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REHABILITATION COUNSELOR SUPERVISION: CURRENT KNOWLEDGE,

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REHABILITATION COUNSELOR SUPERVISION: CURRENT KNOWLEDGE, SKILLS, PREPARATION AND PRACTICES OF CERTIFIED REHABILITATION COUNSELORS

By

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ABSTRACT

REHABILITATION COUNSELOR SUPERVISION: CURRENT KNOWLEDGE, SKILLS, PREPARATION AND PRACTICES OF CERTIFIED REHABILITATION COUNSELORS

By

Virginia A. Thielsen

Field-based clinical experiences, supervised by Certified Rehabilitation Counselors (CRCs), have been a critical component in the professional development process of novice rehabilitation counselors for over 20 years. Despite the significant role of CRCs in the professional preparation of rehabilitation counselors little is known about the supervisory knowledge, skills, preparation or practices of CRCs. The primary purpose of this study was to begin the inductive process of identifying the supervisory knowledge and skills that are necessary for effective field-based supervision of rehabilitation counselors. In addition, this study also sought to determine the perceived preparedness of CRCs to provide supervision, and to provide a foundation of knowledge about the current scope and nature of supervision provided by CRCs. A Delphi study was conducted in conjunction with a review of the literature for the development of the instrument utilized in this study. The sample for this national study consisted of 1,500 randomly selected CRCs and data was collected via a mail survey.

Principal components analysis in which all of the supervisory knowledge and skill areas were loaded revealed six factor areas that were perceived by CRCs to be important for the effective field-based supervision of rehabilitation counselors. Relatively few significant ($\rho < .008$) differences in the perceived importance of the six factors were identified.

Results of this study indicate that perceptions of perceived preparedness varied primarily as a function of training in clinical supervision, supervisory experience, and the degree level of CRCs in relation to the majority of supervisory knowledge and skill factors. No significant differences in perceived preparedness were found in relation to the number of years of counseling experience for the participants.

Baseline data about the demographic characteristics and supervisory practices of CRCs who have provided field-based supervision within the last five years was also secured in this study.

This investigation is the first to empirically determine that CRCs believe that there are specific supervisory knowledge and skills that are important for the field-based clinical supervision of rehabilitation counselors. This study also demonstrated that training in clinical supervision has a positive impact on the perceived preparedness of CRCs to provide supervision. The findings of this study suggest that CRCs support the contention that clinical supervision in rehabilitation counseling is a distinct intervention requiring training and preparation in a distinct body of knowledge.

Dedicated with all my love to my husband Gary and our sons Adam and Brian. Without your unconditional and unwavering love, support, and understanding this project and process would have never been completed. We did it guys!

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No single individual can achieve a goal such as this without the help of many people. Although only one name is listed as author, this project is really a reflection of the many people who have so willing shared their invaluable knowledge, skills, guidance, wisdom, support, and time with me.

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LIST OF ABBREVIATIONS

ANOVA . . . . . **Analysis of Variance**

CRC . . . . . **Certified Rehabilitation Counselor**

CRCC . . . . . **The Commission on Rehabilitation Counselor Certification**

CORE .. . . . . **The Council on Rehabilitation Education**

MANOVA . . . . . **Multivariate Analysis of Variance**

RCSI . . . . . **Rehabilitation Counselor Supervision Inventory**

Chapter 1

INTRODUCTION

Over the past 20 years, Certified Rehabilitation Counselors (CRCs) have played a critical role in the professional development of novice rehabilitation counselors. It is through clinical experiences, supervised by CRCs, that the applied skills, knowledge, attitudes, and values of the rehabilitation counseling profession are modeled and shared with the next generation of rehabilitation counselors (Maki & Delworth, 1995). In their roles as clinical supervisors, CRCs also function as the "gatekeepers" of the profession. It is their responsibility to ensure that trainees have demonstrated the minimal level of professional competency necessary to provide quality services to persons with disabilities (English, Oberle, & Byrne, 1979; Scofield and Scofield, 1978; Tarvydas, 1995).

The importance of supervised clinical experiences are reflected in the requirements for certification, established by the Commission on Rehabilitation Counselor Certification (CRCC), and the accreditation standards, established by the Council on Rehabilitation Education (CORE). Both CORE and the CRCC require candidates who have been trained at CORE accredited programs to complete 600 hours of field based experience under the supervision of a CRC as a prerequisite for graduation and certification.

Currently, under the CRCC and CORE guidelines, all CRCs are qualified to provide clinical supervision. Despite the significant role of CRCs in the professional preparation of rehabilitation counselors, little is known about the supervisory beliefs or practices of CRCs. Given, as Tarvydas (1995) contends,

that "certification and licensing bodies are under increasing pressure to appropriately identify and examine supervisory experiences and practices to monitor the integrity of their standards." (p.295), it is essential that the supervisory knowledge, skills, preparation and practices of CRCs be empirically investigated.

Supervision and Counselor Licensure

Until recently, issues pertaining to the counseling supervision process were predominantly within the jurisdiction of the various accreditation and certification bodies of the counseling profession. External pressures, however, are now bringing the issues of supervision into the public domain as legislators, insurance companies, and consumers become more aware of appropriate standards for supervision (Tarvydas, 1995). As a result, supervision is now considered a critical issue in counselor licensure regulation.

Currently, there are 45 states with counselor licensure regulations. Every state with regulations requires some form of supervision as part of their licensing process (Sutton, 1997). As states develop new, or revise and amend current counselor licensure regulations, the standards for clinical supervisory experience and preparation have become more stringent. Sutton (1998) recently reported 17 states (as compared to the three states identified by Borders and Cashwell in 1992) now require supervisors to have received training in supervision prior to supervising licensure applicants. In addition, the legal responsibility of supervisors to ensure that supervisees provide competent services has also intensified. Sutton (1998) reports that of the 42 state licensure regulations he

reviewed: (a) 14 states require supervisors to ensure that counseling services provided to clients are professional, (b) 17 states require supervisors to take responsibility for the actions of the supervisee, (c) 21 states mandate that supervisors monitor the clinical performance and professional development of their supervisee, (d) 18 states prescribe ongoing evaluation and assessment of supervisees, (e) 17 states prohibit supervisors from endorsing supervisees who are not qualified.

It can be anticipated that this trend to increase the legal responsibilities as well as the preparation and experience requirements for supervisors will continue in light of increasing pressure from the American Counseling Association (ACA) for the standardization of all state counselor licensure regulations. It is ACA's goal that the 1994 ACA Model Legislation for Licensed Professional Counselors, which recommends that states require that clinical supervision be provided by a Licensed Professional Counselor (LPC), with five years of experience, and training in supervision, be adopted by all states (Glosoff, Benshoff, Hosie, & Maki, 1995).

Supervision as a Specialty Area

The perspective that clinical supervision is not only a separate intervention, but a specialty area requiring specific preparation, unique competencies and credentialing is becoming more widely accepted within the counseling profession (Bernard & Goodyear, 1998). In 1989, the American Association of Counseling and Development (AACD), now ACA, adopted the "Association for Counselor Education and Supervision (ACES), Standards for

Counseling Supervisors", which defines supervision as a distinct intervention requiring specific training and competencies (Dye & Borders, 1990).

The movement in the counseling professions, including rehabilitation counseling, to recognize clinical supervision as a professional specialty area has recently intensified. Most recently, the CRCC created a new adjunct designation in clinical supervision which requires 60 months of post-CRC experience and is designed only for certified counselors who practice in the area of clinical supervision (The Counselor, 1999). In response to a request from ACES, a division of ACA, the National Board for Counselor Certification (NBCC) initiated a task force in 1997 to develop a supervision specialty credential (Eubanks, 1997). IN 1998, NBCC announced the establishment of the Approved Clinical Supervisor credential which offers standards for training, supervised experience, and ethical practice (Bernard, 1998). The American Association for Marriage and Family Therapy (AAMFT) and the National Academy of Certified Mental Health Counselors, (NACMHC) also have specific training and certification procedures for approved supervisors (Dye & Borders, 1990).

Impact on Rehabilitation Counseling Profession

Licensure has been identified as a critical step in the professionalization process for qualified providers of rehabilitation counseling services (Tarvydas & Leahy, 1993). Although the importance of licensure has been recognized by the rehabilitation counseling professionals associations (e.g. ARCA, NRCA, and ARC), the professional community has been slow to respond to licensure issues for CRCs, especially in the area of supervision.

Currently, only three states grant licensure specifically to rehabilitation counselors, and only seven states appear to allow the use of the CRCC examination to fulfill examination requirements. The process of becoming licensed may therefore be a very complex process for many rehabilitation counselors. Not only must they successfully complete the required examination process; they must also secure appropriate supervision to meet the post-degree supervision requirements of the state. Bernard and Goodyear (1998) contend that it is essential that supervision be provided by a senior member to a junior member of the same profession. Given the unique role and functions of rehabilitation counselors, it appears imperative that not only the pre-service, but also the post-training supervision of rehabilitation counselors be provided by a CRC. There is however, a question as to whether CRCs have the necessary supervisory knowledge, skills, experience, and preparation required to provide supervision in most states.

Maki and Delworth (1995) suggest that "...clinical supervision in rehabilitation counseling is a distinct intervention, the use of which requires the trained supervisor to have specific knowledge and skills in multiple domains, including, but not limited to, education, consultation, and counseling" (p. 284). Although standards of practice which delineate the roles, functions, competencies, experience and training requirement for counseling supervisors have been developed by ACES and adopted by ACA, the professional organizations and the credentialing bodies (CORE, CRCC) in rehabilitation counseling have not formally adopted them. At this time, it unknown whether the

standards are appropriate and sufficient for the supervision of rehabilitation counselors or whether, due to the unique preparation and functions of rehabilitation counselors, unique supervisory knowledge and skills are required.

Statement and Significance of the Problem

Supervision is a critical component in the pre-service preparation and post-training professionalization process for rehabilitation counselors. Both the CRCC and CORE require supervised clinical experiences for rehabilitation counseling trainees and certification applicants. Little is known, however, about the supervisory practices, preparation or beliefs of the CRCs who provide field supervision. The research that has been conducted in this area has focused primarily on the supervisory experience, training, practices, skills and ethical beliefs of samples predominantly composed of educators (Dickey, Housley, & Guest, 1993; Herbert & Ward, 1989; Herbert & Ward, 1990). Only English, Oberle, and Byrne (1978) specifically addressed the supervisory practices of field supervisors. Their study, however, was limited to supervisors in the state/federal rehabilitation system and focused primarily on the administrative functions of supervisors. The authors did find, however, that counselors in these settings reported a high level of dissatisfaction with the quality and nature of supervision as it pertains to clinical practices such as case conceptualization, personal adjustment counseling and vocational counseling (English et al., 1978).

The lack of research in the area of clinical supervision in rehabilitation counseling might be due to the fact that, as Herbert and Ward (1989) suggest, rehabilitation counselors adhere to the myth that a good counselor is

automatically a good supervisor (McCarthy, DeBell, Kanuha, & McLeod, 1988). Or perhaps supervised clinical experiences in rehabilitation counseling are viewed primarily as on the job training experiences with the supervisor in the role of a job coach. Regardless, clinical supervision has become a critical issue in the professionalization process for rehabilitation counselors. As CRCs attempt to secure licensure and as the counseling profession continues to promote supervision as a specialty credential, the supervisory qualifications of CRCs will come under increased scrutiny from consumers, legislators, payers, and the general public.

Purpose of the Study

The purpose of this national study was to begin the inductive process of identifying the supervisory knowledge and skill areas that are necessary for effective clinical supervision of rehabilitation counselors. The perceived preparedness of CRCs to provide clinical supervision was also explored. In addition, this study sought to provide a foundation of knowledge about the demographic characteristics and current supervisory practices of CRCs who have provided field-based clinical supervision. The specific research questions for this study were as follows:

1. What are the clinical supervisory knowledge and skill areas that are perceived by CRCs to be essential for the provision of effective supervision in rehabilitation counseling?
2. In what supervisory knowledge and skill areas do CRCs perceive themselves to be the most and least prepared to provide supervision?

3. Do perceptions of importance and preparedness of essential supervisory skill and knowledge areas differ according to demographic characteristics or professional characteristics of CRCs?
4. What are the demographic characteristics and professional experiences of CRCs who provide field-based clinical supervision?
5. What are the supervisory practices that characterize the work of CRCs who provide field-based clinical supervision?

Clinical supervision has been identified as a critical component in the professional preparation of rehabilitation counselors. This study is unique and represents the first effort to describe the supervisory practices of CRCs who have provided field-based clinical supervision. In addition, this study has begun the inductive process of identifying the essential supervisory knowledge, skills and preparation required by all CRCs for effective clinical supervision.

Definition of Terms

Certified Rehabilitation Counselor: Practitioners who have attained a master's degree in rehabilitation counseling or a closely related degree program and who have been certified by the Commission on Rehabilitation Counselor Certification (CRCC) as having at least an acceptable minimum level of knowledge and skills to practice as a professional in rehabilitation counseling.

Clinical Supervision: "An intervention that is provided by a senior member of the profession to a junior member of the same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of

services offered to the clients he, she or they see(s), and serving as a gatekeeper for those who enter a particular profession."(Bernard & Goodyear, 1992, p.4)

Field-based Clinical Supervision: Term which refers to the provision of clinical supervision services in a community, based agency or facility.

Clinical Supervisors: Counselors who have volunteered or been designated to directly oversee and monitor the professional clinical work of counselors-in-training, or counselors seeking state licensure or national certification.

Supervisee: Counselors-in-training or counselors seeking state licensure or national certification who work with clients in a community based agency or facility.

Supervision Knowledge and Skills: Term which refers to the specific supervision related knowledge (what one knows) and skill (what one can do) areas that are essential to enhance the professional functioning of the supervisee and to monitor the quality of services offered to the supervisees' clients.

Supervision Practices: Term which refers to the conscience, observable actions or behaviors utilized by clinical supervisors to enhance the professional functioning of the supervisee and to monitor the quality of services offered to the supervisees' clients.

Assumptions and Limitations

The primary assumption underlying this study is the validity of using self-report methods. It was assumed that CRCs have the prerequisite skills, abilities,

and professional judgment necessary to accurately and honestly assess the supervisory knowledge and skills that are essential for the effective clinical supervision of pre and post-graduate rehabilitation counselors. It is further assumed that CRC's accurately and honestly assessed their preparedness to provide clinical supervision and to describe their current supervisory practices.

A second assumption of this study concerns the generalizability of the results. Since under current the CRCC and CORE guidelines, all CRCs are considered qualified to provide clinical supervision, a random sample of CRCs was drawn for this study. It is therefore assumed that the CRCs in the study are representative of all CRCs. A limitation is recognized, however, that it is possible that only those CRCs in the sample who had a significant interest in the area of clinical supervision may have responded. As a result, the findings of this study might not reflect the perceptions or practices of the majority of CRCs.

Chapter 2

REVIEW OF THE LITERATURE

Certified Rehabilitation Counselors (CRCs) who serve as clinical supervisors provide a major contribution to the pre-service preparation of rehabilitation counselors. Maki and Delworth (1995) note, however, although clinical supervision is recognized as an essential component of counselor training, it has been a neglected area of investigation by the rehabilitation counseling profession. Until a recent special issue of Rehabilitation Counseling Bulletin (1995) focused on this topic, very little theoretical or empirically based information about supervision has been available in the rehabilitation counseling literature. As a result, little is known about the clinical supervisory knowledge, skills, preparation or practices of the CRCs who provide field-based supervision.

While there is limited information available about supervision in the rehabilitation counseling literature, the same can not be said about the literature of other helping professions. The supervision literature in the areas of counseling and clinical psychology, marriage and family therapy, social work, and rehabilitation counseling were reviewed in order to provide a context for this study.

