs to develop, and any potential barriers to competency attainment.

Guidance and training for how to develop an internship manual could be a component of

the CS education that was previously recommended.

Suggestions for RT Educators

This study also has implications for educators in RT. For instance, CARTE

requires university programs to provide internship supervisors with an orientation and

evaluation (CAAHEP, 2017). However, there are no current guidelines on how to provide

this orientation (i.e., number of hours, in person, online), or what the content should be.

Using the results of this current study as a guide, RT Program Directors could

include content regarding their expectations of clinical supervisors (i.e., direct student

supervision, student evaluations, targeted competencies, how and when to communicate with faculty). Additional training content reflective of this study, could include suggestions for effective communication with interns, how to be a mentor versus a supervisor, and how to adjust their leadership style based on intern personality. Being equipped with these methods for how to appropriately respond in these situations could help internship supervisors to be feel more prepared, as well as promote the development of stronger relationships with interns. Because there is the potential for bad supervisory habits to develop, interns and practitioners would be better prepared if their first exposure to the concept of CS was at the bachelor's level, which was also suggested by Bedini and Anderson (2003). Additional CS education could also be offered at the master's level.

While CARTE and NCTRC do not currently require a CS course in RT undergraduate curriculum, CARTE does require universities to provide an orientation for clinical supervisors (CAAHEP, 2017). However, it is recommended that the content for this orientation be more clearly outlined. At this time, it is not clear whether CARTE refers to an orientation to the university's internship requirements (as they tend to differ between universities) or an orientation on the components of successful CS practices. A more standardized approach would promote success among internship supervisors in the field.

Suggestions for the RT Profession

The mixed methods results of this study show that relationship quality, as well as the skills and competencies demonstrated by the supervisor, influence competency development among interns. Results from this study also show that approximately half of

the supervisors had some type of CS education or training, which is similar to the

findings in the Jones and Anderson (2004) study. Additionally, the Gruver and Austin

(1990) study found that CS education was not taught consistently among undergraduate

or graduate programs. This lack of education and training implies that recreational

therapists are not prepared when they first supervise an intern.

The findings of the ATRA Higher Education Task Force Committee (Hawkins et

al., 2018) stated, "The most current and pressing need in higher education is to improve

the quality and consistency of the bachelor's degree." (p. 415). Task force

recommendations related to this need include increasing the amount and quality of

fieldwork experience in the bachelor's RT curriculum, and improving fieldwork

supervision. Regarding fieldwork experiences specifically, the 560-hour internship is the

capstone experience for RT students. Ensuring that each RT student has a quality

internship that consistently meets the same standards would therefore be included in these

recommendations. Therefore, receiving guidance on orientation content for internship

supervisors, and/or requiring internship supervisors to complete a CS training program

prior to supervising interns could help to improve the "quality and consistency" of RT

internship experiences.

Based on the findings of the ATRA Higher Education Task Force, ATRA (2019)

discussed the need to improve the quality of fieldwork experiences for students in their

2025 strategic plan document. Two specific suggestions made in this document are to

develop a set of competencies to be part of an internship supervisor training, and then

promote this training as an accreditation requirement. Using the findings from this study,

ATRA could develop a CS training program, which could then become a requirement by

RT education accreditation bodies for all RTs to complete prior to supervising their first

intern. NCTRC could then offer continuing education units (CEUs) toward

recertification.

Based on the mixed methods results of this study, the following is a list of

suggested content for a CS training/certificate program for RTs; a) how, when, and in

what manner to provide feedback that is constructive and promotes growth in the intern;

b) how to communicate in an authentic manner that promotes mutual trust and respect; c)

how to systematically introduce competencies that build upon one another (i.e.,

scaffolded learning); d) the importance of modeling skills and professional behaviors; e)

how to locate resources that will expose the intern to skills and competencies in which

the supervisor themselves is deficient; f) when and how to intervene during an interaction

with a client (i.e., assessment or intervention) that does not diminish the intern's authority

with the client; g) how to adjust their style and approach based on intern personality and

situational needs; h) evidenced-based research on leadership theories and leadership

behaviors that promotes the development of high-quality relationships; i) and

understanding the difference between serving as a professional mentor versus a clinical

supervisor.

A final recommendation for the profession would be to add CS as a professional

practice standard in the ATRA-SOP manual, which was also suggested by Murray and

Shank (1994). While CS benefits the therapist, it ultimately benefits the client who

receives services by a skilled and competent therapist. As a professional standard of

practice, clinical supervisors in RT could use this as a guide to structure their clinical supervisory practices in the field, for interns and RT practitioners.

Future Research

While the findings in the current study support the need for CS and leadership education, additional research is needed to identify the most effective content and structure of this education. Once the content is developed, it will then need to be tested, which could help to determine at which stage it is most appropriate to receive CS education and training. It may also benefit the profession to have a CS model that is specific to RT practice. In order to develop this model, additional research is needed to identify its critical components. The Leadership Making model used in the current study, as well as literature on organizational coaching, could serve as a foundation.

This study also highlighted the need for a new competency measure that is better suited for research. The competency assessment tool used in this study was designed for students and practitioners to identify gaps in their knowledge, as well as for curriculum development and evaluation. While it served an important role in this study, developing a research related competency measure would allow for rigorous testing to determine validity and reliability of the tool. Such a tool could be used by other researchers to conduct additional CS and competency studies in RT. The tool could also be used as a self-measure for clinical supervisors and students to determine their areas of strength and deficit in the field.

An additional suggestion for future research would be to replicate this same study, but with the addition of a standardized client outcomes measure. While it is important for

the intern/practitioner to receive quality CS and mentorship to improve their skills and

competence, the ultimate purpose is so the intern/practitioner can provide quality RT

services to their clients. With this in mind, it will be necessary to test the effectiveness of

any CS education curriculum or program that is developed.

Study Limitations

Given the small sample size and the diverse nature of each participant's working

environment, the generalizability of this study is limited. However, the results of this

study do support the need for CS education and the importance of developing high-

quality relationships with interns. Recruitment time was also limited, which limited the

number of participants included in the study. Additionally, the design of this study

required the use of paired samples of intern and supervisor dyads, which prohibited the

use of random sampling. Therefore, convenience sampling was used, which limited the

ability to generalize the results of the study to other RT interns. Essentially, any intern or

CTRS who responded to recruitment efforts, with the consent of their counterpart to

participate, and who met the inclusion criteria, was allowed to participate in the study.

While news of the study likely reached several potential participants, only those

who contacted the PI, and subsequently agreed to sign the informed consent were able to

participate in the study. It is also possible that the sample of participants in this study

represent only those supervisors and interns who felt confident in their knowledge and

skills. A study of this nature, where one's vulnerabilities may be brought to light, could

have been a barrier for some to volunteer. Additionally, this could also have been a factor

in survey completion. In other words, someone who initially agreed to participate in the

study was later reluctant to complete the RT Competency Assessment for fear of

highlighting their knowledge deficits. This possibility became evident during the pilot

test, as two of the seasoned CTRSs verbalized that the content in the competency survey

caused them to question the extent of their own knowledge and skills.

Other potential limitations include the use of self-assessments and the length of

the RT Competency Assessment. Use of self-assessments to obtain data from participants

was thought to be a potential barrier, as they are not always deemed as reliable. Survey

fatigue was an additional concern in this study, as the RT Competency Assessment is a

lengthy instrument. Although it is currently the most comprehensive and detailed of the

available competency measures in the RT field, and it was later used to develop the

current CARTE guidelines for the accreditation of RT education, it is possible that survey

fatigue affected the reliability of participant responses.

Additional limitations were found in the demographic survey for the supervisors,

which should have included a question that asks how many interns each clinical

supervisor previously supervised. This question was not included in the current study,

and it is possible that it could be a factor related to intern competency development, or

clinical supervisor competence and leadership behaviors, as it relates to CS. The

demographic survey should have also requested an alternate email for all participants,

both students and interns, as school emails and work emails were not always reliable.

Following the end of their internship it became difficult to keep in contact with the

student interns, as most of them initially contacted the PI using their school email

address. Because of this, it is possible that some participants did not receive the email

with the final survey link, or the email that invited them to participate in a follow up

interview.

       While there are several opportunities to improve the methods of the current study,

the study design should continue to use supervisor-intern pairs. Using pairs was unique to

this study and will be vital to understanding the impact of relationship quality on intern

competency development in future studies.

Chapter 9

Conclusions

The purpose of this study was to understand the association between the leadership behaviors and competencies among clinical supervisors, the relationship quality between supervisors and interns, and how those variables impact competency development among RT interns. There is limited research available on CS in the RT field, which limits our ability to understand the effectiveness of what is being practiced by clinical supervisors. Additionally, there are no current requirements for recreational therapists to receive any type of training prior to supervising an intern.

Using a competency self-assessment and a relationship quality (i.e., leadership) measure, intern competency at the beginning of their internship and relationship quality between intern and supervisor were identified as prominent factors in intern competency development. Mixed methods results revealed that interns developed competencies as a result of effective communication, mentorship, leadership and supervisory skills from their supervisor, as well as from observing their supervisor demonstrate skills. Other relevant secondary findings highlighted the need for increased exposure to theories and modalities in the undergraduate level, as well as during the internship. Findings also highlighted that RT students begin their internship with adequate preparation in foundational knowledge, planning treatment/programs, and implementing treatment/programs.

Based on the findings in this study, several suggestions were made for clinical supervisors, RT educators, as well as for the RT profession, that could improve the

education, preparation, and provision of CS to RT interns and other professionals.

Suggestions were also made for how to improve the methods of the current study, as

further research is needed in this area.

Appendix A

Demographic Surveys

Practitioner demographics

1. Enter your assigned participant number. For example, CS-5 for "Clinical Supervisor 5"

2. What is your current age? (drop down menu ranging from 18-80)

3. What is your gender? (select one option)
   - ☐ Female
   - ☐ Male
   - ☐ Transgender Female
   - ☐ Transgender Male
   - ☐ Gender Variant/Non-Conforming
   - ☐ Prefer not to answer

4. How many years have you worked as a CTRS? Round to the nearest year (drop down menu ranging from 1-60 years)

5. How many years have you worked at your current facility? (drop down menu, ranging from less than 1 year to 60 years)

6. In what type of facility are you currently working? (check all that apply)
   - ☐ Hospital
   - ☐ Skilled Nursing Facility
   - ☐ Long-term care
   - ☐ Acute care
   - ☐ Sub-acute care
   - ☐ Residential/Transitional
   - ☐ Community
   - ☐ Outpatient rehabilitation/Day treatment
   - ☐ Inpatient rehabilitation
   - ☐ Adaptive Recreation Program
   - ☐ Assisted Living
   - ☐ Behavioral/mental health
   - ☐ Parks/recreation organization

☐ Correctional institution
☐ Disability support organization
☐ School/Education
☐ Private practice

7. What population do you currently work with? (check all that apply)
☐ Children
☐ Adolescents
☐ Young adults
☐ Adults
☐ Older adults

8. What's your highest level of education?
☐ Bachelor's degree
☐ Master's degree
☐ Doctorate degree

9. What degrees do you have in RT/TR? (Concentration or degree in RT/TR are applicable) (check all that apply)
☐ Bachelor of Science
☐ Master of Science
☐ Doctorate

10. What is the name of the university where you received your RT/TR degree? (fill in)

11. Was your RT/TR program accredited by the Committee on Accreditation of Recreational Therapy Education (CARTE) or the Council on Accreditation of Parks, Recreation, Tourism and Related Professions (COAPRT) at the time of your graduation?
   a. *Yes, it is accredited by CARTE*;
   b. *Yes, it is accredited by COAPRT*;
   c. *My program is in the process of obtaining CARTE accreditation*,
   d. *My program is in the process of obtaining COAPRT accreditation*, or *I don't know*.
   e. *No, my program is not accredited or in the process of being accredited by either organization*

12. Have you received any type of *clinical supervision education or training*?
    (Clinical supervision education or training includes any training that educated you
    on how to provide supervision and education to colleagues or interns while in the
    workplace for the purpose of enhancing their knowledge and improving their
    skills as a therapist.)
    - ☐ Yes
    - ☐ No

13. If yes to #12, please check all that apply
    - ☐ One or more lectures as part of a class in an undergraduate program
    - ☐ One or more lectures as part of a class in a graduate program
    - ☐ One or more classes during undergraduate program
    - ☐ One or more classes during a graduate program
    - ☐ Attended one session at a conference or workshop
    - ☐ A half-day training or workshop on clinical supervision
    - ☐ A full-day training or workshop on clinical supervision

14. Do you implement, in practice, the Standards of Practice published by the
    American Therapeutic Recreation Association?
    - ☐ Yes
    - ☐ No

15. If yes to #14, which documents within the ATRA-SOP do you use?
    - ☐ Self-Assessment
    - ☐ Management Audit
    - ☐ Documentation audit
    - ☐ I have written policies and procedures based on results from the self-
      assessment audit

Student demographics
1. Enter your assigned participant number. For example, In-5 for "Intern 5"

2. What is your current age? (drop down menu ranging from 18-80)

3. What is your gender? (select one option)
    - ☐ Female

☐ Male
☐ Transgender Female
☐ Transgender Male
☐ Gender Variant/Non-Conforming
☐ Prefer not to answer

4. What is the name of university where you currently attend? (fill in)

5. What is your current class standing?
   ☐ Freshman
   ☐ Sophomore
   ☐ Junior
   ☐ Senior
   ☐ Graduate student

6. Is your RT/TR program currently accredited by the Committee on Accreditation of Recreational Therapy Education (CARTE) or the Council on Accreditation of Parks, Recreation, Tourism and Related Professions (COAPRT)? Options will be;
   a. *Yes, it is accredited by CARTE*;
   b. *Yes, it is accredited by COAPRT*;
   c. *My program is in the process of obtaining CARTE accreditation*,
   d. *My program is in the process of obtaining COAPRT accreditation*, or *I don't know*.
   e. *No, my program is not accredited or in the process of being accredited by either organization*
   f. I don't know

7. As a student, have you received any classes thus far in clinical supervision? Clinical supervision education or training includes any training that educated you on how to provide supervision and education to colleagues or interns while in the workplace for the purpose of enhancing their knowledge and improving their skills as a therapist.
   ☐ Yes
   ☐ No