Historical Context

Rehabilitation Counseling is the only counseling specialty which can trace its roots to an Act of Congress (Wright, 1980). The Smith-Fess Act of 1920, which established the state-federal rehabilitation program in this country, mandated the provision of vocational rehabilitation services to persons with

disabilities. During the next twenty years, specialized training for rehabilitation workers was not required or funded. With the continued expansion of federal funding and the broadening of service options as well as the populations to be served, it was recognized that better trained personnel were needed to provide quality services to persons with disabilities (Scalia & Wolfe, 1984).

The Vocational Rehabilitation Act Amendments of 1943 first addressed the need for states to subsidize the training of rehabilitation workers although specific funds were not allocated for this purpose. Through the 1940's, training for the heterogeneous group of rehabilitation professionals who provided rehabilitation services was conducted by the federal Office of Vocational Rehabilitation and the state agencies (Wright, 1980). In recognition of the need for professional rehabilitation counselors, the 1954 Vocational Rehabilitation Amendments allocated federal funds for the development of training programs in rehabilitation counseling (Wright, 1980). The impact of the rapid infusion of federal funds for the development of training programs was clearly effective. In the 1940's there were only three graduate training programs in rehabilitation counseling. By 1956 however, 26 universities had established graduate training programs (Hershenson, 1988).

In 1955, a group of rehabilitation leaders and graduate counselor educators met to develop the federal policy statement which established the training criteria and curriculum guidelines for universities receiving federal training grants (Ebener & Wright, 1991). It was determined by this committee that rehabilitation counseling education would be provided at the graduate level,

and would include training in a variety of didactic course work including psychology, social work, and/or education. It was also determined that clinical experiences were a critical and essential component in the pre-service training of rehabilitation counselors (Wright, 1980, Ebener & Wright, 1991). The guidelines and criteria established by this committee laid the foundation for a combined didactic and field-based model for the pre-service training of rehabilitation counselors which still exists today.

By the mid 1960's, there were approximately 70 rehabilitation counselor education (RCE) programs (Wright, 1980). With the rapid growth of programs, the need for an accrediting mechanism to standardize and accredit the RCE programs becomes imperative. Following two years of planning, the Council on Rehabilitation Education (CORE) was established in 1972 as the accreditation body for the RCE programs (CORE, 1997). Since it's inception, CORE has mandated a combined didactic course work and clinical experience model of pre-service training in the accreditation standards (Patterson, personal communication, October 12, 1996). The current CORE clinical experience standards require students to have a minimum of 100 hours of supervised rehabilitation counseling practicum. Practicum experiences can occur on or off campus, and do not require the clinical supervisor to be a CRC. The standards specifically state, however, that the 600 hour internship experience must be completed in a rehabilitation setting under the supervision of a CRC (CORE, 1997).

In 1973, the Commission on Rehabilitation Counselor Certification (CRCC) was established to ensure that "professionals engaged in rehabilitation counseling are of good moral character and possess at least an acceptable minimum level of knowledge, as determined by the Commission, with regard to the practice of their profession" (Leahy, 1997, p.107). Since 1980, the CRCC has required all candidates for certification to complete at least 600 hours of clinical experience, in a rehabilitation setting, under the supervision of a CRC (Graves, 1983).

Both CORE and the CRCC have a rich history of utilizing empirical research in order to validate and evaluate the standards for accreditation standards and the certification examination (Leahy, 1997). It is interesting to note, however, that although extensive empirical research, utilizing a variety of methodologies, has been conducted as to the specific role and functions of rehabilitation counselors (Muthard & Salomone, 1969; Rubin et al., 1984); and the essential knowledge and skills for the effective practice of rehabilitation counseling (Beardsley & Rubin, 1988; Leahy Shapson & Wright, 1987; Leahy, Szymanski, & Linkowski, 1993), no research has explicitly investigated the efficacy of the clinical experience in the professional preparation of rehabilitation counselors or certification candidates.

Definition of Clinical Supervision

Atkins (1981) contends that it is the lack of a standardized definition of supervision that has inhibited the clarification of the structure, content, and purpose of supervision in rehabilitation counseling. Although supervised clinical

experiences have been identified as a critical and mandatory requirement in rehabilitation counseling education and for certification, consensus as to a standardized definition of clinical supervision has not been achieved. One reason for this might be that the definitions of supervision have typically been closely tied to a specific counseling or supervision theory (Carroll, 1995; Stebnicki et al., 1997). Recently, however, a comprehensive definition of supervision proposed by Bernard and Goodyear (1992) has begun to receive support as being applicable to all rehabilitation professionals (Herbert, 1995; Maki & Delworth, 1995; Maki & Riggar, 1997; Stebnicki, Allen, & Janikowski, 1997).

Bernard and Goodyear (1992) define supervision as "An intervention that is provided by a senior member of the profession to a junior member of the same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior member(s), monitoring the quality of services offered to the clients he, she or they see(s), and serving as a gatekeeper for those who enter a particular profession."(p.4)

Herbert (1995) proposes that the strength of this definition is that it encompasses a number of supervisory goals including enhancing and monitoring client treatment; expanding and evaluating practitioners knowledge, skills and competency; integrating theory and practice; and facilitating program effectiveness. In addition, this definition is sensitive to the professional socialization goal of supervision by acknowledging that each counseling

discipline has a unique history, philosophy, and service delivery paradigm which can only be modeled by a senior member of the same profession (Bernard & Goodyear, 1998). It should also be noted that this definition does not limit supervision to enhancing and evaluating only counseling skill competency, but includes the full array of professional competencies required within specialized areas of practice.

Maki and Delworth (1995) propose the use of this definition by the rehabilitation counseling profession as a template from which to conceptualize the supervision relationship. They contend that by "using this definition, then clinical supervision in rehabilitation counseling is a distinct intervention, the use of which requires the trained supervisor to have specific knowledge and skills in multiple domains, including, but not limited to, education, consultation and counseling." (p.284).

Supervision as a Specialized Area of Practice

The perspective that clinical supervision is not only a separate intervention, but a specialty area requiring specific preparation, competencies and credentialing is becoming more widely accepted within the counseling professions. (Bernard & Goodyear, 1998; Sutton, 1998). The adoption of the "Association for Counselor Education and Supervision (ACES) Standards for Counseling Supervisors", by the American Association of Counseling and Development (AACD), now ACA in 1989 was the first strategic step towards the professionalization of clinical supervision as a specialty area (Dye & Borders. 1990). Shortly, there after, ACES adopted the Ethical Guidelines for Clinical

Supervisors (1995). Most recently, the National Board for Certified Counselors (NBCC) established an Approved Clinical Supervisor credential (Bernard, 1998). The credential, which offers standards for training, supervised experience, and ethical practice, is intended to be a general credential, appropriate for supervisors across all specialty areas of counseling practice (Clawson, personal communication, April 28, 1998). Rothman (1987) contends that the regulation of practice through certification is an important characteristic of professions. Given the current movement, supervision may be viewed as a specialized area of practice, in the near future.

Standards of Practice

The "ACES Standards for Counseling Supervisors" was developed over the course of about five years, through a multistage process (Dye & Borders, 1990). The primary purpose of the standards is to establish the generic skills and knowledge required by a wide range of counseling supervisors, including those who provide rehabilitation counseling supervision (Dye & Borders, 1990).

Borders completed the first step in the development of the standards in 1985. Following a literature review and a Delphi procedure, Borders generated a list of 88 competencies that were identified as the essential skills and knowledge for clinical supervisors (Borders & Leddick, 1987). In a separate study Dye (1987), following a review of the literature, constructed an instrument consisting of 92 supervisory knowledge and skill items. The instrument was published in the ACES Spectrum, the newsletter for the ACES division of ACA (then the AACD). All ACES members received a copy of the newsletter, and were asked to

complete and return the survey, 724 responses were received for a return rate of approximately 25% (Dye, 1987).

The final instrument consisted of three sections. The first section was composed of the 92 specific supervisory knowledge and skill factors. Respondents were asked to determine the criticality of each items based on a five point Likert-type scale. Dye (1987) reported that 26 items were retained representing six cluster scales: Personal traits and qualities, facilitating skills, conceptual skills and knowledge, technical and direct intervention skills, program management and supervision skills, knowledge of program management and supervision. Although the six cluster areas are identified, the full findings were not published, nor was information provided as to the criteria for determining which items to maintain, or how the clusters were derived.

The second and third sections of the instrument pertained to how the clusters of skills and knowledge identified should be acquired, and whether they should be included in a certification program. The findings indicated strong support for a specific set of training criteria for supervisors as well as support of a specialty certification.

It should be noted that sociodemogrpahic information was not collected for this survey. Professional demographics indicated that the respondents' primary employment setting was in a university or college setting and that more than half of the respondents had completed a supervision training experience. No information was available, however, as to the professional identity or the academic training levels of the respondents. Nor was information provided as to

whether the responses differed as a result of setting. It is impossible to determine therefore, if CRCs or rehabilitation counseling educators were included in the sample, or if their responses differed in any way when compared to respondents from different specialty areas.

In 1988, Dye and Borders were asked by the Supervision Interest Network of ACES to draft the standards upon which a supervision credential could be based (Dye & Borders, 1990). Following completion of the draft, and review by multiple committees, the current standard was adopted by the ACES Executive Council in 1988, the AACD (now ACA) Governing Council in 1989, and the American Association of State Counseling Boards (AASCB) in 1990 (Dye & Borders, 1990). Although the ACES standards have been in place for almost 10 years, no further research has been conducted to determine if they are adequate and sufficient for all supervisors, regardless of the academic level of the supervisor, setting in which they work, or specialization area. This could be of significant concern if specialized supervisory knowledge or skills are required due to the uniqueness of a specialized area of practice.

For example, for more than 25 years, family therapy training and supervision has been a specialty area within the family therapy field requiring specific training and certification procedures for supervisors (Dye & Borders, 1990; Liddle, Becker, & Diamond, 1997). Liddle et al. (1997) contend that unlike traditional counseling theories or models which focus on the dynamics of the individual, family therapeutic models tend to endorse a systems theory approach to counseling in which the mechanisms of change are the interactional processes

of the family, rather than insight into the individual. They propose that due to the uniqueness of the intervention process, specialized supervisory knowledge and skills are required. White and Russell (1995) recently completed a modified Delphi study to identify the essential supervisory knowledge and skills, and setting factors that are required for the effective supervision of marriage and family counselors. The Delphi panel for the study was composed of 108 practicing marriage and family therapists. White and Russell (1995) determined that there were 117 supervisor variables, distributed in nine conceptual clusters and 74 contextual or setting based variables, clustered in 8 conceptual clusters that were associated with successful supervisory outcome.

Although research has not been conducted to determine if specific knowledge and skills are required for the clinical supervision of rehabilitation counselors, there are indications that this might the case. Rehabilitation counseling is a unique area of practice among the counseling professions. The scope of practice for rehabilitation counseling states that "Rehabilitation counseling is a systematic process which assists persons with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible through the application of the counseling process" (Maki & Riggar, 1997, p. 297). Rehabilitation counselors are cognizant of the fact that the problems experienced by persons with disabilities are frequently environmentally based. Not only does the counselor assist the individual in adjusting to their disability but also to their environment. Counselors also assist environments in accommodating to meet

the needs of the individual in order to provide each individual with the opportunity to work and to participate fully in all aspects of society (Szymanski, 1985). Among the counseling professions, only rehabilitation counseling assumes this perspective and provides these types of interventions.

Extensive empirical research has provided construct validity that specialized knowledge and skills are essential for the effective practice of rehabilitation counseling (Beardsley & Rubin, 1988; Leahy et al., 1987; Leahy et al., 1993). The importance of these specialized skills and knowledge in the provision of services to persons with severe disabilities has also been demonstrated. A series of studies investigating the relationship between rehabilitation counseling education and service delivery outcomes have confirmed that persons with severe disabilities who received services from a counselor with a master's degrees in rehabilitation counseling achieved better outcomes than did similar clients who received services from counselors with unrelated master's or bachelor's degree (Cook & Bolton, 1992; Szymanski, 1991; Syzmanski & Danek, 1992; Syzmanski & Parker, 1989).

Supervisor Factors That Impact Supervision

Experience

The early models of supervision, which were based on the theoretical counseling models, advocated that supervision be conducted by an experienced "master counselor" (Bernard & Goodyear, 1992). The purpose of this approach was to train the supervisee indirectly via a modeling approach and it was assumed that every supervisor would be an excellent therapist (Leddick &

Bernard, 1980). As the models of counselor development and skill training began to emerge, questions began to arise as to whether or not experience alone was sufficient as the sole criterion to determine supervisory qualifications (Leddick & Bernard, 1980).

As a result, several studies where conducted to investigate whether experience played a factor in the focus of supervision (Goodyear & Robyak, 1982), planning statements of supervisors (Marikas, Russell, & Dell, 1985; Stone, 1980), the attribution of cause for supervisee traits (Worthington, 1984a), and supervisees' perceptions of supervisors competency (Worthington, 1984b; Worthington & Stern, 1985; Zucker & Worthington, 1986). Following his review of the empirical research on how supervisors change as they gain experience, Worthington (1987) concluded, "Unwilling as we might be to accept it, most supervisors simply might not improve with experience" (p. 206). The findings from these studies, however, can also be viewed from an alternative perspective. In each of these studies, the stated or implicit assumption was that experienced supervisors would be "better" than the inexperienced supervisors. In fact, what was determined was that inexperienced supervisors were equal (versus deficit) to more experienced supervisors. What can be determined from these studies is that experience level alone is an unreliable variable in determining the skills of a supervisor.

Training Issues

The perspective that training in clinical supervision is essential for the effective, ethical delivery of supervisory services has gained momentum over the

last 15 years. Currently, the ACES "Standards for Counseling Supervisors" (Dye & Border, 1990), and "The 1994 ACA Model Legislation for Licensed Professional Counselors" (Glosoff, Benshoff, Hosie, & Maki, 1995), recommend that supervisors complete training in supervision that includes both didactic courses and experiential learning opportunities.

Arguments have also been made that untrained supervisors are practicing outside their area of expertise (Hoffman, 1994; Sherry, 1991; Upchurch, 1985). Carroll (1996) contends that training in supervision is no longer an option, but an ethical responsibility. His contention is supported by "The Ethical Guidelines for Counseling Supervisors" (1995) which states that supervisors should have training in supervision prior to initiating their roles as supervisors, and should pursue professional and personal continuing education activities pertaining to supervision (Section 2.01/2.02).

The awareness by consumers and legislators of the importance of supervision in the pre and post-degree preparation of counselors has brought the issue of supervision training into the public domain. Sutton (1998), recently reported that of the 43 state licensure regulations he reviewed, 17 states (as compared to the three states identified by Borders and Cashwell in 1992) now require supervisors to have received training in supervision prior to supervising licensure applicants. With the continued emphasis on accountability regarding the provision of appropriate services by consumers and legislators, it can be anticipated that this trend will continue (Tarvydas, 1995). Currently neither the CRCC nor CORE require field based supervisors to receive training in clinical

supervision. There has, however, been support within the rehabilitation counseling literature for such training (Allen et al., 1995; Atkins, 1981; Herbert & Ward, 1989, Maki & Delworth, 1995).

Curriculum Guidelines

Several curriculum guidelines for the training of clinical supervisors of counselors have been proposed (Bernard, 1979, 1992; Borders et al., 1991; Richardson & Bradley, 1984, Russell & Petrie, 1994; Stenack & Dye, 1983). Of these, the "Curriculum Guide for Training Counselor Supervisors" (Borders et al., 1991) has been identified as the most comprehensive set of recommendations for supervisor training (Russell & Petrie, 1994). Based on the "Standards for Counseling Supervisors" (Dye & Borders, 1990), the authors suggest that training in supervision should address seven core topic areas: Models of supervision, counselor development, supervision methods and techniques, supervisory relationship, ethical, legal and professional regulatory issues, evaluation, and supervision executive (i.e. managerial) skills. The authors also suggest three sets of learning objectives (e.g. self-awareness, theoretical and conceptual knowledge, and skills and techniques) for each of the seven areas resulting in 21 types of learning objectives. While this model is comprehensive, it is also extremely complex. In contrast, Russell and Pert (1994) propose that there are only three essential areas for supervisor training: Theoretical models of supervision, supervision research; and ethical and professional issues.