8. If yes to #7, please check all that apply
   ☐ One or more lectures as part of a class in an undergraduate program
   ☐ One or more lectures as part of a class in a graduate program

☐   One or more classes during undergraduate program
☐   One or more classes during a graduate program
☐   Attended one session at a conference or workshop
☐   A half-day training or workshop on clinical supervision
☐   A full-day training or workshop on clinical supervision

9. Thinking back to the RT/TR classes you have taken so far, which of the following content areas were covered in those classes?
☐   Foundations of Professional Practice
☐   Individualized Patient/Client Assessment
☐   Planning Treatment/Programs
☐   Implementing Treatment/Programs
☐   Modalities and Facilitation Techniques
☐   Evaluating Treatment/Programs
☐   Managing Recreational Therapy Practice

10. When is the last week of your internship? Example: August 20-24 (fill in)

Appendix B

LMX-7: Revised, mirrored version

Supervisor version

1. **I know where I stand with my follower and I usually know how satisfied my follower is with what I do.**
   1= strongly disagree
   2= disagree
   3= neutral
   4= agree
   5= strongly agree

2. **My follower understands my job problems and needs.**
   1= strongly disagree
   2= disagree
   3= neutral
   4= agree
   5= strongly agree

3. **My follower recognizes my potential.**
   1= strongly disagree
   2= disagree
   3= neutral
   4= agree
   5= strongly agree

4. **Regardless of how much formal authority my follower has built into his or her position, my follower would use his or her power to help me solve problems in my work.**
   1= strongly disagree
   2= disagree
   3= neutral
   4= agree
   5= strongly agree

5. **Again, regardless of the amount of formal authority my follower has, my follower would "bail me out" at his or her expense.**
1= strongly disagree
2= disagree
3= neutral
4= agree
5= strongly agree

6. **I have enough confidence in my follower that I would defend and justify his or her decision if he or she were not present to do so.**
1= strongly disagree
2= disagree
3= neutral
4= agree
5= strongly agree

7. **I would characterize my working relationship with my follower as;**

1= Extremely Ineffective
2= Worse than average
3= Average
4= Better than average
5= Extremely effective

Intern version

1. **I know where I stand with my leader and I usually know how satisfied my leader is with what I do.**
1= strongly disagree
2= disagree
3= neutral
4= agree
5= strongly agree

2. **My leader understands my job problems and needs.**
1= strongly disagree
2= disagree
3= neutral

4= agree
5= strongly agree

3. **My leader recognizes my potential.**
   1= strongly disagree
   2= disagree
   3= neutral
   4= agree
   5= strongly agree

4. **Regardless of how much formal authority my leader has built into his or her position, my leader would use his or her power to help me solve problems in my work.**
   1= strongly disagree
   2= disagree
   3= neutral
   4= agree
   5= strongly agree

5. **Again, regardless of the amount of formal authority my leader has, my leader would "bail me out" at his or her expense.**
   1= strongly disagree
   2= disagree
   3= neutral
   4= agree
   5= strongly agree

6. **I have enough confidence in my leader that I would defend and justify his or her decision if he or she were not present to do so.**
   1= strongly disagree
   2= disagree
   3= neutral
   4= agree
   5= strongly agree

7. **I would characterize my working relationship with my leader as;**

Extremely ineffective	Worse than average	Average	Better than average	Extremely effective

Appendix C

RT Competency Assessment

COMPETENCY SELF-ASSESSMENT – DETAIL FORM

FOUNDATIONS OF PROFESSIONAL PRACTICE:

The curriculum should provide students with the opportunity to integrate an understanding of history, service models, theory/philosophy, ethics, credentials, professional conduct, evidence-based practice and professional development with recreational therapy (RT) practice.

Competency Statements:	Perceived Level of Competence: 1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence				
1. Knowledge of the historical foundations and evolution of the RT/TR profession.	1	2	3	4	5
2. Knowledge of the philosophical concepts/definitions of TR/RT and implications for service delivery.	1	2	3	4	5
3. Knowledge of the health care and human service systems and the role and function of RT and allied disciplines within each.	1	2	3	4	5
4. Knowledge of the role of RT in relation to allied disciplines and the basis for collaboration with patient care services.	1	2	3	4	5
5. Knowledge of personal and societal attitudes related to health, illness and disability.	1	2	3	4	5
6. Knowledge of RT service delivery models and practice settings.	1	2	3	4	5
7. Knowledge of the RT process: assessment, treatment planning, implementation and evaluation.	1	2	3	4	5
8. Knowledge of the concepts of health, habilitation, rehabilitation, treatment, wellness, prevention and evidence-based practice as related to RT practice.	1	2	3	4	5
9. Knowledge of the role and responsibilities of levels of personnel providing RT services (RT, RT assistant, supervisor/manager and volunteers).	1	2	3	4	5
10. Knowledge of the role and responsibilities of a recreational therapist working as an integral part of the interdisciplinary treatment process.	1	2	3	4	5
11. Knowledge of the theories and principles of therapeutic/helping relationships.	1	2	3	4	5
12. Knowledge of recreational therapist's role as an advocate for client's rights.	1	2	3	4	5
13. Knowledge of the principles and processes of interdisciplinary treatment teams.	1	2	3	4	5
14. Knowledge of the development and purpose of TR/RT professional organizations at the local, state, and national levels.	1	2	3	4	5
15. Knowledge of TR/RT standards of practice and ethical codes.	1	2	3	4	5
16. Knowledge of current ethical issues in health care and human services.	1	2	3	4	5
17. Knowledge of professional credentialing requirements and processes: registration, certification, licensure.	1	2	3	4	5
18. Knowledge of agency accreditation processes applicable to RT services.	1	2	3	4	5
19. Knowledge of personal responsibility for continuing professional education and of appropriate resources.	1	2	3	4	5

CURRICULUM SELF-ASSESSMENT – DETAIL FORM

FOUNDATIONS OF PROFESSIONAL PRACTICE:
(continued)

Competency Statements:	Perceived Level of Competence: 1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence				
20. Knowledge of principles of the normalization, inclusion, self-determination, social role valorization, empowerment and personal autonomy.	1	2	3	4	5
21. Knowledge of issues/influences shaping the future of RT.	1	2	3	4	5
22. Skill in applying the principles of the RT process in individual and group treatment programs service delivery).	1	2	3	4	5
23. Skill in applying techniques of evidence-based practice to recreational therapy practice.	1	2	3	4	5
24. Ability to communicate the purpose, techniques and effectiveness of RT to colleagues, consumers, and the public.	1	2	3	4	5
25. Ability to analyze, evaluate and apply models of practice in various settings.	1	2	3	4	5
26. Ability to use standards of practice and ethical codes in directing interactions with patients/clients and colleagues and in the design and implementation of RT Services.	1	2	3	4	5
27. Ability to comply with professional credentialing standards.	1	2	3	4	5
28. Ability to comply with agency or institutional clinical privileging and/or competency requirements.	1	2	3	4	5
29. Ability to evaluate personal practice skills; seek resources to continually improve practice skills; and incorporate enhanced knowledge and skill into daily practice.	1	2	3	4	5

COMPETENCY SELF-ASSESSMENT – DETAIL FORM

INDIVIDUALIZED PATIENT/CLIENT ASSESSMENT:

The curriculum should provide students with the opportunity to develop competence to individually screen, assess and systematically collect comprehensive and accurate data about patients/clients in an efficient and effective manner and to analyze the data collected to determine the course of actions subsequent to an individualized treatment/program plan.

Competency Statements:	Perceived Level of Competence: 1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence				
1. Knowledge of psychometric properties of tests and measurements.	1	2	3	4	5
2. Knowledge of evidence-based recreational therapy/therapeutic recreation assessment instruments used to determine physical, cognitive, emotional, and social functioning of patients/clients.	1	2	3	4	5
3. Knowledge of the evidence of problems and limitations for the specific medical, psychiatric or other disabling conditions being treated.	1	2	3	4	5
4. Knowledge of the impact of limitations in physical, cognitive, social and emotional functioning upon independence in life activities including work/school, self-maintenance and leisure.	1	2	3	4	5
5. Knowledge of evidence-based assessment instruments from other health care disciplines that may be relevant to recreational therapy practice.	1	2	3	4	5
6. Knowledge of the World Health Organization's (WHO) International Classification of Functioning, Disability and Health (ICF) as a method of assessing individual functioning and the impact of activity limitations and restrictions to participation in life activities, independence, satisfaction and quality of life.	1	2	3	4	5
7. Knowledge of interviewing stages and strategies.	1	2	3	4	5
8. Knowledge of the nature and function of documentation procedures and systems related to client assessment.	1	2	3	4	5
9. Knowledge of goals and mission of the various service settings as determinants for assessment procedures and protocols.	1	2	3	4	5
10. Skill in defining and measuring a variety of functional behaviors relevant to specific disabling conditions and to the practice of RT.	1	2	3	4	5
11. Skill in the use of behavioral observations.	1	2	3	4	5
12. Skill in the use of a variety of standardized and non-standardized instruments, batteries and rating systems.	1	2	3	4	5
13. Skill in the use of functional performance testing.	1	2	3	4	5
14. Skill in the use of rapid assessment instruments (RAI) and their application to recreational therapy practice.	1	2	3	4	5
15. Skill in gathering and use of relevant information from records, charts, family, significant others, and other professionals.	1	2	3	4	5
16. Ability to determine the need for further assessment(s).	1	2	3	4	5
17. Ability to determine and document the appropriateness of a referral for RT services.	1	2	3	4	5
18. Ability to involve clients/patients, families and their significant others in the assessment process.	1	2	3	4	5

CURRICULUM SELF-ASSESSMENT – DETAIL FORM

INDIVIDUALIZED PATIENT/CLIENT ASSESSMENT:

(continued)

Competency Statements:	Perceived Level of Competence:				
	1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence				
19. Ability to conduct a systematic interview.	1	2	3	4	5
20. Ability to select the appropriate assessment instrument(s) for a selected patient/client.	1	2	3	4	5
21. Ability to analyze, interpret and incorporate assessment and evidence-based practice findings into a patient/client data base that is used to develop functional outcome goals to be included in an individualized treatment plan.	1	2	3	4	5
22. Ability to document assessment findings and review findings and implications for treatment with client, family, significant others, and team members.	1	2	3	4	5
23. Ability to assess the need for assistive technologies and devices to maximize functional abilities and independence in life activities.	1	2	3	4	5

COMPETENCY SELF-ASSESSMENT – DETAIL FORM

PLANNING TREATMENT/PROGRAMS:

The curriculum should provide students with the opportunity to develop competence in the planning and development of individualized treatment plans that identify functional outcome goals, modalities, facilitation techniques and interventions, based on assessment data collected and evidence regarding the diagnosis and treatment of specific medical, psychiatric and other disabling conditions. The curriculum should prepare students to use structured, systematic and evidence-based treatment interventions and facilitation techniques to improve patient/client functioning and independence in life activities.

Competency Statements:	Perceived Level of Competence:				
	1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence				
1. Knowledge of the components of a comprehensive treatment/program plan as required by regulatory agencies and professional standards of practice.	1	2	3	4	5
2. Knowledge of the scope of practice of therapeutic recreation for treatment/program planning.	1	2	3	4	5
3. Knowledge of the systems approach to program planning and service delivery.	1	2	3	4	5
4. Knowledge of documentation procedures relevant to the processes of treatment and discharge planning.	1	2	3	4	5
5. Knowledge of assistive techniques and devices to facilitate appropriate treatment interventions.	1	2	3	4	5
6. Knowledge of resources available to the recreational therapist in planning and implementing services.	1	2	3	4	5
7. Skill in constructing treatment plans that incorporate patient/client strengths, resources and preferences.	1	2	3	4	5
8. Skill in designing discharge/transition plans relevant to patient/client resources, support systems and needs.	1	2	3	4	5
9. Skill in activity and task analysis.	1	2	3	4	5
10. Skill in integrating systematic methods of patient/client evaluation and program evaluation into treatment/program plans.	1	2	3	4	5
11. Ability to involve the patient/client, family and significant others, as appropriate, in the design of the treatment plan.	1	2	3	4	5
12. Ability to systematically apply assessment, quality improvement and evidence-based practice data in designing the treatment plan.	1	2	3	4	5
13. Ability to communicate and document the treatment plan to the patient/client, family, significant others, and all members of the treatment team.	1	2	3	4	5
14. Ability to apply accreditation, regulatory and therapeutic recreation standards of practice in the development, implementation, and evaluation of treatment plans/programs.	1	2	3	4	5
15. Ability to develop and use interdisciplinary collaboration in the design and implementation of treatment/program plans.	1	2	3	4	5
16. Ability to select evidence-based treatment interventions/programs according to diagnosis, age, cultural, socioeconomic factors, and patient/client preferences to treat problems and limitations associated with specific medical, psychiatric or other disabling conditions.	1	2	3	4	5

CURRICULUM SELF-ASSESSMENT – DETAIL FORM

PLANNING TREATMENT/PROGRAMS:
(continued)

Competency Statements:	Perceived Level of Competence:
	1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence
17. Ability to design and plan evidence-based treatment interventions/programs, protocols, guidelines and pathways, including such factors as contraindications, precautions, accommodations and adaptations, to improve physical, cognitive, social or emotional functioning of patients/clients.	1 2 3 4 5
18. Ability to select appropriate treatment interventions/programs, including such factors as type, frequency, duration and intensity, to achieve stated goals and outcomes.	1 2 3 4 5
19. Ability to use evidence-based treatment interventions/programs, protocols, guidelines, and pathways and facilitation techniques to accomplish desired outcomes.	1 2 3 4 5
20. Ability to write functional outcome goals, and other forms of documentation related to treatment design.	1 2 3 4 5

COMPETENCY SELF-ASSESSMENT -- DETAIL FORM

IMPLEMENTING TREATMENT/PROGRAMS:

The curriculum should provide students with the opportunity to develop competence to implement the individualized treatment/program plan using appropriate evidence-based treatment interventions and programs to restore, remediate, or rehabilitate patient/client functioning as well as to reduce or eliminate the limitations to participation in life activities resulting from medical, psychiatric or other disabling conditions. Treatment interventions/modalities and facilitation techniques commonly used by recreational therapists are identified on page 15. It is not suggested that all entry-level recreational therapists should have competence in every treatment intervention identified. However, those entering the profession should have measured competence (e.g., knowledge, skill and ability) to lead and facilitate the treatment interventions used to achieve evidence-based outcomes for the patients/clients served. It is recommended that the recreational therapist have specific education/training, assessed competency and/or the prevailing credentials in each treatment intervention used.