Within the rehabilitation counseling literature, only one curriculum model for the training of rehabilitation counseling clinical supervisors has been

proposed within the last 15 years. Allen, Stebnicki and Lynch (1995) developed a model specifically designed for the training of doctoral level supervisors. The model is based on the general counseling supervision literature. The authors do suggest, however, that while the training of rehabilitation counseling supervisors might be more similar than different from the training of supervisors in other related disciplines, there may be unique issues in rehabilitation counseling that require unique supervisory skills and training (Allen et al., 1995).

It is interesting to note that although the professional, legal and ethical pressures for supervision training have intensified in recent years, there has not been a corresponding amount of research to validate the efficacy of supervision training (Bernard & Goodyear, 1998; Holloway, 1995). The research that has been conducted has focused on the training of pre-doctoral students to utilize specific supervisory roles (Stenack & Dye; 1983); to illustrate particular training techniques, (Bernard, 1989; Williams, 1988), or to validate the impact of supervision training on supervisor cognitions (Borders & Fong, 1994; Borders et al., 1996). Although these studies have provided insight into the issues of supervisory training, none have proven conclusively that training in supervision alters the supervisory approach, roles, cognitions or competencies of supervisors-in-training.

It must be noted, however, that all of the studies were completed in an average of 15 weeks with small groups of doctoral level students. As a result, it impossible to determine if the lack of conclusive findings are because of the brevity of the training intervention, the lack of a logintudinal design, or the result

of low power increasing the chance of a Type II error (i.e. failure to detect an actual change). In addition, none of the studies specifically investigated the issue of the role identity of the supervisors. Doctoral students are still in the process of learning to become professional counselors and may not be developmentally ready to make the shift to the role of supervisor.

Models of Supervisor Development

Becoming a supervisor is an additional step in the professional development of counselors (Shechter, 1990). This step requires a shift in focus, identity, cognitions, and responsibility (Bernard & Goodyear, 1998; Borders, 1989; Liddle, 1988; Watkins, 1995). Although more than 20 models of counselor development have been identified, only a few models of supervisor development have been proposed (Bernard & Goodyear, 1998). Although all of the supervision development models are based on stages of development, each provides a unique aspect that might be important to the developmental processes of clinical supervisors.

Alonso's (1983) developmental theory of supervision identifies three stages: Novice, midcareer and late career. Alonzo's model is unique in that it recognizes that at each stage of development, supervisors are influenced by institutional factors, self-identity issues, as well as the relationship between the supervisor and the supervisee. She proposes that as the supervisor matures professionally, they are able to evaluate and negotiate not only their own issues and position within the agency, but those of the supervisee as well. Alonso

(1983) takes the position that supervisors can and should continue to evolve throughout the course of their professional careers.

Hess (1986, 1987) also suggests that supervisor development occurs across three stages: Beginning, exploration, and confirmation of supervisor identity. Hess was the first to identify that a shift in roles is essential for supervisor development. Hess contends that in the beginning stage, novice supervisors struggle with a change in role status from trainee to supervisor. As a result, they tend to focus on the concrete tasks of supervision, specifically the needs of the client, and tend to be highly self-conscious. In the second stage, supervisors begin to recognize their impact on the supervisee and to develop more competence and confidence. They begin to view supervision as a worthwhile professional activity and are less concerned with self and more concerned about meeting the needs of the of the supervisee. Hess contends that it is in this stage that most supervisors begin to investigate the literature regarding supervision. Supervisors in the third stage have consolidated their identity as supervisors. They are excited about supervision and take professional pride in the accomplishments of their supervisees. They are less concerned with the pragmatics of the relationship and more concerned with meeting the supervisees learning needs as a means of ensuring a successful supervision experience.

Stoltenberg and Delworth (1987) suggest a four stage model of supervisor development. Their model of supervision development mirrors the stages they first proposed in their counselor development model. In Level I, they contend

that supervisors are very anxious and/or somewhat naive. Supervisors at this level tend to assume an expert role, take a mechanistic approach to supervision, and are still dependent on their own supervisors. In Level II, the supervisor realizes supervision is complex, and perhaps not always valued. Confusion and conflict characterize this stage. Stoltenberg and Delworth (1987) contend that this tends to be the shortest of the proposed stages. Supervisors either quickly move on to Level III or, if they get stuck at this stage, tend to withdraw from doing supervision. Stoltenberg and Delworth (1987) argue that most supervisors reach Level III, which is characterized by motivation to provide supervision, and an ability to function autonomously. The fourth stage in this model is considered an extension of Level III, or the integrated level. At this stage supervisors can work equally well with all level of supervises and are considered to be "master supervisors".

More recently, Watkins (1990, 1993) has proposed a four stage model of psychotherapy supervision, based on Hogan's (1964) and Stolenberg's (1981) models of counselor development. Watkins proposes in stage one, role shock, is marked by the "impostor phenomenon" (Watkins, 1990) in which new supervisors question their competencies and confidence. Supervisors at this level struggle with issues of role boundaries and definition, tend to be rule bound, intolerant of ambiguity, and focus little on process issues in supervision. In Stage Two, role recovery and transition, supervisors begin to feel more comfortable with the supervisory role and corresponding responsibility and begin to develop an identity as a supervisor. At this stage of development, the supervisor is better

able to tolerate ambiguity, recognize some of their own strengths, and becomes aware that process issues can be dealt with during supervision. Stage Three, role consolidation, is marked by more accurate self awareness of supervisory strengths and limitations, increased confidence in supervisory abilities and a more solidified identity as a supervisor. Supervisors at this level are less controlling and more supportive of supervisees and have increased skill in identifying and addressing process issues (e.g. transference, countertransference.

Watkins (1993) contends that throughout each stage, development occurs in response to increased challenges along several dimensions. Although a variety of challenges are thought to occur, the four key issues supervisors must address in order to develop include competency versus incompetence, autonomy vs. dependency, identity versus identity diffusion and self-awareness versus unawareness.

Research into the factors that impact supervisor development is still in the infancy stage (Watkins, 1995). Although recent efforts have been made, to date, no single instrument has been constructed that can adequately measure this construct (Watkins, Schneider, Haynes & Neiberding, 1995). Recognition that supervisor development is a complex process that is impacted by a variety of factors beyond experience and training has led to the identification of several factors not specifically addressed in the current developmental models. Heid (1997) points out that for most counselors, clinical supervision occurs only intermittently throughout their professional lives. As a result, it represents a

relatively small percentage of their professional time and responsibility. This may have a profound effect on the opportunities and motivations for supervisors' growth in this area (Heid, 1997). Holloway (1995) contends that supervisors are impacted not only by their interactions with their supervisees and the clients, but also by the expectations, requirements and relationships with agencies and institutions. Demographic characteristics such as gender, ethnicity and culture, and sexual orientation have also been identified as possible variables that must also be considered. (Bernard & Goodyear, 1998; Carroll, 1997; Holloway, 1995). Watkins (1997) contends that there must be a personality trait that motivates some supervisors to become more skilled and effective supervisors while others remain complacent. He suggests that this trait might be a self-critical attitude that drives some supervisors to self-evaluate their supervisory knowledge and actions and motivates them to seek additional training.

Holloway and Hosford (1984) and Borders (1989) contend that a limitation of the developmental research that has been conducted in the past has been the lack of exploratory, descriptive studies to establish a foundation of knowledge about the supervisors who provide supervision as well as the supervisory process. While the purpose of this study is not to investigate the developmental process of rehabilitation counseling supervisors, many of the issues presented in the models and current thinking about supervisory development are relevant to establishing a baseline of knowledge about rehabilitation counseling supervisors.

Supervisory Practices

Sergiovani (1983) states that the first essential question that must be addressed before a theory of practice in supervision can be developed is "What is the reality in a given context?" (p. 177). Although extensive research has been conducted in the area of clinical supervision for more than 20 years, little systematic research has been focused on identifying the clinical supervisory practices of field-based supervisors. The majority of the supervision research conducted in this area has primarily utilized as participants pre-doctoral or doctoral level supervisors and supervisees in academic training programs and counseling centers (Stoltenberg, McNeill, & Crethar, 1994; Russell et al., 1984; Worthington, 1987). As a result, very little is known about the supervisory practices of field-based supervisors with a master's degree as their highest degree.

This is of significant concern because although there seems to be an assumption that supervision is a doctoral level activity (Bernard, 1981; Hess, 1980; Watkins, 1993; Wright, 1980) awareness that the majority of field based supervision is conducted by master's level counselors is coming to light. In a survey of CACREP accredited training programs, Bernard (1992) concluded that over 70% of the supervisors for practicum and internship have a master's degree as their highest degree.

Although this issue has not been investigated, it can be assumed that a similar situation occurs in CORE accredited programs. In a recent national study of 1,535 CRCs (approximately 11% of the population) who were renewing their

certification, only 1.7% reported that they had doctoral degrees (Leahy, Szymanski, & Linkowski, 1993). It therefore seems logical to assume that the majority of field-based clinical supervision, at least for internship, is provided by master's level CRC's.

Only four studies have specifically focused on identifying the field-based supervision services provided to master's level counselors (Borders & Usher, 1992; Borders, Cashwell, & Rotter 1995; Hart & Falvey, 1987; Rogers & McDonald, 1995). Hartand and Falvey (1987) conducted a survey to investigate the extent and nature of supervision at field sites for master's level counselors in training in the North Atlantic region. Of the 102 supervisors surveyed, 76.5% reported that they had a master's degree. Respondents indicated that they provided an average of 1-2 hours of supervision per week, and that 72% addressed both clinical and administrative supervision issues with the supervisees. Individual supervision was the most frequently reported modality (94%), and case conceptualization, case review, and skill development were the primary foci of the supervisors in this study. Feedback and monitoring of cases and skill and development were predominantly based on the self-reports of the supervisees and conducted one or more days after the supervisees' counseling sessions with clients. The survey did not include questions pertaining to supervision training, or previous supervisory experience. This study did not investigate how summative or formative evaluation was provided, nor did it investigate variations in service delivery by setting, job functions, or degree levels.

Rogers and McDonald (1995) conducted a similar study investigating the supervisory practices of social workers in Canada who provided pre-service supervision in one university. The authors of this study did not provide information as to the percentage of participants with master's degrees, but indicated that 70% of the respondents had either MSW or BSW degrees. Although no information was requested pertaining to supervision training, the authors did note that the university did not provide supervision training. The results of this study indicated that the supervisors focused on a wide range of content issues in supervision including assessment, helping relationships, professional values, interview and intervention skills, and understanding the agency. The predominant methods used by the supervisors to monitor client welfare and supervisee learning were one-to-one discussion, student self-evaluation, and case notes. No information was secured pertaining to the formal evaluation methods used by supervisors, or the impact of setting on the focus of supervision.

Borders and Usher (1992) conducted the first national study of the existing and preferred supervision experiences of post-degree National Certified Counselors (NCCs). The sample was composed of 357 (51% response rate) randomly selected participants. The typical respondent was a white (88%), female (66%), with a master's degree in counseling (84%), who worked full time in a counseling position (83%). The demographics of the sample were reported to be representative of the NCC population. The respondent's work settings included schools (39%), private practice (19%), counseling centers (11%),

community mental health centers (9%), higher education offices (3%), hospitals (2%), and business and industry (2%). The authors noted that 15% of the sample were employed in vocational rehabilitation settings or a combination of settings, but classified this group in an "other" category.

Of the total sample, 32.1% were not receiving any post-degree supervision. A chi-square analysis by setting indicated that community mental health counselors and private practitioners were more likely to be receiving supervision once a month, and school counselors were more likely to be receiving no supervision. Of the respondents that were receiving supervision, the majority (n = 181) were receiving individual supervision, predominantly utilizing a self-report method. The majority of the respondents indicated that they preferred at least monthly supervision sessions (63%), in order to obtain professional support, and that they preferred their supervisor to be a credentialed counselor with additional training in supervision. The overall results of this study indicate that counselors (particularly school counselors) receive little post-degree supervision, that supervision practices varied, and that the majority of post-master's level counselors desired at least monthly supervision sessions.

Borders et al. (1995), conducted an exploratory comparison study of supervisors' practices in two states, one with supervisor regulations (South Carolina, n = 107) and one without regulations (Missouri, n = 83). A majority of the respondents held doctoral degrees (SC, n = 42; MO, n = 30) or master's degrees (SC, n = 41; MO, n = 46), in counselor education or counseling psychology and many worked in private practice settings (SC, n = 36; MO, n =

39) or community mental health agencies (SC, n = 16; MO, n = 20). Supervisors in both states reported a variety of clinical supervisor training experiences, but the South Carolina supervisors reported significantly more total hours of reported clinical supervisor training.

Supervisors reported that self-report was the most frequently used intervention method, although supervisors from South Carolina used review of audiotapes and video tapes significantly more often. In both states, individual supervision was the most frequently used format, supervisors reported taking the teacher or consultant role more often then the counseling role, and were more likely to focus on the client (versus the counselor) in supervision sessions. Supervision content was quite varied, although supervisors in both states reported giving frequent attention to counselors' skills and techniques, case conceptualization and counselor's self-awareness. Supervisors in South Carolina were significantly more likely to focus on the supervisor-counselor relationship, and parallel process. When evaluating supervisees' work, supervisors in both states typically provided informal ongoing feedback rather than written feedback. Few respondents indicated that they had formal contracts with their supervisees or charged fees for supervision sessions. Finally, supervisors were also asked to rate their knowledge and skills in six core supervision areas. Supervisors in both states indicated that they felt they were at least moderately competent in all areas listed. The authors noted that while the supervisors in South Carolina had significantly more training experiences, their training did not significantly alter their reported supervisory practices, nor did it

seem to be related to the supervisors' confidence in their supervision skills or knowledge. It should also be noted, that it is impossible to determine if the responses of this group are representative of the non-respondents. This study is the most comprehensive investigation of field-based supervisory practices that has been completed to date. As such, this study provides an excellent model for the current investigation to build upon.

Contextual Issues

A limitation of all the field-based supervision studies is that setting based variables have not been addressed. Field-based supervision occurs within the context of an organization or agency. The goals and functions of the clinical supervisor will be influenced by the service demands of the agency (Holloway, 1995). The influence of organizational variables, however, has received little attention in the professional literature. As a result, it is unknown if variables such as employment setting, or job title influence clinical supervision practices.

In summary, this review of the literature has shown that there is a significant need to investigate the current knowledge, skills, preparation and practices of the CRCs who are currently or will potentially provide field-based supervision. While in the past the determination of the qualifications required to provide supervision was left up to the various accrediting and credentialing boards, pressure is coming to bear for the standardization of qualifications across all the helping professions. Unfortunately, limited empirical research has been conducted to validate the current recommendations for supervisory training or

experience to determine if they are appropriate for all supervisors, regardless of specialty area.

Although clinical experiences have been identified as an essential component in the pre-service preparation of rehabilitation counselors, no research has been conducted to determine if specialized skills or knowledge are required for the supervision of rehabilitation counselors. While most field-based supervision is provided by master's level supervisors, little is known about the supervisory practices of this group of professionals, especially in rehabilitation counseling. The studies that have been conducted, however, have provided valuable information and serve as models for the current study.

Currently, both CORE and the CRCC are under considerable pressure to evaluate their current supervisor qualifications by legislators, professional organizations and licensure boards (Holt, personal communication, March 24, 1998). Rehabilitation counseling has a history of empirically validating the professional role and functions as well as the knowledge and skills required to provide effective service. This study represents the next logical step in the development of a base of knowledge about the profession.