Competency Statements:	Perceived Level of Competence: 1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence				
1. Knowledge of goals and mission of the institution/agency/organization as determinants for treatment/program intervention.	1	2	3	4	5
2. Knowledge of principles underlying the therapeutic/helping process, with emphasis upon interaction between the RT and the patient/client.	1	2	3	4	5
3. Knowledge of the role of the recreational therapist as a member of the interdisciplinary treatment team.	1	2	3	4	5
4. Knowledge of counseling theories and their relevance to specific interventions.	1	2	3	4	5
5. Knowledge of individual and group leadership and helping theories and techniques.	1	2	3	4	5
6. Knowledge of adjustment or activity modification principles for adaptation to the needs of the individual patient/client.	1	2	3	4	5
7. Knowledge of evidence-based treatment interventions/programs typically used to reach treatment outcomes for specific medical, psychiatric or other disabling conditions.	1	2	3	4	5
8. Knowledge of legal and ethical ramifications of treatment service delivery.	1	2	3	4	5
9. Skill in establishing an effective therapeutic/helping relationship.	1	2	3	4	5
10. Skill in designing evidence-based treatment interventions to implement the individual treatment plan of the patient/client.	1	2	3	4	5
11. Skill in effective oral and written communication.	1	2	3	4	5
12. Skill in applying individual and group leadership/helping techniques.	1	2	3	4	5
13. Skill in assisting the patient/client to process the treatment intervention, thereby enhancing self-awareness and formulating conclusions relevant to treatment goals and objectives.	1	2	3	4	5
14. Skill in facilitating a variety of evidence-based treatment interventions or modalities, such as games, exercise, community reintegration, etc., to reach treatment outcomes.	1	2	3	4	5
15. Skill in using a variety of facilitation techniques, such as social skills training, cognitive learning theories or behavioral theories, etc., to reach treatment outcomes.	1	2	3	4	5
16. Ability to develop and/or select and implement treatment interventions appropriate to the goals and objectives and consistent with evidence-based practice and patient/client preferences to achieve optimal functional outcomes for patients/clients.	1	2	3	4	5

CURRICULUM SELF-ASSESSMENT – DETAIL FORM

IMPLEMENTING TREATMENT/PROGRAMS:
(continued)

Competency Statements:	Perceived Level of Competence:
	1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence

Competency Statements:	1	2	3	4	5
17. Ability to effectively involve patient/client, family and significant others in implementing treatment interventions.	1	2	3	4	5
18. Ability to apply knowledge of the effects of pharmaceutical agents upon the health and behavior of patients/clients when implementing treatment.	1	2	3	4	5
19. Ability to apply knowledge of multicultural considerations when implementing treatment.	1	2	3	4	5
20. Ability to effectively use a variety of assistive techniques, devices and equipment to meet patient/client needs.	1	2	3	4	5
21. Ability to modify or discontinue treatment interventions, as appropriate in adapting to changing conditions in the patient/client or treatment environment.	1	2	3	4	5
22. Ability to apply behavior management strategies and helping techniques.	1	2	3	4	5
23. Ability to document patient's/client's response to interventions.	1	2	3	4	5

COMPETENCY SELF-ASSESSMENT – DETAIL FORM

MODALITIES AND FACILITATION TECHNIQUES:

It is not suggested that all entry-level recreational therapists should have competence in every treatment intervention identified or that all possible modalities or facilitation techniques are identified. However, those entering the profession should have measured competence (e.g., knowledge, skill and ability) to lead and facilitate the treatment interventions used to achieve evidence-based outcomes for the patients/clients served. It is recommended that the recreational therapist have specific education/training, assessed competency and/or the prevailing credentials in each treatment intervention used. It is also recommended that the recreational therapist have specific training in the facilitation techniques or theories used as the basis for the treatment intervention or modality used.

Modalities:	Perceived Level of Competence: 1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence				
Activities of daily living	1	2	3	4	5
Adventure experiences/initiatives	1	2	3	4	5
Animal-facilitated interventions	1	2	3	4	5
Anger Management training	1	2	3	4	5
Aquatics	1	2	3	4	5
Arts/crafts	1	2	3	4	5
Assertiveness training	1	2	3	4	5
Athletics/sports	1	2	3	4	5
Behavior Management Training	1	2	3	4	5
Bibliotherapy/storytelling	1	2	3	4	5
Biofeedback Training	1	2	3	4	5
Cognitive retraining	1	2	3	4	5
Conditioning/weight training	1	2	3	4	5
Community reintegration	1	2	3	4	5
Communication skills training	1	2	3	4	5
Coping skills training	1	2	3	4	5
Dance/movement	1	2	3	4	5
Drama	1	2	3	4	5
Empowerment/self esteem experiences	1	2	3	4	5
Exercise (all types including Yoga, Qigong, etc.)	1	2	3	4	5
Games/sports	1	2	3	4	5
Horticulture	1	2	3	4	5
Humor	1	2	3	4	5
Journaling/writing	1	2	3	4	5

CURRICULUM SELF-ASSESSMENT – DETAIL FORM

MODALITIES AND FACILITATION TECHNIQUES:
(continued)

Modalities:	Perceived Level of Competence:
	1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence

Modalities:					
Leisure education experiences	1	2	3	4	5
Martial arts (all types including Tai Chi, etc.)	1	2	3	4	5
Meditation	1	2	3	4	5
Music	1	2	3	4	5
Outdoor recreation experiences	1	2	3	4	5
Pre/post operative/procedural training	1	2	3	4	5
Problem solving experiences	1	2	3	4	5
Reality orientation experiences	1	2	3	4	5
Relaxation training	1	2	3	4	5
Remotivation training	1	2	3	4	5
Resocialization experiences	1	2	3	4	5
Sensory stimulation	1	2	3	4	5
Service activities/projects	1	2	3	4	5
Social Skills Training	1	2	3	4	5
Special events	1	2	3	4	5
Spirituality	1	2	3	4	5
Stress management/relaxation training	1	2	3	4	5
Therapeutic play activities	1	2	3	4	5
Values clarification experiences	1	2	3	4	5

CURRICULUM SELF-ASSESSMENT – DETAIL FORM

MODALITIES AND FACILITATION TECHNIQUES:
(continued)

Facilitation Techniques/Theories:	Perceived Level of Competence: 1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence				
Behavioral theory/therapy/modification	1	2	3	4	5
Behavioral medicine theories	1	2	3	4	5
Cognitive behavioral therapy	1	2	3	4	5
Crisis intervention theory	1	2	3	4	5
Developmental theory	1	2	3	4	5
Dialectical behavior therapy	1	2	3	4	5
Existential theories	1	2	3	4	5
Family treatment theories	1	2	3	4	5
Gestalt therapy	1	2	3	4	5
Group treatment theories	1	2	3	4	5
Helping/counseling theories	1	2	3	4	5
• Behavioristic theories	1	2	3	4	5
• Cognitive-Behavioral	1	2	3	4	5
• Growth or Positive psychology	1	2	3	4	5
• Psychoanalytic	1	2	3	4	5
Learned optimism/positive psychology	1	2	3	4	5
Motivational Interviewing theory	1	2	3	4	5
Person-Centered therapy	1	2	3	4	5
Rational-emotive therapy	1	2	3	4	5
Reminiscence theory	1	2	3	4	5
Resiliency/Hardiness theories	1	2	3	4	5
Social learning theory	1	2	3	4	5
• Attribution	1	2	3	4	5
• Learned helplessness	1	2	3	4	5
• Self-concept	1	2	3	4	5
• Social support	1	2	3	4	5
• Self-efficacy, etc. .	1	2	3	4	5