Chapter 3

METHODOLOGY

The purpose of this study was to begin the inductive process of identifying the supervisory knowledge and skill areas that are necessary for effective clinical supervision of rehabilitation counselors, and the perceived preparedness of CRCs to provide clinical supervision. This study also sought to provide a foundation of knowledge about the scope and nature of the field-based clinical supervision provided by CRCs. The specific research questions for this study were as follows:

1. What are the clinical supervisory knowledge and skill areas that are perceived by CRCs to be essential for the provision of effective supervision in rehabilitation counseling?
2. In what supervisory knowledge and skill areas do CRCs perceive themselves to be the most and least prepared to provide supervision?
3. Do perceptions of importance and preparedness of essential supervisory skill and knowledge areas differ according to demographic characteristics or professional characteristics of CRCs?
4. What are the demographic characteristics and professional experiences of CRCs who provide field-based clinical supervision?
5. What are the supervisory practices that characterize the work of CRCs who provide field-based clinical supervision?

The survey research design for this exploratory project called for the development of a new survey instrument that was constructed in two phases

utilizing a Delphi method. This chapter will outline the participants, instrument development process, procedures, and data analysis that were employed in this study.

Subjects

Description of Sample

According to current certification and accredidation guidelines (CRCC and CORE), all CRCs are qualified to provide clinical supervision. The sample for this study therefore consisted of subjects drawn from the national database maintained by the CRCC of individuals who are currently certified as rehabilitation counselors.

In order to ensure a representative, unbiased sample, a simple random sample of 1,500 CRCs was drawn utilizing a computer generated table of random numbers from the current population of approximately 14,000 CRCs with known addresses. In estimating the size of the sample, several issues were taken into consideration. Currently, there are no pre-existing sampling frames that identify CRCs (or non-CRCs) who have provided field-based clinical supervision to rehabilitation counselors. Although the CRCC does require applicants to provide the name and certification number of their internship supervisors the CRCC does not maintain a database of this information. The percentage of CRCs who provide clinical supervision is therefore unknown. This information could only be determined after subjects were selected and returned the questionnaire. It was anticipated that by sampling approximately 10% of the population, that a representative sub-sample of CRCs with clinical supervision

experience would be captured in order to address research questions three, four, and five of this study.

A second concern was that a sufficient number of usable surveys be available to conduct a factor analysis of the data collected pertaining to the supervisory knowledge and skills necessary for the effective supervision of rehabilitation counselors. The guidelines for conducting a factor analysis indicate that a minimum of 5 subjects per item is required (Tabachnick & Fidell, 1996). The primary instrument for this study consists of 95 supervisory knowledge and skill items. Given that a response rate of approximately 50-60% was anticipated, it was determined that a sample of 1,500 would yield a sufficient number of usable surveys to ensure that the subject per item ratio guidelines for a factor analysis was met. It should be noted that the CRCs who participated as Delphi panelists in the instrument development phase of this project were excluded from the final random sample of CRCs.

Instrumentation

Instrument Development

Limited research has been conducted to identify the essential knowledge and skills necessary for effective supervision (Dye, 1987; White & Russell, 1995), or the practices of master's level supervisors who provide field-based supervision for master's level counselors (Borders, Cashwell, & Rotter, 1995; Borders & Usher, 1992; Hart & Falvey, 1987; Rogers & McDonald, 1995). No research has been conducted to investigate the specific knowledge and skills required for the effective clinical supervision of rehabilitation counselors, CRCs perceived

preparedness to provide clinical supervision, or the current clinical supervisory practices of CRCs. Following a careful review of the literature, and the instruments used in previous studies, it was determined that a new instrument would be required to conduct this study.

The research design for this project therefore called for the development of a new instrument. A three part self-report questionnaire was constructed consisting of a supervisory skills and knowledge section, a demographic section, and a supervisory practices section. The procedure to construct the instrument occurred in two phases.

Delphi Method

In order to ensure that a comprehensive pool of clinical supervisory knowledge and skill areas were identified, a Delphi study was utilized in conjunction with a comprehensive review of the literature for the development of Supervisory Knowledge and Skills section of the instrument.

The Delphi Method, which was originally developed by the RAND Corporation, is a systematic method for gathering and organizing a panel of expert opinions about a complex issue or problem (Linstone & Turoff, 1975). It is conducted in writing and allows, through a series of iterations and controlled feedback, for the development of consensus regarding the importance of specific variables. The method has been identified as superior over other methods for achieving group consensus because it allows the greatest degree of anonymity for respondents thus reducing the social pressure to conform (Hornsby, Smith, & Gupta, 1994).

The first task in the Delphi study was to identify a panel of experts that could provide diverse yet informed perspectives about field-based rehabilitation counselor clinical supervision. The pool of eligible panelists for this study included experts chosen on the basis of their active contribution to the rehabilitation counseling literature in the area of clinical supervision over the last 15 years (n = 10), and members of the CRCC Supervision Committee (n = 5). In addition, practitioners with extensive experience in providing field-based clinical supervision to novice rehabilitation counselors (n = 5) were also included in the pool of potential panelists. Prior to initiating the Delphi procedure, each potential panelist was contacted, either by phone or e-mail to review the purpose of the study, ensure their willingness to participate, and to respond to any questions or concerns a panelist might have about participating in the study. Each panelist was also informed that the CRCC had agreed to provide 3 hours of continuing education credits for each panelist who completed all three rounds of the Delphi study. Following contact with the potential panelists, 18 professionals agreed to participate.

A mail survey method was utilized for the Delphi method portion of the instrument development process. In order to ensure confidentiality, an identification number was assigned to each of the panelists and recorded in a tracking book and on mailing labels. Only the primary investigator for this project had access to the tracking book. The identification number was encoded on each of the questionnaires and on the demographic forms.

For each round of the Delphi study, panelists were mailed a packet of materials which included: A transmittal letter, instructions, a questionnaire, a demographic form (all panelists in Round-1, panelists in Round-2 who did not respond in Round-1) and a self addressed, stamped return envelope. Returns of the questionnaires were monitored daily. Panelists were asked to return their responses within 14 days. Three weeks after the initial mailing of Round-1 and Round-2, a second complete packet was sent to non-responders with a follow-up letter of appreciation for their participation in the study and re-iterating the importance of completing and returning the questionnaire. Three rounds or iterations were conducted between October, 1998 and March, 1999.

In Round-1, an open-ended approach was used to solicit input from the panel of experts. There were three sections in Questionnaire A. In the first section, panelists were asked to complete a brief demographic form. In the second section, panelists were asked to provide three to five clinical supervisory knowledge domain areas with three to five corresponding knowledge items that they considered essential for the effective field-based supervision of novice rehabilitation counselors. In the third section panelists were asked to provide three to five clinical supervisory skill domain areas with three to five corresponding skill items that they considered essential for the effective field-based supervision of novice rehabilitation counselors.

Following completion of Round-1 (response rate = 78%, $\underline{N}$ = 14) a content analysis was conducted on the 428 supervisory knowledge and skill items identified by the panelists to minimize redundancy and to ensure that all

significant knowledge and skill areas identified in the literature were addressed. There were two unexpected outcomes of the content analysis. Although they were asked to distinguish between supervisory knowledge areas and supervisory skill areas, many of the panelists had difficulty doing so. As a result, identical items were classified by as both knowledge areas and as skill areas by a few panelists. In addition, some items were classified as knowledge areas by some panelists and as skill areas by others. It was therefore decided to combine the knowledge and skill items into a single section. This resulted in list of 114 discrete areas that appeared to be a comprehensive listing of the essential supervisory knowledge and skill areas when compared to those identified in the clinical supervision literature.

The second unexpected outcome of the content analysis was the identification by the panelists of 60 supervisory activities and responsibilities. The identification of supervisory activities and responsibilities was not a focus of this study however, since the panelists felt these items were important, it was decided that the items would be retained and included in a new section of the Delphi study. It is anticipated that these items will be utilized in future research.

A revised questionnaire (Questionnaire B) consisting of two sections was then developed for Round-2. The 114 items in the Clinical Supervision Knowledge and Skills section were organized into 8 supervisory knowledge and skill domain areas identified by panelists in Round-1 to facilitate the panelists in identifying any potential missing items. The 60 items in the Supervisory Activities and Responsibilities section were randomly arranged. All of the items were

rewritten as necessary to ensure so that each item began with a verb and had a consistent format.

The purpose of Round-2 was to begin the process of building group consensus regarding the supervisory knowledge and skills and the supervisory activities and responsibilities that are critical for the effective field-based supervision of rehabilitation counselors. The Delphi panelists were asked to rate the importance of each statement in both sections of Questionnaire B using the following 5-point Likert-type scale: 1) = Not important, 2) = Somewhat important, 3) = Important, 4) = Very important, 5) = Extremely important. In addition, panelists were asked to review and edit each item for clarity, and to identify any missing supervisory knowledge and skill areas or supervisory activities and responsibilities areas they believed were essential for the effective field-based supervision of rehabilitation counselors. Upon the completion of Round-2 (response rate = 94 %, $\underline{N}$ = 17) the means and standard deviations were computed for each item in Questionnaire B.

The purpose of the third and final round of the Delphi study was to move the panelists towards consensus and reduce the variability of the responses. In order to facilitate this process, Questionnaire C was developed. In Questionnaire C, each panelist received their previous response to each item in Questionnaire B, as well as the group mean and standard deviation for each item. Although the items were organized as they were in Questionnaire B, seven items were revised for clarity based upon recommendations made by the panelists in Round-2. In Round-3, the panelists were encouraged to re-evaluate their previous response

to each item in light of the mean and standard deviation for that item using the same five point Likert-type scale utilized in Questionnaire B. The panelists where provided an opportunity to retain or change their previous response to each item and to comment on why they did or did not choose to change their response to a given item. The panelists were also asked to rate the importance of the four new supervisory knowledge and skill items and the three new supervisory activities and responsibilities items that were recommended by panelists in Round-2. The new items were added to the end of the appropriate sections of Questionnaire C.

Only those panelist who completed Round-2 (n=17) were included in Round-3. Given the strong response rate (94%, N =16) to the initial mailing for Round-3, a follow-up mailing was not conducted. Following completion of Round-3 the means and standard deviations were computed for the final responses to each of the 118 supervisory knowledge and skill items.

The original design for this study limited the Delphi study to three rounds. The reduction in the average variance from Round-2 (mean variance = .5534) to Round-3 (mean variance =. 3904) for the original 114 items indicated that a reasonable level of consensus had been reached and lent further support for this design.

Phase Two of Instrument Development

Upon completion of the Delphi study, 118 supervisory knowledge and skill areas had been identified (the means and standard deviations for each item is provided in Appendix A). In order to determine which items would be retained or revised for the final instrument, each items was carefully evaluated in terms of

the mean of the item (greater than 2.5), a review of the empirical and theoretical literature, and the comments and recommendations of the Delphi panelists. Following this process, 95 items were retained for use in the RSCI. In order to take advantage of cognitive ties that respondents were likely to make among groups of questions and to reduce the potential for fatigue in completing the instrument, items were grouped by similar content areas (Dillman, 1978).

The second section of the RCSI consisted of an extensive demographic questionnaire developed to secure information about the demographic characteristics (e.g. gender, race/ethnicity, age, etc.) and professional experiences (e.g. educational background, job title, job setting, professional identity, etc.), of the respondents. Information about the respondent's clinical supervisory experience and training was also requested.

The third section of the RCSI was constructed to identify the supervisory practices (e.g. individuals supervised, frequency of supervision, approach to supervision, etc.) of CRCs who have provided clinical supervision. This section was developed following a comprehensive review of the literature.

Upon completion of the instrument development process, the instrument was field tested with a small group of CRCs. The subjects ($\underline{N}$ = 8) selected had diverse demographic characteristics and professional backgrounds specifically in the areas of supervision training and/or experience. The subjects were administered the entire instrument using draft instructions and rating scales for each item. The subjects were asked to complete the instrument and to evaluate the instrument for instruction clarity, item clarity, and length of time to complete

the instruments. Following the administration of the instrument, each participant was interviewed regarding the adequacy of the instructions, item clarity, use of the scales, length of time to complete the instrument, and any fatigue encountered when completing the instrument. Following the field-testing of the instrument, several demographic items where revised for clarity prior to finalizing the instrument.

Description of Final Instrument (See Appendix B)

The Rehabilitation Counselor Supervision Inventory (RCSI) consists of three sections. The 95 supervision knowledge and skill statements in the first section were rated on two, five point Likert-type scales (0-4) (Table 1). On the first scale, respondents were asked to determine to what extent each knowledge or skill statement is important in providing effective field-based clinical supervision to rehabilitation counselors. On the second scale, respondents were asked to rate the degree of preparedness they have in each area as a result of their education and training.

The second section of the RCSI is a 17 question demographic questionnaire. Major sections within this questionnaire include: (1) identifying information, (2) employment information, (3) higher education information, (4) credentials, (5) clinical supervision training and experience information, and (6) belief statements regarding the establishment by the CRCC of experience and training requirements for clinical supervisors.

Table 1

Importance and Preparedness Scales for the

Rehabilitation Counselor Supervision Inventory

Listed below are knowledge and skill areas related to field-based clinical supervision of rehabilitation counselors. Please rate each statement on a scale of 0-4 for both of the following:

Scale 1. The IMPORTANCE of the area described in the statement for the effective field-based supervision of rehabilitation counselor supervisees:

SCALE FOR IMPORTANCE

0 = Not Important

1 = Little Importance

2 = Moderately Important

3 = Highly Important

4 = Very Highly Important

Scale 2. The PREPAREDNEDNSS you feel you have in each area as a result of your education and training:

SCALE FOR Preparedness

0 = No Preparation

1 = Little Preparation

2 = Moderate Preparation

3 = High Degree of Preparation

4 = Very High Degree Preparation

The third section of the RCSI consists of 22 supervisory practice questions. Major sections within this section include: (1) identifying information, (2) supervisory style information, (3) supervisory role information, and (4) supervisory methods information. Only respondents with supervisory experience within the last five years were asked to complete this portion of the questionnaire. Content validity of the RCSI was addressed through the development methodology used in the construction of this instrument. The use of the Delphi Method for the purpose of item development, consensus building, and expert content review provides some assurance that the major knowledge and skill areas essential for the effective clinical supervision of rehabilitation counselors were identified.

Procedures

Design

The intent of this study was to begin the inductive process of identifying the clinical supervisory knowledge and skills that are essential for the effective field-based supervision or rehabilitation counselors, the perceived preparedness of CRCs to provide supervision, and the supervision practices utilized by CRCs who have provided clinical supervision. Two research designs were used for this study, exploratory and ex post facto.

This study utilized a self-report format. Self-report measures are commonly used to obtain information that can not be readily and cost effectively obtained from other sources (Babbie, 1995). Many of the items included in this instrument are knowledge and skill areas that can not be easily observed or

empirically measured by others. The participants were therefore in the best position to evaluate the importance of specific knowledge and skill areas, their degree of preparedness in those areas. The use of self-report for this investigation was based on the assumption that CRCs were able and willing to respond honestly and accurately to this survey. In order to increase the potential response rate, the CRCC agreed to approve three hours of continuing education credits for each subject who completed and returned the questionnaire.

Data Collection

Upon selection of the sample for this study, four mailing labels per respondent (N=1,500) were printed. On May 1, 1999, a packet of materials which included: A transmittal letter, the CRCC continuing education credit request form pre-encoded with the respondents CRC number, a copy of the RCSI with preprinted instructions, and a self addressed stamped return envelop, were sent via first class mail to each subject (N = 1,500) by the CRCC (see Appendix B).

Returns of the questionnaires were monitored daily. Packets returned as undeliverable, but with a forwarding address were immediately remailed to the subject. Packets returned as undeliverable without a forwarding address were recorded in a tracking book. Returns were monitored daily by the CRCC staff and tracked via the CRC number on the continuing education credit form. Five weeks after the initial mailing, a second complete packet was sent via first class mail to non-respondents including those who had not returned the CRC

continuing education credit form. Data for the present study was collected between May 1 through July 1, 1999.

Data Analysis

Descriptive statistics were computed on sample characteristics from the demographic questionnaire. Specific demographic characteristics variables which define selected characteristics of the sample include the following continuous variables: (1) age; (2) total number of years of post CRC experience in rehabilitation; and (3) number of hours of training in clinical supervision. The group means and standard deviations for these variables were computed for the entire sample. In addition, frequencies and percentages were computed on the following categorical variables: (1) gender, (2) race/ethnicity, (3) current job title, (4) current employment setting, (5) professional identity, (6) credentials, (7) degree level, (8) academic major, (9) type of training in supervision, (10) supervision training topics, (11) supervision experience.