CURRICULUM SELF-ASSESSMENT – DETAIL FORM

MODALITIES AND FACILITATION TECHNIQUES:
(continued)

Facilitation Techniques/Theories:	Perceived Level of Competence:				
	1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence				
Transactional analysis theories	1	2	3	4	5
Validation theory	1	2	3	4	5

COMPETENCY SELF-ASSESSMENT – DETAIL FORM

EVALUATING TREATMENT/PROGRAMS:

The curriculum should provide students with the competency to systematically conduct evaluation and research to determine the effectiveness of treatment interventions and programs used to reach patient/client outcomes.

Competency Statements:	Perceived Level of Competence: 1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence				
1. Knowledge of a variety of systematic methods of evaluation and research.	1	2	3	4	5
2. Knowledge of formative and summative methods and resources used to evaluate the efficiency and effectiveness of recreational therapy services.	1	2	3	4	5
3. Knowledge of documentation procedures for program planning, accountability, and payment of service.	1	2	3	4	5
4. Knowledge of methods for interpreting client/patient progress and outcomes as a basis for program evaluation.	1	2	3	4	5
5. Knowledge of evaluation requirements of regulatory agencies.	1	2	3	4	5
6. Skill in designing and using a variety of evaluation methods to analyze client/patient outcomes and the effectiveness of the treatment interventions.	1	2	3	4	5
7. Ability to evaluate the recreational therapy program for effectiveness and efficiency.	1	2	3	4	5
8. Ability to interpret data, to modify treatment interventions and programs and to formulate recommendations for continued patient/client treatment or aftercare.	1	2	3	4	5
9. Ability to use treatment/program evaluation data and research to develop or refine protocols, guidelines and pathways to achieve effective client/patient outcomes on a predictable and consistent basis.	1	2	3	4	5
10. Ability to involve patients/clients and significant others in the reassessment of functioning and progress related to the individualized treatment/program plan, plans for discharge and aftercare, and intervention/program evaluation.	1	2	3	4	5
11. Ability to use program evaluation and applied research techniques to demonstrate program/service accountability.	1	2	3	4	5

COMPETENCY SELF-ASSESSMENT – DETAIL FORM

MANAGING RECREATIONAL THERAPY PRACTICE:

It is expected that the curriculum will provide students with the opportunity to develop the basic competencies to manage their practice. Additional competencies are needed to manage a department and/or additional staff.

Competency Statements:	Perceived Level of Competence: 1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence				
1. Knowledge of the organization and delivery of health care and human services.	1	2	3	4	5
2. Knowledge of position design, classification, recruitment, orientation/training, supervision and performance management of personnel as an integrated human resource system.	1	2	3	4	5
3. Knowledge of techniques of financing, budgeting, cost accounting, rate setting and fiscal accountability.	1	2	3	4	5
4. Knowledge of governmental, professional, agency, and accreditation standards and regulations.	1	2	3	4	5
5. Knowledge of the principles and practices of promotions, public relations, and marketing.	1	2	3	4	5
6. Knowledge of practices of managing resources including personnel, facilities, supplies, and equipment.	1	2	3	4	5
7. Knowledge of principles and requirements for safety and risk management.	1	2	3	4	5
8. Knowledge of facility planning processes.	1	2	3	4	5
9. Knowledge of strategic planning processes.	1	2	3	4	5
10. Knowledge of legal requirements pertaining to delivery of health care and human services and recreational therapy.	1	2	3	4	5
11. Skill in using computers/systems for managing information and data.	1	2	3	4	5
12. Skill in applying ethical and conduct standards to practice.	1	2	3	4	5
13. Skill in practicing safety, emergency, infection control and risk management procedures.	1	2	3	4	5
14. Skill in scheduling, time management, and prioritization of tasks and decisions.	1	2	3	4	5
15. Skill in managing productivity and labor resources.	1	2	3	4	5
16. Skill in providing clinical supervision and education to staff and students.	1	2	3	4	5
17. Ability to apply knowledge of theory, techniques, and practices of quality improvement to managing service delivery.	1	2	3	4	5
18. Ability to balance cost and quality to provide necessary and effective evidence-based care.	1	2	3	4	5

CURRICULUM SELF-ASSESSMENT – DETAIL FORM

MANAGING RECREATIONAL THERAPY PRACTICE:
(continued)

Competency Statements:	Perceived Level of Competence:
	1 = No perceived competence 2 = Minimal perceived competence 3 = Average perceived competence 4 = High perceived competence 5 = Very high perceived competence
19. Ability to manage and use scientific, technological and patient/client information to assess and adapt physical/environmental barriers to optimize patient/client independence in life activities.	1 2 3 4 5
20. Ability to manage the practice of recreational therapy within legal and ethical requirements of health care, the agency and the profession.	1 2 3 4 5
21. Ability to collaborate with administrators and allied disciplines regarding the delivery and management of recreational therapy services provided to patients/clients.	1 2 3 4 5

Appendix D

Individual Interview Guide

Read verbatim: *My name is Heather and I am a Clemson University PhD student. We are here to understand your experience as a clinical supervisor or intern. You are encouraged to share any thoughts related to your experience. Your participation will only be needed once. Please keep in mind that your participation is voluntary, and you can request for the interview to stop at any time. You can also pause the interview at any time to ask clarifying questions. Upon request I can supply you with contact information of the faculty supervising this study. The information provided will remain strictly confidential and you will not be identified by your answers. Deidentified data will only be shared with the PI and possibly the Clemson faculty assisting with the research project. You may choose not to answer any question. Your name will not be disclosed in any way. Data will be compiled as a whole with no individual responses tied to your name or any identifying information about you. All information disclosed during the interview will be kept in a secure location. This conversation will be recorded using audio and video, and I will take notes as well. After this interview is transcribed, you will receive an email with a copy of the transcription attached, which will allow you to verify your responses. Do you have any questions before we get started? Do I have your permission to begin video and audio recording?*

Checklist:
- ☐ Laptop opened/turned on and Word document or notebook open in order to take notes
- ☐ Script is read verbatim
- ☐ Is the video and audio recording working
- ☐ Can the participant hear me?
- ☐ Can I hear the participant?
- ☐ Verbally **state the session number**, **participant number**, and **the date** (same as participant number used during the quantitative portion of the study.
- ☐ Engage the participant in informal conversation to decrease anxiety, before starting the interview
- ☐ Document all follow up questions in the session notes, as well as the participant responses
- ☐ Take notes on the participants environment and body language, and my interpretation of these things.
- ☐ Provide participant with an opportunity to share information that was not asked about

At the end of the interview:
- ☐ Inform participant that the interview is over.
- ☐ Thank them for their participation

☐ Remind them they will be contacted by the PI via email to confirm the accuracy of the transcription of the interview.