Prior to any further analyses concerning the specific research questions for this study, a principal components analysis (PCA) of the 95 RCSI items was conducted based on the subjects (N= 774) responses to the Importance scale. The purpose of PCA is to reduce a relatively large number of variables (items) into relatively few components or subsets by summarizing the linear patterns of intercorralations among the items. PCA was determined to be the best data reduction method for this study because it explains the most variance by taking into consideration not only the variation that is unique to an item, but error variance as well (Pedhazur & Schmelkin, 1991). In order determine the number

of factors to retain, The Kaiser-Guttman rule of eigenvalues greater than one was utilized. The Cattell's scree test was then used to determine the number of factors to be retained (Tinsley & Tinsley, 1987). In order to ensure that the best solution was identified, factor solutions were also rotated using both using both varimax and oblimin methods.

In order to address the first research question, descriptive statistics (mean and standard deviation) were computed for each item on the RCSI according the subjects response to the five point Likert-type importance scale (see Appendix B). The items were then rank ordered within the factors identified by the PCA. A mean score for each factor was then computed.

In order to address the second research question, descriptive statistics (mean and standard deviation) were computed for each item on the RCSI according the subjects response to the five point Likert-type preparedness scale (see Appendix B). The items were then rank ordered within each factor identified in the PCA. A mean score for each factor was then computed.

To address the third research question and determine whether perceptions of importance of essential supervisory skill and knowledge areas differed according to demographic characteristics or professional characteristics of CRCs, a series of multivariate analyses of variance (MANOVA) were conducted. The dependent variables for these analyses were the mean scores on the six factor scores computed from the subject's responses to the five point Likert-type Importance scales. One independent variable was used in each MANOVA. The independent variables for these analyses were: (1) gender, (2)

current job title, (3) current employment setting, (4) professional identity, (5) degree level, (6) major area of study, (7) supervision training, (8) supervision experience, and (9) number of years of post CRC experience.

In order to determine whether perceptions of preparedness in essential supervisory skill and knowledge areas differed according to demographic characteristics or professional characteristics of CRCs, another series of MANOVAs were conducted. The dependent variables for these analyses were the mean scores on the six factor scores computed from the subject's responses to the five point Likert-type preparedness scales. The same independent variables for these analyses as were used in the previous analyses.

The purpose of the MANOVA was to test the differences among the groups in the independent variables on the linear combinations of the six (importance or preparedness) factors. Upon finding a significant multivariate F (Wilk's Lamda $\leq .05$), post hoc univariate ANOVA's were conducted. Bonferroni comparisons were conducted for each dependent variable for the six independent variables with three or more levels. Independent-samples t tests comparisons were conducted for the three independent variables with two levels.

In order to address the fourth research question, descriptive statistics were computed for the subsample of CRCs who reported that they have provided field-based clinical supervision in the last five years. Group means and standard deviations where computed for the following continuous variables: (1) age, (2) total number of years of post CRC experience in rehabilitation, (3) number of hours of training in clinical supervision, (4) number of individuals supervised in

the last 5 years, (6) number of individuals supervised at one time. In addition, frequencies and percentages where computed for the subsample on the following categorical variables: (1) gender, (2) race/ethnicity, (3) current job title, (4) current employment setting, (5) professional identity, (5) credentials, (6) degree level, (7) academic major, (8) supervision training; (9) supervision setting; and (10) type of individuals most frequently supervised.

In order to address the fifth research question frequencies and percentages were computed for the following categorical supervisory practice items: (1) format of supervision sessions, (2) frequency of supervision sessions, (3) length of supervision sessions, (4) documentation of supervision sessions, (5) the five supervisory roles, and (6) the eight supervisory methods.

Additional Analyses

In order to determine the CRCs (N = 774) opinions regarding the establishment by the CRCC of specific experience requirements and specific training requirements for clinical supervisors, descriptive statistics (frequencies and percentages) were computed for items 12 and 13 in section two of the RCSI (see Appendix B).

Finally, with the exception of the post-hoc ANOVA procedures, the .05 level of significance was used as the minimum rejection level for all statistical analyses. For the post hoc ANOVA procedures, the alpha was divided by the number of factors (n = 6) for each pair-wise comparison to control for Type I error (Alpha = .05/6 = .008).

Chapter 4

RESULTS

Of the 1,500 RCSIs mailed to CRCs throughout the country, four (.26%) were returned as undeliverable, and 12 (.8%) blank questionnaires were returned with notes indicating that the subjects did not wish to participate in the study. Of the remaining RCSIs (n =1,484) sent out, 793 (53.4%) were returned which yielded 774 usable questionnaires. The response rate in the current study was therefore within the anticipated 50-60% range.

Preliminary Examination of the Variables

Prior to initiating any data analysis procedures, the general demographic and supervision experience variables from Section Two of the RCSI were examined. Several minor issues were identified and addressed. Seven subjects indicated 27 or more years of post CRC work experience in rehabilitation counseling. Given that the CRC credential has only been available since 1973 (Leahy & Holt, 1993), it was determined that these responses were potential outliers and the responses were changed to missing values. A change was also made to one category of the credentials variable. Subjects had been asked to specify, in writing, any additional credentials that were not listed. Seventeen subjects reported that they were licensed as rehabilitation counselors (LRCs) in the three states that provide this credential. For the purposes of this study it was determined that the LRC and the Licensed Professional Counselor (LPC) credentials should be treated as equivalent credentials. Therefore, the LRC

responses were combined with the LPC responses and the category was re-labeled LPC/LRC.

Issues of more significant concern arose during the preliminary examination of the four variables that addressed formal training in clinical supervision (items 11, 11a, 11b and 11c) in the demographic questionnaire (see Appendix B). Of the 234 subjects who responded to item 11c, 18% (n = 42) reported that they had between 200 and 999 hours of formal training in clinical supervision. In a few of these cases the number of hours seemed plausible. For example, one individual who reported 800 hours of training also indicated that they held the LPCS (licensed supervisor credential). In many other cases, however, the pattern of responses seemed to indicate possible confusion in the interpretation of the terms used in these items. For example, many subjects seemed to confuse supervised supervision with supervised counseling. In one case for example, a 23-year-old individual with a masters degree in rehabilitation counseling and less than one year of experience reported 600 hours of training in clinical supervision. In another case, a subject with 13 years post-CRC work experience reported 700 hours of formal training in clinical supervision via masters level academic coursework. The only training topic reported by this individual, however, pertained to evaluation issues and techniques. Similar response patterns were noted for individuals who reported 100 or less hours of clinical supervision training indicating that the number of hours reported was not a reasonable criterion to determine the reliability of the responses for items 11a, 11b, and 11c.

The patterns of responses to items 11, 11a and 11b indicated that there was a possible lack of distinction by some respondents between clinical and other types of supervision training. Several respondents indicated some or all of the supervision training received had been secured via in-service training and had been limited to only a couple topic areas such as supervision methods and techniques and management skills for supervision. These topics could be considered the foundation for training in administrative supervision. In addition, twelve (12) subjects who completed items 11a, 11b and 11c answered "no" to item 11 indicating that they had not received formal training in clinical supervision.

Given the apparent lack of clarity and/or the variability in the interpretation of items 11a, 11b, and 11c, it was decided that these items would not be utilized in this study. Item 11 was retained for two reasons. The majority the sample subjects (68.2%, n = 528) who responded "no" to item 11 apparently interpreted the question correctly. Secondly, the overall pattern of responses of the 222 subjects who responded yes to this item indicates that these individuals believe that they have received training in clinical supervision and it was from this perspective that they responded to the other items in the instrument.

In order to determine if the CRCs who responded to the survey were representative of the population, descriptive statistics for the population were secured from the CRCC for the following variables: Gender (percentages), race/ethnicity (percentages), highest earned degree (percentages), job title (percentages) and employment setting (percentages). A review of the population

and sample statistics (Appendix C) indicated that the CRCs who elected to respond to the survey had demographic characteristics very similar to those of the population.

For the gender and race/ethnicity, degree level, the population and sample distributions were very similar, with the largest discrepancy between the population and sample percentages being approximately 2%. A similar distribution was found for the employment setting variable with the exception of the state-federal rehabilitation agency field office, private practice and other categories which had slightly larger discrepancies. The largest discrepancy for any of the variables was identified in the job titles variable with 12.8% more of population than the sample reporting a job title of full time student. It should be noted, however, that the CRCC data represents the demographic information reported by each CRC at the time of the initial application for certification and/or at the five year reapplication renewal point. Therefore, if a CRC reported that they were a student at the time of application, they are maintained by CRCC in this job title classification until new information is provided at the five year renewal point.

Prior to further data analyses the job title, employment setting, and post CRC work experience variable were reviewed. Before combining, adding or deleting categories in the job title and job setting variables (items 4 and 5 in section two of the RCSI, see Appendix B) each variable was evaluated to determine if a unique contribution to this study could potentially be made by the unaltered category. A review of the literature was then conducted to identify

which of the remaining categories in either variable could reasonably be combined. Finally, cross tabulations of the job title and employment setting variables by the other demographic variables were computed prior to collapsing the variables to ensure that any potentially unique characteristics of a particular group was identified.

For the job title category it was determined that 10 categories could be utilized to reflect the data. The job development/placement, work adjustment specialist, vocational evaluator and independent living specialist categories were combined to form a new "other rehabilitation specialties" category. The five full time doctoral students were merged into the rehabilitation educator category. The 33 individuals who indicated via hand written responses that their job title was as a counselor or therapist other then rehabilitation (e. g. marriage and family counselor, mental health counselor, counseling psychologist, etc.) were combined with the substance abuse counselors to form a new "other counseling specialties" category. A new category was formed to identify individuals who reported that they were either retired or unemployed when they completed the instrument and the rehabilitation nurse (n = 1) category was merged with the "other" category. Following the reclassification of the job title categories, all hand written responses were reevaluated and reclassified if appropriate.

For the job setting category it was determined that 10 categories could be utilized to reflect the data. The state-federal rehabilitation agency field office and the state rehabilitation agency facility were combined to form the new "state-federal rehabilitation" category. The private (proprietary) rehabilitation company,

worker's compensation agency, business or industry, and insurance company categories were combined into the new "private proprietary" category. The independent living center, mental health center, mental hospital, mental retardation center, and correctional institution categories were combined to form the new "social support agency" category. Finally, the public school category was relabeled "K-12 school systems" in order to acknowledge other types of K-12 educational service delivery systems and the state fund category (n = 0) was dropped.

In order to utilize the number of years of post CRC work experience in rehabilitation variable (item 6 in section two of the RCSI, see Appendix B), in the MANOVA and post hoc ANOVA analyses, the variable was partitioned into a four level categorical variable as indicated in Table 2. The continuous descriptive statistics (mean and standard deviation) for this variable will only be utilized for the purpose of describing the demographic characteristics of the sample.

Table 2 - Years of Post CRC Work Experience Categorical Variable

Level	Years of Experience	N	Valid %
1	0 to 4 years	194	25.5
2	5 to 9 years	227	29.9
3	10 to 14 years	126	16.6
4	15 or more years	213	28.0

Note: The Ns do not compute to 774 due to missing data

Characteristics of the Sample

The final sample for this study consisted of 774 CRCs. Tables 3 and 4 provide the breakdown of the sample by demographic and professional characteristics. The sample consisted of 280 males (36.3%) and 491 females (63.7%) and was predominately Caucasian/non-Hispanic (n= 684, 88.4%). The CRCs ages ranged from 22 to 80, with mean age of 45 years. The CRCs reported an average of 10 years of post CRC work experience, with the amount of experience ranging from less than one to 27 years. Both rehabilitation and counseling (n = 495, 64.5%) followed by rehabilitation (n = 160, 20.8%) were the professional identities most frequently reported by the respondents. Rehabilitation counselor (n = 317, 41.4%), administrator (n = 85, 11.1%), supervisor (n = 72, 9.4%) and case manager (n = 68, 8.9%) were the most frequently cited job titles. The job settings most frequently reported were private proprietary (n = 190, 24.8%), state-federal rehabilitation (n = 185, 24.1%), social support agency (N = 83, 10.8%), and private practice (n = 79, 10.3%).

In terms of education, 86.4% (n = 660) of the sample indicated that the masters degree was the highest degree earned and 66.5% (n = 517) indicated their major area of study was in rehabilitation counseling for their highest degree. The majority of the CRCs (n = 422, 56%) indicated they did not hold any additional credentials. Of the 44% of the CRCs who did hold additional credentials, 21.1% (n = 163) indicated that they were licensed as professional or rehabilitation counselors (LPC/LRC), 11.2% (n = 87) reported they were certified

Table 3

Demographic Characteristics of the Sample

Variable	N	Valid %
Gender		
Male	280	36.3
Female	491	63.7
Race/Ethnicity		
African American	31	4.0
Native American	7	.9
Black/non-African	6	.8
Latino/a	15	2.0
Caucasian/non-Hispanic	684	89.1
Asian American/Pacific Islander	11	1.4
Other	14	1.8
Professional Identity		
Rehabilitation	160	20.8
Counseling	52	6.8
Both Rehabilitation and Counseling	495	64.5
Psychology	15	2.0
Other	46	6.0
Degree Level		
Bachelors	49	6.4
Master	660	86.4
Ph.D.	55	7.2
Academic Major		
Rehabilitation Counseling	517	68.5
Psychology	47	6.2
Social Work	9	1.2
Other Counseling Specialty	88	11.7
Other Rehabilitation Specialty	20	2.6
Other	74	9.8

Note: The Ns do not compute to 774 due to missing data.

Table 4 – Professional Characteristics of the Sample

Variable	N	Valid %
Job Title		
Rehabilitation counselor	317	41.4
Supervisor	72	9.4
Other rehabilitation specialist	38	5.0
Administrator	85	11.1
Rehabilitation educator	29	3.8
Social worker	10	1.3
Case manager	68	8.9
Other counseling specialties	46	6.0
Retired/unemployed	22	2.9
Other	79	10.3
Employment Setting		
State-federal rehabilitation	185	24.1
Private non-profit rehabilitation facility	76	9.9
Private proprietary	190	24.8
College or University	47	6.1
Medical center or general hospital	26	3.4
Social support agency	83	10.8
K-12 school system	17	2.6
Private practice	79	10.3
Retired/unemployed	20	2.2
Other	44	5.7
Additional Credentials *		
CCM	87	11.2
CVE	38	4.9
CDMS	62	8.0
NCC	47	6.1
LPC/LRC	163	21.1
LLPC	5	.6
LPCS (Licensed Supervisor)	7	.9
NBCC Approved Clinical Supervisor	3	.4
CWA	2	.3
Licensed Psychologist	6	.8
Limited Licensed Psychologist	3	.4
Other	130	16.8

Note: The Ns do not compute to 774 due to missing data.

* Subjects could report more then one additional credential

as case managers (CCM), and 1.3 % (n = 10) indicated that they held either the LPCS (licensed supervisor) or NBCC Approved Clinical Supervisor credentials. Formal training in clinical supervision was reported by 28.7% (n = 222) of the CRCs and clinical supervision had been provided within the last five years by 41.5% (n = 321) of the CRCs.

Principal Components Analysis

Prior to conducting any statistical analyses concerning the specific research questions for this study, the RCSI importance scale items were grouped into empirically defined categories through the use of a principal components analysis technique. In order determine the number of factors to retain, the Kaiser-Guttman rule of eigenvalues greater than one rule was utilized. A total of 17 factors were indicated. Because the Kaiser-Guttman rule tends to yield too many factors when there are a large number of variables, the Cattell's scree test was then used as an alternative to determine the number of factors to be retained (Tinsley & Tinsley, 1987). A six-factor solution was indicated. A scree plot of the eigenvalues for the 17 factors is provided in Appendix D.

The six factor solution with a varimax rotation proved to be optimal for this study. The use of the varimax (orthogonal) rotation procedure made the solution more interpretable by maximizing the variances of the factors without changing the underlying mathematical properties of the solution (Tabachnick & Fidell, 1996). The resulting six-factor solution was parsimonious, had good simple structure, and could be most meaningfully interpreted as compared to the other solutions investigated.

Eigenvalues for the six-factor solution ranged from 28.92 to 2.49 and accounted for 46.3% of the variance. All items loaded on at least one factor and loading coefficients ranged from .32 to .83. Factor membership was based on the highest loading for each item. The items, particularly those with the highest loadings, were then reviewed in order to identify an appropriate label that succinctly described the content of the items in each factor. The factor loading for each item is available in Appendix E. Finally, in order to estimate the internal consistency of each factor, reliability coefficients were computed. Table 5 presents the label for each supervisory knowledge and skill importance factor, eigenvalue and percentage of variance accounted for by each factor and the alpha coefficient for each factor.

Table 5 -Component Eigenvalues, Percent Variance and Cronbach Alphas Based on Principal Components Analysis

Factor	Eigenvalue	% Variance	Alphas
1. Ethical and Legal Issues	28.92	30.45	.94
2. Theories and Models	3.99	4.20	.91
3. Intervention Techniques and Methods	3.14	3.30	.90
4. Evaluation and Assessment	2.82	2.97	.93
5. Rehabilitation Counseling Knowledge	2.61	2.76	.89
6. Supervisory Relationship	2.49	2.63	.84

Supervisory Knowledge and Skills

In order to identify the clinical supervisory knowledge and skill areas that are perceived by CRCs to be essential for the provision of effective supervision in rehabilitation counseling (research question number one) the mean and standard deviation of each item on the RCSI importance scale was computed. The items were then rank ordered within the identified factors and a mean score and standard deviation for each factor was computed. For the purposes of conceptual clarity, an a priori criterion level (≥ 2.00) was established for group mean scores on any item to denote at least moderate importance. This criterion level will be used in discussing the relative importance of the supervisory knowledge and skills factors and items. Factor and item means and standard deviations are provided in Tables 6 through Table 11.

The first importance factor, Ethical and Legal Issues (Table 6), contains 17 items related to the legal and ethical responsibilities of the supervisor, codes of ethics, and ethical issues pertaining to supervision. CRCs rated all items as having at least moderate (≥ 2.00) importance. The overall mean score ($\underline{M} = 3.20$) of this factor indicates that knowledge and skills pertaining to supervisory related ethical and legal issues are perceived by CRCs to be highly important for the effective field-based supervision of rehabilitation counselor supervisees. The Cronbach's alpha coefficient computed for the total sample was .94 indicating a high internal consistency of the items contained in this factor.

Table 6 – Importance Factor 1: Ethical and Legal Issues

Means and Standard Deviations

	Mean	SD
Ethical and Legal Issues	**3.20**	**.85**
61. Confidentiality issues in supervision	3.62	.64
51. CRCC Code of Professional Ethics for Rehabilitation Counselors	3.49	.72
57. Ethical responsibilities of the supervisor to the supervisee	3.44	.70
56. Ethical responsibilities of the supervisor to the client	3.43	.72
58. Legal responsibilities as a supervisor to the client	3.38	.78
60. Issues pertaining to informed consent in supervision	3.34	.78
59. Legal responsibilities as a supervisor to the supervisee	3.30	.85
55. Ethical dilemmas specific to supervision	3.26	.80
54. Ethical decision making models	3.20	.83
65. Legal and ethical issues pertaining to determining supervisee competency	3.20	.85
62. Dual relationship issues in supervision	3.05	.88
66. Ethical issues in group supervision	3.02	.95
67. Relevant state and case law regarding supervision	2.97	.94
52. ACA code of Ethics	2.97	1.06
64. Due process rights of the supervisee	2.96	.92
63. ACES Ethical Guidelines for Clinical Supervisors	2.90	1.07
63. Vicarious liability issues in supervision	2.88	1.01

Table 7 – Importance Factor 2: Theories and Models

Means and Standard Deviations

	Mean	SD
Theories and Models	**2.64**	**.92**
45. Applications of theoretical knowledge to real world situations	3.23	.84
44. The effectiveness of specific counseling strategies with a variety of client populations	3.19	.78
43. A variety of counseling theories and techniques	3.10	.87
28. Counseling techniques in supervision to facilitate supervisee awareness and change	2.98	.88
18. Stages of clinical development (e.g. novice through master counselor)	2.93	.85
33. A variety of live supervision techniques	2.87	.88
12. Transference and countertransference issues on the supervisory relationship	2.65	.98
49. A variety of case conceptualization techniques	2.63	.89
14. Operational definition(s) of clinical supervision	2.57	.96
17. A variety of models and theories of supervision (e.g. Developmental, Psychotherapy theory based, etc.)	2.55	.97
15. Similarities and differences between clinical and administrative supervision	2.56	.93
22. Adult learning theories	2.54	.90
23. Group supervision theories and techniques	2.53	.93
92. University versus on-site based expectations about supervision training goals	2.50	1.02
21. Models and theories of supervisor development	2.48	.92
24. Rehabilitation counseling supervision literature	2.45	.91
13. Parallel process issues in supervision	2.39	.94
31. Role play exercises in supervision	2.39	1.05
25. Generic counseling supervision literature	2.25	.91
29. Use of video/audiotapes in supervision	2.06	1.08

Table 8 – Importance Factor 3: Intervention Techniques and Methods

Means and Standard Deviations

	Mean	SD
Intervention Techniques and Methods	**2.97**	**.84**
1. Rapport building in supervision	3.38	.67
32. Verbal feed-back as supervisory method	3.34	.70
40. Methods to assist supervisees who are not adequately progressing	3.31	.75
47. Crises intervention techniques	3.30	.78
42. Methods to accommodate supervisees with disabilities	3.22	.85
41. Intervention techniques to deal with a resistive supervisee	3.19	.79
38. Sources of anxiety and stress for novice counselors	3.16	.80
48. Sources of resistance to change	3.10	.75
19. Changing needs of supervisees over the course of supervision	3.06	.82
46. Models of how and why people change	3.05	.82
20. Multiple supervisory roles (e.g. teacher, counselor, consultant, evaluator)	2.99	.86
50. Power dynamics/issues in counselor client relationship	2.98	.96
36. Humor as a supervision technique/intervention	2.92	.93
30. Case presentation method of supervision	2.90	.89
16. Personal needs and values regarding supervision	2.83	.88
27. Consultation as a supervision technique	2.81	.85
34. Modeling counseling as a supervision technique	2.81	.91
39. Sources of role strain for supervisees	2.74	.86
26. Teaching as a supervision technique	2.72	.90
35. Use of self-disclosure as a supervision technique	2.36	.96
37. Metaphor as a supervision technique	2.29	.99

Table 9 – Importance Factor 4: Assessment and Evaluation

Means and Standard Deviations

	Mean	SD
Assessment and Evaluation	**2.89**	**.85**
86. Methods for providing effective, appropriate feedback to supervisees	3.30	.72
69. Self appraisal of counseling competencies	3.07	.80
70. Self-appraisal of training needs as a supervisor	3.05	.79
68. Self appraisal of supervisory competencies	2.98	.83
88. A variety of direct and indirect methods for evaluating supervisees	2.95	.83
87. Methods to reduce supervisee anxiety about the evaluative component of supervision	2.91	.84
90. Supervisor evaluation instruments	2.82	.88
89. Instruments to evaluate supervisee performance	2.80	.88
95. Methods for documenting supervision sessions	2.80	.92
93. Strategies to assist supervisee to establish written goals/contract for field-based experience	2.79	.88
83. Techniques to assess the pre-supervision counseling skill/developmental level of supervisees	2.78	.89
85. Strategies to focus supervision sessions	2.77	.83
84. Methods to identify the supervisory learning style of supervisees	2.69	.90
94. Phases of supervision (e.g. beginning, middle, end/termination)	2.69	.93

Table 10 – Importance Factor 5: Rehabilitation Counseling Knowledge

Means and Standard Deviations

	Mean	SD
Rehabilitation Counseling Knowledge	**3.26**	**.75**
75. Disability related issues (e.g. physical, psychological, medical, social, legal)	3.61	.60
74. The rehabilitation process from assessment through job placement	3.58	.63
76. Case management and service coordination	3.51	.62
80. Environmental and attitudinal barriers for individuals with disabilities	3.41	.70
81. Assessment interpretation and evaluation techniques	3.34	.68
79. Vocational counseling and consultation services	3.30	.73
73. Rehabilitation systems and how to interact with them	3.19	.77
91. Time management techniques	3.17	.81
72. Scope of Practice for Rehabilitation Counseling	3.17	.82
71. Philosophy of rehabilitation counseling	3.16	.85
77. Family, gender and multicultural issues in rehabilitation counseling	3.15	.79
78. Foundations of rehabilitation counseling	3.04	.89
82. Various professional credentials and their importance for the supervisor	2.80	.89

Table 11 – Importance Factor 6: Supervisory Relationship

Means and Standard Deviations

	Mean	SD
Supervisory Relationship	**2.73**	**.93**
2. Trust issues in the supervisory relationship	3.53	.63
3. Supervisory working alliance	3.10	.76
11. Sources of conflict in the supervisory relationship	3.06	.84
5. Impact of various supervisory styles and approaches on the supervisory relationship	3.01	.85
10. Influence of the supervisor's counseling orientation on the supervisory relationship	2.75	.89
11. Implications of culture/ethnicity similarities/differences between the supervisor and the supervisee	2.69	1.00
4. Power issues in supervision	2.56	1.00
8. Implications of gender similarities/differences between the supervisor and the supervisee	2.35	1.07
9. Implications of disability similarities/differences between the supervisor and the supervisee	2.27	1.12
7. Implications of sexual orientation similarities/differences between the supervisor and the supervisee	1.99	1.16

The second importance factor, Theories and Models (Table 7), contains 20 items related to supervision and counseling theories, supervision and counseling strategies, a variety of supervision models, supervision and counseling models and issues, and resource information for supervisors. CRCs rated all items as having at least moderate (≥ 2.00) importance. The overall mean score (M =2.64) of this factor indicates that knowledge and skills pertaining to a variety of supervision and counseling related theories, models and resources are perceived by CRCs to be moderately important for the effective field-based supervision of rehabilitation counselor supervisees. The Cronbach's alpha coefficient computed for the total sample was .91 indicating a relatively high internal consistency of the items included in this factor.

The third importance factor, Intervention Techniques and Methods (Table 8), contains 21 items that represented supervision methods, intervention techniques to address the needs of supervisees, and potential issues for counselors in supervision. CRCs rated all items as having at least moderate (≥ 2.00) importance. The overall mean score (M =2.97)) of this factor indicates that knowledge and skills pertaining to a variety of supervisory related Intervention techniques and methods are perceived by CRCs to be of moderately high importance for the of for the effective field-based supervision of rehabilitation counselor supervisees. The Cronbach's alpha coefficient computed for the total sample was .90 indicating a moderately high internal consistency of the items contained in this factor.

The fourth factor, Evaluation and Assessment (Table 9), was comprised of 14 counselor and supervisor evaluation and assessment techniques, methods, needs and issues. CRCs rated all items as having at least moderate (≥ 2.00) importance. The overall mean score (M =2.89) of this factor indicates that knowledge and skills pertaining to a variety of supervisory evaluation and assessment issues are perceived by CRCs to be of moderately high importance for the effective field-based supervision of rehabilitation counselor supervisees. The Cronbach's alpha coefficient computed for the total sample was .93 indicating a high internal consistency of the items included in this factor.

The fifth factor, Rehabilitation Counseling Knowledge (Table 10) contains 13 rehabilitation counseling related knowledge and skill areas. CRCs rated all items as having at least moderate (≥ 2.00) importance. The overall mean score (M = 3.26) of this factor indicates that knowledge and skills pertinent to rehabilitation counseling are perceived by CRCs to be highly important for the effective field-based supervision of rehabilitation counselor supervisees. The Cronbach's alpha coefficient computed for the total sample was .89 indicating a moderately high internal consistency of the items in this factor.

The sixth factor, Supervisory Relationship (Table 11), consisted of 10 items that addressed the implications of demographic similarities and differences between the supervisor and the supervisee, and factors that might impact the supervisory relationship. CRCs rated all but one of the items as having at least moderate (≥ 2.00) importance. CRCs rated implications of sexual orientation similarities/differences between the supervisor and the supervisee (item 8) as

less than moderately important. The overall mean score (M =2.73) of this factor indicates that knowledge and skills regarding issues that may impact the relationship between the supervisor and the supervisee are perceived by CRCs to be of moderately high importance for the effective field-based supervision of rehabilitation counselor supervisees. The Cronbach's alpha coefficient computed for the total sample was .84 indicating a moderate internal consistency of the items within this factor.

Perceived Preparedness

In order to address the second research question and determine the supervisory knowledge and skill areas CRCs perceived themselves to be the most and least prepared to provide supervision the mean and standard deviation was computed for each item on the RCSI preparedness scale (see Appendix B). The items were then organized into the six previously identified factors and rank ordered within each factor. A mean score for each factor was computed.

For the purposes of conceptual clarity, three a priori criterion levels were established for group mean scores on any item to denote the perceived degree of preparedness: High perceived preparedness (≥ 3.00), moderate perceived preparedness (Ms = 2.00 – 2.99), low perceived preparedness (≤ 1.99). These criterion levels will be used in discussing perceived preparedness of CRCs in each preparedness factor and item. The preparedness factor and item means and standard deviations are provided in Tables 12 through Table 17.

The first preparedness factor, Ethical and Legal Issues (Table 12), contains of 17 items. CRCs reported that they had a high degree (≥ 3.00) of

perceived preparedness in the item pertaining to the CRCC Code of Professional Ethics for Rehabilitation Counselors. Moderate levels of preparedness (Ms = 2.00 – 2.99) were reported for 10 items pertaining to ethical responsibilities and decision making in supervision. CRCs indicated low levels (≤ 1.99) of perceived preparedness for six items. CRCs indicated that they were least prepared in the areas of state and case law regarding supervision, ACES Ethical Guidelines for Clinical Supervisors, and vicarious liability issues in supervision. The overall mean score (M = 2.26) of this factor indicates that the CRCs perceived themselves to be moderately prepared to address ethical and legal issues in supervision.

The second preparedness factor, Theories and Models (Table 13), contains 20 items. CRCs did not perceive themselves to be highly prepared (≥ 3.00) in any area in this factor. Moderate levels of preparedness (Ms = 2.00 - 2.99) were reported for 12 items pertaining to counseling theories and applications and supervision related theories and models. CRCs indicated low levels (≤ 1.99) of perceived preparedness for eight items. CRCs indicated that they were least prepared in the areas of models and theories of supervisor development, parallel process issues in supervision, use of video/audiotapes in supervision, and university versus on-site based expectations about supervision training goals. The overall mean score (M =2.14) of this factor indicates that the CRCs perceived themselves to be in the low moderate range of preparedness to address supervision related theories and models.