After the interview:

☐ Label all handwritten or electronic notes using the session number, participant number and date.

Qualitative Interview Guide (for supervisor)

1. How many interns have you supervised as a CTRS?

2. How would you describe the intern's RT competency development during her/his internship?
   a. Can you provide some specific examples of how you identified this competency development?

3. In what ways do you think you influenced the competency development of your student during their internship?
   a. How has your own level of <u>RT competency</u> impacted your intern's competency development?
      i. Can you provide specific examples of this?
      ii. Can you think of any RT competencies where you need improvement in order to help the intern develop more in those areas?

   b. What role do you think <u>your leadership behaviors</u> have played in the intern's competency development?
      i. Which of your leadership behaviors do you think have been the most influential?
      ii. Can you think of any examples of your leadership behaviors that may have hindered this specific intern's competency development?

4. What ways do you think your intern has further developed competencies during her/his internship that had nothing to do with your supervision?
   a. What <u>environmental or administrative factors</u> do you think impacted your ability to supervise or be the kind of leader you want to be?

5. What prepared you to be a clinical supervisor?

6. What leadership behaviors do you think you mimic from your own supervisor, from when you completed your own internship?

Qualitative Interview Guide (for intern)

1. How would you specifically describe your competency development during your internship?
    a. Can you provide some specific examples of how you identified your development in these areas?

2. In what ways has your supervisor influenced your competency development?
    a. How has your supervisor's competency in RT practice impacted the development of your own competencies during this internship?
        i. Can you provide specific examples of this?
        ii. Can you think of any examples where you think your development as an intern would be improved if your supervisor was stronger in specific competencies?

    b. What role do you think your supervisor's leadership behaviors have played in your competency development during internship?
        i. Which of those behaviors do you think influenced your development the most?
        ii. Can you think of any leadership behaviors that negatively impacted your development as an intern?

3. What ways have you developed competencies during your internship that were unrelated to your supervisor's influence?
    a. Were there any environmental or administrative factors that you think impacted your ability to learn and develop competencies, as it specifically relates to RT/TR?

4. What prepared you to receive clinical supervision?

5. What leadership behaviors would you likely mimic based on how these behaviors made you feel and/or their effect on your competencies?

Appendix E

Definitions for Reference During Interview

Competencies: Refers to the knowledge, skills, and abilities needed to perform a specific job or job tasks

Competency development- refers to those competencies that are developed over the course of the internship, through direct contact with supervisor or through other means.

Leader: in the study, refers to the clinical supervisor

Leadership Behaviors: Refer to the actions, decisions, and personality of the leader (i.e., clinical supervisor).

Follower: in this study, refers to the RT/TR intern

Follower behaviors: refers to the actions, decisions and personality of the follower (i.e., RT/TR intern).

Appendix F

Stream of Consciousness Reflexivity Statement

I have been a Certified Therapeutic Recreation Specialist (CTRS) since 2007. My experience includes physical rehabilitation, long term care, community inclusion programs, and community day programs for older adults. Based on my experience in each of these settings, my opinion of clinical supervision in Recreational Therapy is that that the profession lacks focus on this important issue and as a result the interns do not receive a quality experience, which likely effects client outcomes. The connection between leadership and clinical supervision is centered around my belief that a good supervisor will have also have good leadership qualities. Essentially, poor leadership leads to poor clinical supervision, which leads to poorly trained RT interns, which impacts the quality of care that those interns eventually provide to their clients and/or the quality of supervision that they provide to their subsequent interns. As a practitioner I had a volatile working relationship with a supervisor that lasted for nearly four years. My experience with this individual had a significant and negative impact on my self-esteem and made me question my own competence. Ironically, this supervisor preached about the importance of leadership, and even shared quotes and short videos as a part of our weekly staff meetings. Unfortunately, she was not good at practicing what she preached. Quite honestly, she was the last person on Earth who should have been leading anyone. Her mood was unpredictable, and she had no qualms about belittling her subordinates in the presence of other staff. She made sure to assert her authority any time her back was against the wall. As a staff member who worked directly beneath her, I often felt the need

to protect my own subordinates from her, as I did not want them to be subjected to her

abusive ways. This experience had a profound effect on my own management and

leadership style. As a manager I was not always perfect, but I strived to never make my

followers feel the way she made her followers feel. This experience, plus my experience

as an intern and then as a clinical supervisor led me to my interest in studying clinical

supervision, specifically clinical supervision in Recreational Therapy.

As a student intern myself I completed a 15-week internship under the supervision of four

Recreational Therapists and one music therapist. I had a primary supervisor, who was a

Certified Therapeutic Recreation Specialist (CTRS), who was responsible for facilitating

my rotations on each of the treatment teams at the rehabilitation hospital. As a student, I

noted that the approach of each Recreational Therapist was different, and their individual

skills as a practitioner varied. One RT was quite meticulous about detailed

documentation, while another RT had such horrible handwriting that it was nearly

impossible to read her notes, some of which consisted of five to ten words to describe the

session. These were the two extremes of clinical competencies that were demonstrated by

my team of supervisors during my internship, as the rest of my supervisors fell

somewhere in the middle of this spectrum. Fast forward to me supervising my first two

interns (about seven years after being an intern myself), while working at a community-

based camp for people with disabilities. While both interns were equally friendly and

eager to learn, each required differing amounts of one on one supervision. One intern

picked up on things quickly, had good intuition when working participants, and did well

with adjusting her performance based on my feedback. The other intern required more

one on one time to ensure that she understood the connection between identifying client

deficits and the chosen interventions. She also received feedback well but was not as

good at applying it in order to improve her performance. For example, she also got along

well with the participants in the program, but at times her communication style and tone

of voice was infantizing. By the end of her internship, she was still inconsistent with

eliminating that infantizing approach. I think this had a lot to do with her personality and

maturity level, rather than how she viewed the participants. Despite the difference in

approaches I used with these two interns, my opinion of our working relationship

throughout their internships were positive. Although, I will never know how they truly

felt about it, which is one of the reasons why I chose to use the Leader-Member

Exchange theory for my dissertation. Because no one is perfect, including clinical

supervisors, I think the student's thoughts, feelings, and opinions should also be

considered.

Fast forward a few years, and I am in a new position, working as an RT, providing direct

client care again. My first summer in this position and I find myself with my first difficult

RT intern. This particular intern was difficult because she became confused easily and

had difficulty understanding or even accepting feedback. I spent a significant amount of

one on one time with her to review proper documentation and implementation

techniques. The frustration I had with this intern was that I spent a large amount of time

giving her feedback, but then she did not apply my feedback to improve her performance.