Table 12 - Preparedness Factor 1: Ethical and Legal Issues

Means and Standard Deviations

	Mean	SD
Ethical and Legal Issues	**2.26**	**1.19**
51. CRCC Code of Professional Ethics for Rehabilitation Counselors	3.16	.95
61. Confidentiality issues in supervision	2.99	1.08
56. Ethical responsibilities of the supervisor to the client	2.62	1.16
57. Ethical responsibilities of the supervisor to the supervisee	2.54	1.18
54. Ethical decision making models	2.47	1.13
60. Issues pertaining to informed consent in supervision	2.46	1.20
58. Legal responsibilities as a supervisor to the client	2.34	1.21
62. Dual relationship issues in supervision	2.32	1.17
55. Ethical dilemmas specific to supervision	2.30	1.16
52. ACA code of Ethics	2.20	1.36
59. Legal responsibilities as a supervisor to the supervisee	2.15	1.22
65. Legal and ethical issues pertaining to determining supervisee competency	1.92	1.22
66. Ethical issues in group supervision	1.92	1.22
64. Due process rights of the supervisee	1.85	1.19
63. Vicarious liability issues in supervision	1.78	1.19
53. ACES Ethical Guidelines for Clinical Supervisors	1.69	1.35
67. Relevant state and case law regarding supervision	1.62	1.22

Table 13 - Preparedness Factor 2: Theories and Models

Means and Standard Deviations

		Mean	SD
Theories and Models		**2.14**	**1.09**
43.	A variety of counseling theories and techniques	2.96	.89
44.	The effectiveness of specific counseling strategies with a variety of client populations	2.74	.94
44.	Applications of theoretical knowledge to real world situations	2.68	1.01
28.	Counseling techniques in supervision to facilitate supervisee awareness and change	2.33	1.07
31.	Role play exercises in supervision	2.30	1.13
18.	Stages of clinical development (e.g. novice through master counselor)	2.28	1.15
17.	A variety of models and theories of supervision (e.g. Developmental, Psychotherapy theory based, etc.)	2.21	1.15
33.	A variety of live supervision techniques	2.18	1.14
49.	A variety of case conceptualization techniques	2.17	1.02
12.	Transference and countertransference issues on the supervisory relationship	2.17	1.11
22.	Adult learning theories	2.15	1.05
23.	Group supervision theories and techniques	2.11	1.12
15.	Similarities and differences between clinical and administrative supervision	1.99	1.16
14.	Operational definition(s) of clinical supervision	1.98	1.11
24.	Rehabilitation counseling supervision literature	1.86	1.12
25.	Generic counseling supervision literature	1.80	1.07
92.	University versus on-site based expectations about supervision training goals	1.78	1.15
29.	Use of video/audiotapes in supervision	1.76	1.17
13.	Parallel process issues in supervision	1.70	1.11
21.	Models and theories of supervisor development	1.66	1.12

Table 14 - Preparedness Factor 3: Intervention Techniques and Methods

Means and Standard Deviations

	Mean	SD
Intervention Techniques and Methods	**2.34**	**1.09**
32. Verbal feed-back as supervisory method	2.84	1.02
1. Rapport building in supervision	2.67	1.03
30. Case presentation method of supervision	2.61	1.12
47. Crises intervention techniques	2.59	1.06
42. Methods to accommodate supervisees with disabilities	2.58	1.12
46. Models of how and why people change	2.48	.99
48. Sources of resistance to change	2.46	.96
50. Power dynamics/issues in counselor client relationship	2.46	1.03
38. Sources of anxiety and stress for novice counselors	2.46	1.08
34. Modeling counseling as a supervision technique	2.39	1.10
20. Multiple supervisory roles (e.g. teacher, counselor, consultant, evaluator)	2.35	1.12
36. Humor as a supervision technique/intervention	2.35	1.16
35. Use of self-disclosure as a supervision technique	2.25	1.05
16. Personal needs and values regarding supervision	2.31	1.07
19. Changing needs of supervisees over the course of supervision	2.24	1.16
27. Consultation as a supervision technique	2.20	1.15
26. Teaching as a supervision technique	2.11	1.18
39. Sources of role strain for supervisees	2.03	1.13
40. Methods to assist supervisees who are not adequately progressing	2.02	1.17
41. Intervention techniques to deal with a resistive supervisee	1.92	1.17
37. Metaphor as a supervision technique	1.90	1.12

Table 15 - Preparedness Factor 4: Evaluation and Assessment
Means and Standard Deviations

	Mean	SD
Evaluation and Assessment	**1.99**	**1.13**
69. Self appraisal of counseling competencies	2.39	1.10
86. Methods for providing effective, appropriate feedback to supervisees	2.34	1.13
95. Methods for documenting supervision sessions	2.13	1.18
70. Self-appraisal of training needs as a supervisor	2.10	1.14
87. Methods to reduce supervisee anxiety about the evaluative component of supervision	2.08	1.14
93. Strategies to assist supervisee to establish written goals/contract for field-based experience	2.02	1.14
68. Self appraisal of supervisory competencies	2.01	1.15
88. A variety of direct and indirect methods for evaluating supervisees	1.99	1.11
94. Phases of supervision (e.g. beginning, middle, end/termination)	1.94	1.16
85. Strategies to focus supervision sessions	1.86	1.12
83. Techniques to assess the pre-supervision counseling skill/developmental level of supervisees	1.84	1.08
89. Instruments to evaluate supervisee performance	1.77	1.12
84. Methods to identify the supervisory learning style of supervisees	1.75	1.10
90. Supervisor evaluation instruments	1.66	1.13

Table 16 - Preparedness Factor 5: Rehabilitation Counseling Knowledge

Means and Standard Deviations

	Mean	SD
Rehabilitation Counseling Knowledge	**3.01**	**.90**
75. Disability related issues (e.g. physical, psychological, medical, social, legal)	3.38	.73
74. The rehabilitation process from assessment through job placement	3.36	.79
76. Case management and service coordination	3.23	.84
79. Vocational counseling and consultation services	3.18	.85
80. Environmental and attitudinal barriers for individuals with disabilities	3.16	.85
71. Philosophy of rehabilitation counseling	3.12	.86
78. Foundations of rehabilitation counseling	3.11	.84
81. Assessment interpretation and evaluation techniques	3.00	.86
72. Scope of Practice for Rehabilitation Counseling	2.95	.95
73. Rehabilitation systems and how to interact with them	2.81	.97
77. Family, gender and multicultural issues in rehabilitation counseling	2.80	.93
82. Various professional credentials and their importance for the supervisor	2.52	1.06
91. Time management techniques	2.51	1.15

Table 17 - Preparedness Factor 6: Supervisory Relationship

Means and Standard Deviations

	Mean	SD
Supervisory Relationship	**2.24**	**1.11**
2. Trust issues in the supervisory relationship	2.74	1.04
10. Influence of the supervisor's counseling orientation on the supervisory relationship	2.37	1.05
3. Supervisory working alliance	2.37	1.05
9. Implications of disability similarities/differences between the supervisor and the supervisee	2.35	1.18
11. Sources of conflict in the supervisory relationship	2.23	1.09
6. Implications of culture/ethnicity similarities/differences between the supervisor and the supervisee	2.24	1.10
5. Impact of various supervisory styles and approaches on the supervisory relationship	2.19	1.12
7. Implications of gender similarities/differences between the supervisor and the supervisee	2.09	1.12
4. Power issues in supervision	1.96	1.11
8. Implications of sexual orientation similarities/differences between the supervisor and the supervisee	1.87	1.20

The third preparedness factor, Intervention Techniques and Methods (Table 14), contains 21 items. CRCs did not perceive themselves to be highly prepared (≥ 3.00) in any item in this factor. Moderate levels of preparedness (Ms = 2.00 – 2.99) were reported for 19 items pertaining to a variety of supervisory methods and techniques. CRCs indicated low levels (≤ 1.99) of perceived preparedness for two items. CRCs indicated that they were least prepared in the areas of metaphor as a supervision technique, and intervention techniques to deal with a resistive supervisee. The overall mean score (M =2.34) of this factor indicates that the CRCs perceive themselves to be moderately prepared in the area of supervision interventions and methods.

The fourth factor, Evaluation and Assessment (Table 15), contains 14 items. CRCs did not perceive themselves to be highly prepared (≥ 3.00) in any item in this factor. Moderate levels of preparedness (Ms = 2.00 – 2.99) were reported for seven items pertaining to self appraisal issues related to supervision for the supervisor, methods for providing feedback and reducing supervisee anxiety about the evaluative component of supervision, and methods for documenting supervision sessions. CRCs reported low levels (≤ 1.99) of perceived preparedness for seven items. CRCs indicated that they were least prepared in the areas pertaining to instruments to evaluate the supervisor and the supervisee, methods to identify the supervisory learning styles of supervisees, and techniques to assess the pre-supervision counseling skill/development level of supervisees. The overall mean score (M =1.99) of this factor is only slightly less than the criterion level for moderate perceived

preparedness (Ms = 2.00 – 2.99). This finding indicates that in general, the CRCs perceived themselves to be in the low moderate range of preparedness in relation to issues pertaining to assessment and evaluation in supervision.

The fifth factor, Rehabilitation Counseling Knowledge (Table 16), contains 13 items. CRCs reported a high degree (≥ 3.00) of preparedness items in 8 of the items contained in this factor. Moderate levels of preparedness (Ms = 2.00 – 2.99) were reported for five items. The overall mean score (M =3.01) of this factor indicates that the CRCs perceived themselves to be highly prepared in rehabilitation counseling related knowledge in supervision.

The sixth factor, Supervisory Relationship (Table 17), contains 10 items. The CRCs did not perceive themselves to be highly prepared (≥ 3.00) in any item in this factor. Moderate levels of preparedness (Ms = 2.00 – 2.99) were reported for eight items pertaining to trust and conflict issues, the implications of disability, culture/ethnicity and gender, and the implications of the supervisors counseling orientation and style in the supervisory relationship. The CRCs indicated low levels (≤ 1.99) of perceived preparedness for two items. CRCs indicated that they were least prepared in the areas of implications of sexual orientation issues and power issues in supervision. The overall mean score (M =2.34) of this factor indicates that the CRCs perceive themselves to be moderately prepared in the area of relationship issues in supervision.

Differences According to Demographic and Professional Characteristics.

In order to address the third research question and determine whether perceptions of importance and preparedness of the supervisory skill and

knowledge areas differ according to demographic characteristics or professional characteristics of CRCs, two series of multivariate analyses of variance (MANOVA) were conducted. The purpose of the MANOVAs was to test the differences among the groups in the independent variables on the linear combinations of the six (importance or preparedness) factors. Upon finding a significant multivariate F (Wilk's Lamda $\leq .05$), post hoc univariate ANOVA's were conducted. Bonferroni comparisons were conducted for each dependent variable for the six independent variables with three or more levels. Independent-samples t tests comparisons were conducted for the three independent variables with two levels. In order to control for Type I error, the alpha was divided by the number of factors (6) for each pairwise comparison (alpha = .05/6 = .008).

Because many of the groups had unequal N's, the MANOVAs were computed using the General Linear Model Multivariate procedure with the Type III method sums of squares (GLM Multivariate, SPSS 9.0). "This method calculates the sums of squares of an effect in the design as the sums of squares adjusted for any other effects that do not contain it and orthogonal to any effects (if any) that contain it. The Type III sums of squares have one major advantage in that they are invariant with respect to cell sizes as long as the general form of estimability remains constant " (SPSS Base 9.0 User's Guide, 1999, p. 265).

Differences in Perceived Importance

A total of nine MANOVAs were conducted to determine whether perceptions of importance differed according to demographic or professional

characteristics of the CRCs. The dependent variables for these analyses were the mean factor scores of the six importance factors. The independent variables employed were: (1) gender, (2) job title, (3) employment setting, (4) professional identity, (5) degree level, (6) academic major, (7) supervision training, (8) supervision experience, and (9) years of experience.

A significant multivariate F (Wilks Lamda = .95, F (6, 570) = 5.16, p = < .05) was found for the gender variable. Post hoc comparisons (t test, alpha = .008) indicated that females perceived five of the importance factors as being significantly more important than males. Results indicated that females perceived the Ethical and Legal Issues (Females M = 3.30, Males M = 3.05), Theories and Models (Females M = 2.72, Males M = 2.55), Intervention Techniques and Methods (Females M = 3.05, Males M = 2.90), Evaluation and Assessment (Females M = 2.99, Males M = 2.71), and Rehabilitation Counseling Knowledge (Female M = 3.34, Males M = 3.14) factors as significantly more important than males. The results also indicated that males and females do not differ in terms of the perceived importance of the Supervisory Relationship factor.

A significant multivariate F (Wilks Lamda =. F .86 (54, 2865) =1.60, p = < .05) was found for the job titles variable. Post hoc comparisons (Bonferroni, alpha = .008) indicated that other counseling specialists (M = 2.93) perceive the Theories and Models factor as being significantly more important than rehabilitation counselors (M = 2. 56). They do not differ from supervisors (M = 2.55), other rehabilitation specialists (M = 2.62), administrators (M = 2.60), educators (M = 2.96), social workers (M = 2.88), case managers (M = 2.67),

CRCs with other job titles (M = 2.72), or CRCs who were retired or unemployed (M = 2.70). The results indicated that job title did not impact the perceived importance of the Ethical and Legal Issues, Intervention Techniques and Methods, Assessment and Evaluation, Rehabilitation Counseling Knowledge, or Supervisory Relationship factors.

Significant differences were found for the employment setting variable for two importance factors (Wilks Lamda = .84, F (54, 2855) = 1.80, p = < .05). Post hoc comparisons (Bonferroni, alpha = .008) indicated that CRCs working at a college or university (M = 2.95) perceived the Theories and Models factor as being significantly more important than individuals working in state-federal rehabilitation settings (M = 2.52) or private proprietary settings (M =2.49). They did not differ significantly from individuals working in private non-profit rehabilitation facilities (M = 2.72), medical centers or general hospitals (M = 2.78), social support agencies (M = 2.67), K-12 school systems (M = 2.94), private practice (M = 2.72), other employment settings (M = 2.77), or individuals who are retired or unemployed (M = 2.76). CRCs employed in colleges or universities (M = 3.12) also perceived the Assessment and Evaluation factor to be significantly more important than CRCs employed in private proprietary settings (M = 2.73). They did not differ significantly from individuals working in state-federal rehabilitation settings (M = 2.88), private non-profit rehabilitation facilities (M = 2.88), medical centers or general hospitals (M = 2.86), social support agencies (M = 2.92), K-12 school systems (M = 3.13), private practice (M = 2.90), other employment settings (M = 3.02), or individuals who are retired or

unemployed (M = 3.11). The results indicated that employment setting did not impact the perceived importance of the Ethical and Legal Issues, Intervention Techniques and Methods, Rehabilitation Counseling Knowledge, or Supervisory Relationship factors.

The educational level of the CRCs was found to impact the perceived importance of two factors (Wilks Lamda = .97, F (6, 558) = 2.59, p = < .05). Post hoc comparisons (Bonferroni, alpha = .008) indicated that CRCs with doctorate degrees (M = 2.86) perceived the Theories and Models factor to be significantly more important than the CRCs with bachelors degrees (M = 2.40). They did not differ significantly from the CRCs with masters degrees (M = 2.63). The doctorate level CRCs (M = 2.99) also perceived the Supervisory Relationship factor to be significantly more important than the bachelors level CRCs (M = 2.56). They did not differ significantly from the CRCs with masters degrees (M = 2.72). The results indicated that degree level did not impact the perceived importance of the Ethical and Legal Issues, Intervention Techniques and Methods, Evaluation and Assessment or Rehabilitation Counseling Knowledge factors.

A significant multivariate F (Wilks Lamda =.97, F (6, 558) = 2.59, p = < .05) was found for the training in clinical supervision variable. Post hoc comparisons (t test, alpha = .008) indicated that CRCs who reported training in clinical supervision (M = 2.77) perceived the Theories and Models factor to be significantly more important then the CRC's who did not report supervision training (M = 2.61). The results indicated that training in clinical supervision did

not impact the perceived importance of the Ethical and Legal Issues, Intervention Techniques and Methods, Evaluation and Assessment, Rehabilitation Counseling Knowledge, or Supervisory Relationship factors.

No significant multivariate test differences were found for the years of experience, academic major, professional identity or supervision experience variables in relation to the importance factors.

Differences in Perceived Preparedness

In order to determine if perceived preparedness differed according to the demographic or professional characteristics of the CRCs, a second series of MANOVAs were computed. The dependent variables for these analyses were the mean factor scores of the six preparedness factors. The independent variables were the same as those employed in the importance MANOVAs.