When I brought this to her attention, she would become defensive and say that she was

trying. Unfortunately, from my perspective it seemed like she was giving minimal effort

because she was comfortable with her way of doing things. During one meeting she

began to cry and it was hard for me to have sympathy because at that point I viewed her

as lazy and manipulative. Conversations with her faculty supervisor confirmed that this

was typical behavior for this student. While this information did not help the situation, it

at least provided some context and explanation as to what I was experiencing as her

supervisor. In hind sight I could have taken a different approach with this intern, and

perhaps had better results. As it stood by the end of her 14-week internship, we were both

glad that our time together had come to an end. Based on this experience I always

questioned what exactly she learned from me and/or what specific field competencies she

developed as a result of my guidance and leadership. And then my thoughts expanded

further into what other RT interns experience. This thought, coupled with the myriad

services settings, has me truly wondering what clinical supervision is like in the field of

Recreational Therapy. My hope is to find that the majority of the professionals are

providing quality internship experiences, however, based on anecdotal reports from

colleagues regarding RT's being spread too thin, as well as the "lazy RT's" (a term some

of my colleagues have used) in the field, I fear that the results of this study will show

significant inconsistencies among the quality of RT internship experiences.

Appendix G

Recruitment Letter

June 5, 2018

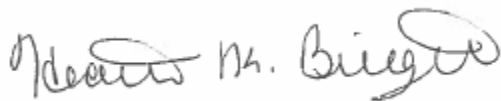Dear colleagues, clinical supervisors, and RT interns,

I am writing to let you know about an opportunity to participate in a research study about clinical supervision in Recreational Therapy/Therapeutic Recreation. This is a national study being conducted by Heather Bright for the completion of her dissertation at Clemson University.

The purpose of this study is to understand the association between the leadership behaviors and competencies among clinical supervisors, the relationship quality between supervisors and interns, and how those impact competency development among RT interns. Due to the limited research in the RT/TR field, this study is needed in order to identify the impact of current clinical supervisory practices on intern competency development.

To encourage enrollment in the study, RT students will be offered an opportunity to enter a drawing to have the registration fee for the National Council for Therapeutic Recreation Certification (NCTRC) exam covered, at a cost of $325. Participants will be eligible for the drawing following successful completion of their internship, and completion of the study. Additionally, RT clinical supervisors will have the opportunity to enter a drawing to have their American Therapeutic Recreation Association (ATRA) membership paid for one year, at a cost of $125.

If you are interested in participating in this study, or have additional questions about this study, please contact Heather Bright at 724-944-1038 or hbrigh2@g.clemson.edu.

Sincerely,

Heather Bright, MS, CTRS

Appendix H

Informed Consent

Information about Being in a Research Study
Clemson University

Leadership and Competencies: A Mixed-Methods Study of Clinical Supervision in Recreational Therapy

Description of the Study and Your Part in It
Brent Hawkins and Heather Bright invite you to take part in a research study. Brent is an assistant professor at Clemson University. Heather Bright is a student at Clemson University, running this study with the help of Dr. Brent Hawkins. The purpose of this research is to develop an understanding of the relationship between the leadership behaviors and competencies among clinical supervisors in Recreational Therapy (RT), what the relationship quality is between supervisors and interns, and how those impact competency development among RT interns.

Your part in the study will be to complete three separate surveys. The first survey will record demographic information, the second survey will ask you to rate the quality of your relationship with your intern or supervisor, and the third survey will ask you rate your competency level. Following completion of the surveys you may be asked to participate in an individual follow up interview with Heather Bright. The follow up interviews will be video and audio recorded. If you agree to participate in this study, it will take you approximately 60 minutes to complete all surveys. If you participate in an individual follow up interview, it will take you an additional 30-60 minutes.

Risks and Discomforts
A potential risk may include the supervisor or the intern feeling vulnerable, based on each pair knowing that the evaluation of their counterpart will be shared with the researchers. To minimize this risk, the researchers will not share information obtained through the course of the study with supervisors or interns. We are not aware of any physical, economical, criminal or liability risks involved in participating in this study. There is no threat to financial stability, employability or reputation.

Possible Benefits
It is reasonable to expect the following benefits from this research:
- Contribute to filling a gap in knowledge regarding nature of and/or effectiveness of clinical supervision in Recreational Therapy (RT)
- Contribute to an increased understanding of the impact of supervisor leadership behaviors on intern competency development
- Contribute to the development of clinical supervision education and training curricula

While we cannot guarantee that you will personally experience benefits from participating in this study, others may benefit in the future from the information that you provide.

Incentives
To encourage enrollment in the study, RT students will be offered an opportunity to enter a drawing to have the registration fee for the National Council for Therapeutic Recreation Certification (NCTRC) exam covered, at a cost of $325. Participants will be eligible for the drawing following successful completion of their internship, and completion of the study. Additionally, RT clinical supervisors will have the opportunity to enter a drawing to have their American Therapeutic Recreation Association (ATRA) membership paid for one year, at a cost of $125. For both the NCTRC exam and the ATRA membership, one name from each group (i.e., interns and supervisors) will be randomly selected upon completion of the study. Those selected will be contacted by phone and email.

Protection of Privacy and Confidentiality
All participant information and data obtained from participants will be stored electronically and will be password protected. Passwords will not be shared with anyone.

The results of this study may be published in scientific journals, professional publications, or educational presentations; however, no individual participant will be identified. We might be required to share the information we collect from you with the Clemson University Office of Research Compliance and the federal Office for Human Research Protections. If this happens, the information would only be used to find out if we ran this study properly and protected your rights in the study.

Choosing to Be in the Study
You may choose not to take part and you may choose to stop taking part at any time. You will not be punished in any way if you decide not to be in the study or to stop taking part in the study. If you decide not to take part or to stop taking part in this study, it will not affect your grade in any way. If you choose to stop taking part in this study, the information you have already provided will be used in a confidential manner. Upon withdrawal from the study, participants will only be asked to state the reason for

withdrawal. At no time will any follow-up, such as questionnaires, be forced upon you if you wish to withdraw.

Inclusion and Exclusion Criteria
Interns must be scheduled to complete their internship during the summer and fall of 2018, or spring 2019, and supervisors must work with their interns no less than 30 hours per week. Both the intern and the supervisor must agree to be in the study in order for the pair to be included, and both must sign an informed consent. All clinical supervisors must have valid and current CTRS credentials and student interns must have completed all university program and NCTRC course requirements to be eligible. If the internship is halted at any time prior to completion of their university's or the internship sites requirements, then the supervisor-intern pair will be removed from the study. The investigators may stop the study or take you out of the study at any time they judge it is in your best interest.

Contact Information
If you have any questions or concerns about your rights in this research study, please contact the Clemson University Office of Research Compliance (ORC) at (864) 656-0636 or irb@clemson.edu. If you are outside of the Upstate South Carolina area, please use the ORC's toll-free number, (866) 297-3071. The Clemson IRB will not be able to answer some study-specific questions. However, you may contact the Clemson IRB if the research staff cannot be reached or if you wish to speak with someone other than the research staff.

If you have any study related questions or if any problems arise, please contact Heather Bright (724-944-1038 / hbrigh2@g.clemson.edu).

By clicking "yes", you indicate that you have read the information written above, are at least 18 years of age, been allowed to ask any questions, and are voluntarily choosing to take part in this research. You do not give up any legal rights by taking part in this research study. By clicking "no" you are choosing to not participate in this study.

Appendix I

Coding Template

Participant:	Participant details:		
Relevant interview notes: • •			
Page#	Salient quote	Meaning related to identified phenomena	Theme
•	•	•	
•	•	•	
•	•	•	
•	•	•	
•	•	•	
Other notes:			

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