A significant multivariate F (Wilks Lamda =. F .93 (24, 1860) =1.60, p = < .05) was found for two factors for the professional identity variable. Post hoc comparisons (Bonferroni, alpha = .008) indicated that in relation to the Theories and Models factor, the perceived preparedness of CRCs who reported their professional identity as both rehabilitation and counseling (M = 2.19) was significantly higher than CRCs who reported their professional identity as only rehabilitation (M = 1.95). They did not differ from CRCs who reported their professional identity as being counseling only (M = 2.00), psychology (M = 2.59), or another professional identity (M = 2.10). CRCs who reported their professional identity as being both rehabilitation and counseling (M = 3.07), indicated significantly higher perceived preparedness in relation to the Rehabilitation

Counseling Knowledge factor than CRCs who reported their professional identity as being counseling only (M = 2.76). They did not differ from CRCs who reported their professional identity as being rehabilitation only (M = 2.95), psychology (M = 3.10), or another professional identity (M = 2.89). The results indicated that professional identity did not impact perceived preparedness in relation to the Ethical and Legal Issues, Intervention Techniques and Methods, Assessment and Evaluation, or Supervisory Relationship factors.

A significant multivariate F (Wilks Lamda =. F .83 (54, 2696) =1.82, p = < .05) was found for the job titles variable. Post hoc comparisons (Bonferroni, alpha = .008) indicated that in relation the to the Theories and Models factor, the perceived preparedness of rehabilitation educators (M = 2.74) was significantly higher than the perceived preparedness of rehabilitation counselors (M = 2.15), supervisors (M = 2.07), other rehabilitation specialists (M = 1.92), case managers (M = 2.01), CRCs with other job titles (M = 2.07), and individuals who were retired or unemployed (M = 1.84). They did not differ significantly from administrators (M = 2.22), social workers (M = 2.11), or other counseling specialists (M = 2.15).

The perceived preparedness of the educators (M = 2.94) was also significantly higher than the rehabilitation specialists (M = 2.08), case managers (M = 2.20), CRCs with other job titles (M = 2.18), or individuals who were retired or unemployed (M = 2.03) in relation to the Intervention Techniques and Methods factor. They did not differ significantly from rehabilitation counselors (M = 2.41), supervisors (M = 2.34), administrators (M = 2.44), social workers (M = 2.33), or

other counseling specialists (M = 2.34). In relation the Assessment and Evaluation factor, the educators (M = 2.60), had significantly higher perceived preparedness than the case managers (M = 1.76), but they did not differ significantly from the rehabilitation counselors (M = 2.03), supervisors (M = 1.86), rehabilitation specialists (M = 1.85), administrators (M = 2.13), social workers (M = 1.80), other counseling specialists (M = 1.82) CRCs with other job titles (M = 1.89), or individuals who were retired or unemployed (M = 1.89). The results indicated that job title did not impact perceived preparedness in relation to the Ethical and Legal Issues, the Rehabilitation Counseling Knowledge or Supervisory Relationship factors.

Significant differences were found for the employment setting variable for two preparedness factors (Wilks Lamda = .85, F (54, 2686) = 1.61, p = < .05). Post hoc comparisons (Bonferroni, alpha = .008) indicated that in relation the to the Theories and Models factor, the perceived preparedness of CRCs working at a college or university (M = 2.57) was significantly higher than the perceived preparedness of CRCs employed at state-federal rehabilitation settings (M = 2.05). They did not differ significantly from individuals working in private non-profit rehabilitation facilities (M = 2.10), private proprietary settings (M = 2.10), medical centers or general hospitals (M = 2.36), social support agencies (M = 2.08), K-12 school systems (M = 2.02), private practice (M = 2.27), other employment settings (M = 1.99), or individuals who are retired or unemployed (M = 1.97).

The perceived preparedness of CRCs employed in colleges or universities (M = 2.74) was also significantly higher than those employed in other employment settings (M = 2.09), in relation to the Intervention Techniques and Methods factor. They did not differ significantly from individuals working in state-federal rehabilitation settings (M = 2.36), private non-profit rehabilitation facilities (M = 2.22), private proprietary settings (M = 2.31), medical centers or general hospitals (M = 2.58), social support agencies (M = 2.32), K-12 school systems (M = 2.30), private practice (M = 2.48), or individuals who are retired or unemployed (M = 2.09). The results indicated that employment setting did not impact perceived preparedness in relation to the Ethical and Legal Issues, Assessment and Evaluation, Rehabilitation Counseling Knowledge or Supervisory Relationship factors.

The educational level of the CRCs was found to impact the perceived preparedness of CRCs for all six factors (Wilks Lamda = .91, F (12, 1064 = 4.15, p = < .05). Post hoc comparisons (Bonferroni, alpha = .008) indicated that in relation to the Ethical and Legal Issues factor, the perceived preparedness of CRCs with doctorate degrees (M = 2.60) was significantly higher than the perceived preparedness of CRCs with bachelors degrees (M = 1.92), but they did not differ significantly from CRCs with masters (M = 2.25) degrees. In relation to the Theories and Models factor, the perceived preparedness of CRCs with doctorate degrees (M = 2.66) was significantly higher than the perceived preparedness of CRCs with masters (M = 2.11) or bachelors (M = 1.80) degrees.

The perceived preparedness of the CRCs with doctorate degrees (M = 2.81) was also significantly higher than CRCs with masters (M = 2.33) or bachelors degrees (M = 2.07) in relation to the Intervention Techniques and Methods factor. The perceived preparedness of the doctoral level CRCs (M = 2.43) also differed significantly from the CRCs with masters degrees (M = 1.96) in relation to the Assessment and Evaluation factor, but did not differ significantly from the CRCs with bachelors degrees (M = 1.89). Results indicated that in relation to the Rehabilitation Counseling Knowledge factor, the perceived preparedness of CRCs with doctorate degrees (M = 3.24) was significantly higher than the perceived preparedness of CRCs with bachelors degrees (M = 2.83), but they did not differ significantly from CRCs with masters (M = 3.00) degrees. The perceived preparedness of the CRCs with doctorate degrees (M = 2.70) was also significantly higher than the CRCs with masters (M = 2.20) or bachelors degrees (M = 2.09) in relation to the Supervisory Relationship factor.

A significant multivariate F (Wilks Lamda = .90, F (6, 524) = 9.71, p = < .05) was also found for the training in clinical supervision variable. Post hoc comparisons (t test, alpha = .008) indicated that the perceived preparedness of CRCs who reported they had received training in clinical supervision (supervision training = Yes) was significantly higher than the perceived preparedness of CRCs who did not report supervision training (supervision training = NO) in relation to five factors. The results indicated that CRCs who reported supervision training had significantly higher perceived preparedness in relation to the Ethical and Legal Issues (Yes M = 2.53, No M = 2.10), Theories and Models (Yes M = 2.43,

No M = 2.00), Intervention Techniques and Methods (Yes M =2.55, No M = 2.22), Assessment and Evaluation (Yes M = 2.32, No M = 1.81), and Supervisory Relationship (Yes M = 2.36, No M = 2.13), factors. The results indicated that the perceived preparedness of CRCs with supervision training and those without did not differ in relation to the Rehabilitation Counseling Knowledge factor.

A significant multivariate F (Wilks Lamda = .96, F (6, 533) = 3.86, p = < .05) was found for the supervision experience variable. Post hoc comparisons (t test, alpha = .008) indicated that the perceived preparedness of CRCs with supervision experience (supervision experience = Yes) within the last five years was significantly higher than the perceived preparedness of CRCs without supervision experience (supervision experience = No) in relation to five of the six factors. The results indicated that CRCs with supervision experience had significantly higher perceived preparedness in relation to the Ethical and Legal Issues (Yes M = 2.41, No M = 2.08), Theories and Models (Yes M = 2.28, No M = 2.00), Intervention Techniques and Methods (Yes M = 2.46, No M = 2.20), Assessment and Evaluation (Yes M = 2.15, No M = 1.81) and Rehabilitation Counseling Knowledge (Yes M = 3.10, No M = 2.93) factors. The results indicated that the perceived preparedness of CRCs with supervision experience and whose without did not differ in relation to the Supervisory Relationship factors.

Significant differences were found for the gender (Wilks Lamda =. F .95 (6, 537) = 4.23, p = < .05) and academic major (Wilks Lamda =. F .90 (30, 2.98) = 1.80 = < .05) variables. Post hoc comparisons, however, failed to reveal any

significant differences for these variables. No significant multivariate test differences were found for the years of experience in relation to the preparedness factors.

Experience in Clinical Supervision

Of the 321 (42.1%) of the CRCs who reported that they had provided clinical supervision experience within the last five years, 86.5% (n = 275) indicated that the supervision had been provided at a field-based agency or facility. In order to address research question number four, descriptive statistics were computed for the demographic characteristics and professional experiences of the 275 CRCs who provided field-based clinical supervision, Tables 18 through Table 21 provide the breakdown of the subsample by demographic and professional experiences of the subsample.

The subsample of CRCs with field-based clinical supervision experience consisted of 119 males (43.3%) and 156 females (56.7%), and was predominately Caucasian/non-Hispanic (n= 246, 90.1%). The age of the subsample ranged from 26 to 80 years, with mean age of 46 years. The supervisors reported an average of 12 years of post CRC work experience, with the amount of experience ranging from less than one to 26 years.

The masters degree (n = 244, 88.7%) was most frequently reported as the highest degree earned by the supervisors with field-based supervision experience. followed by the doctorate degree (n = 18, 6.5 %), and the bachelors degree (n = 13, 4.7%). The most commonly reported academic majors for the subsample were rehabilitation counseling (n = 177, 65.6%), other counseling

Table 18

Demographic Characteristics of Supervisors

Variable	n	Valid %
Gender		
Male	119	43.3
Female	156	56.7
Race/Ethnicity		
African American	9	3.3
Native American	0	0
Black/non-African	2	.7
Latino/a	5	1.8
Caucasian/non-Hispanic	246	90.1
Asian American/Pacific Islander	4	1.5
Other	7	2.6
Highest Degree Earned		
Bachelors	13	4.7
Master	244	88.7
Ph.D.	18	6.5
Academic major		
Rehabilitation Counseling	177	65.6
Psychology	20	7.4
Social Work	4	1.5
Other Counseling Specialty	37	13.7
Other Rehabilitation Specialty	5	1.9
Other	27	10.0

Note: The n's do not compute to 275 due to missing data.

Table 19

Professional Identity and Credentials of Supervisors

Variable	n	Valid %
Professional Identity		
Rehabilitation	55	20.1
Counseling	13	4.7
Both Rehabilitation and Counseling	189	69.0
Psychology	7	2.6
Other	10	3.6
Additional Credentials *		
CCM	40	14.5
CVE	15	5.5
CDMS	27	9.8
NCC	24	8.7
LPC/LRC	72	26.2
LLPC	1	.4
LPCS (Licensed Supervisor)	4	.6
NBCC Approved Clinical Supervisor	3	1.1
CWA	1	.4
Licensed Psychologist	4	.4
Limited Licensed Psychologist	3	1.1
Other	60	21.8

Note: The n's do not compute to 275 due to missing data.

* Subjects could report more than one additional credential

Table 20

Job Titles and Employment Settings of Supervisors

Variable	n	Valid %
Job Title		
Rehabilitation counselor	102	37.5
Supervisor	50	18.4
Other rehabilitation specialist	9	3.3
Administrator	44	16.2
Rehabilitation educator	3	1.1
Social worker	3	1.1
Case manager	20	7.4
Other counseling specialties	16	5.9
Retired/unemployed	6	2.2
Other	19	7.0
Employment Setting		
State-federal rehabilitation	57	20.9
Private non-profit rehabilitation facility	41	15.0
Private proprietary	76	27.8
College or University	5	1.8
Medical center or general hospital	12	4.4
Social support agency	31	11.4
K-12 school system	4	1.5
Private practice	3	1.1
Retired/unemployed	31	11.4
Other	13	4.8

Note: The n's do not compute to 275 due to missing data.

Table 21

Supervisory Experience

Variable	N	Valid %
Type of individuals supervised most frequently		
Practicum students	17	6.3
Internship students	54	20.0
Employees or subordinates	190	70.4
Licensure applicants	9	3.3
Post CRC experience prior to providing supervision		
Less than 1 year	51	18.7
1 year	24	8.8
2 years	49	17.9
3 years	32	11.7
4 years	24	8.8
5 or more years	93	34.1
Training in Clinical Supervision		
Yes	132	49.4
No	135	50.6

Note: The n's do not compute to 275 due to missing data.

specialties (n = 37, 13.7%), and other majors (n = 27, 10.0%). The majority of CRCs who provided field-based supervision reported their professional identity as both rehabilitation and counseling (n = 189, 69%), followed by rehabilitation (n = 55, 20.1%). The majority of the supervisors (n = 154, 66%) indicated they held a minimum of one additional credential. Licensure as a professional or rehabilitation counselor (LPC/LRC), 26.2% (n = 72), other non-listed credentials (n = 60, 21.8%), and Certified Case Manager (CCM) (n = 40, 14.5), were the most frequently cited additional credentials.

The most frequently reported job titles for the field-based supervisors were rehabilitation counselor (n = 102, 37.5%), supervisor (n = 50, 18.4%), and administrator (n = 44, 16,2%). The employment settings most frequently reported by the supervisors were private proprietary (n = 76, 27.8%), state - federal rehabilitation (n = 57, 20.9%), and private non-profit rehabilitation facility (n = 41, 15.0%).

The field based supervisors indicated that they clinically supervise an average of four individuals at a time with 53.6% (n = 147) indicating that they typically supervise only one individual at a time and 16.6% (n = 34) reporting that they supervise from 10 to up to 88 individuals at one time. Over the last five years, the CRCs clinically supervised an average of 11 individuals with 50.9% (n = 139) of the CRCs reporting that they had supervised six or fewer individuals and 9.2% (n = 29) reporting they had supervised 25 to 100. The type of individuals most frequently supervised in the last five years were employees or

subordinates (n = 190, 70.4%), internship students (n = 50, 20%) and practicum students (n = 17, 6.3%).

The supervisors reported that prior to providing clinical supervision for the first time, 34.1% (n = 93) had five or more years of post CRC work experience, 38.4% (n = 105) had two to four years of experience, and 27.5% (n = 75) had one year or less years of experience. In terms of training in clinical supervision, 49.4% (n = 132) of the supervisors indicated that they had received training in clinical supervision.

Supervisory Practices

In order to address the fifth research question and identify the supervisory practices that characterize the work of CRCs who provide field-based clinical supervision, descriptive statistics (frequencies and percentages) were computed for the 17 supervisory practice items on the RCSI (see Appendix B). Tables 22 through 24 provide a breakdown of the supervisory practices reported by the subsample of CRCs with field-based clinical supervision experience.

The majority of supervisors (n = 208, 75.6%) reported that individual supervision is the supervisory format most frequently utilized while 24.4% (n = 29) indicated that a combination of individual and group supervision formats were utilized. None of the supervisors indicated that they utilized only group supervision. The majority of supervisors indicated that formal meetings with supervisees typically occur on a weekly (n = 113, 41.1%) or more than once a week (n = 80, 29.1%) basis, while 6.2% (n = 17) of the supervisors indicated that they met with supervisees monthly and 6.5% (n = 18) indicated that they met with

Table 22

Supervisory Practices

Variable	n	Valid %
Supervision Format		
Individual supervision	208	75.6
Group supervision	0	0.0
Combination of individual and group supervision	67	24.4
Frequency of supervision		
More than once a week	80	29.1
Weekly	113	41.1
Twice a week	47	17.1
Monthly	17	6.2
Less than once a month	18	6.5
Length of supervision sessions		
Less than 1 hour	103	37.5
1 hour	138	50.2
2 hours	24	8.7
More than 2 hours	10	3.6
Document supervision sessions		
Yes	144	52.4
No	131	47.6

Note: The n's do not compute to 275 due to missing data.

Table 23

Supervision Methods

Supervisory Role	Never		Rarely		Often		Always	
	n	%	n	%	n	%	n	%
Self-report of counseling sessions	14	5.1	25	9.2	176	64.7	57	21.0
Live observation	27	10.0	112	41.5	114	42.2	17	6.2
Role playing counseling sessions	71	26.5	137	51.1	56	20.9	4	1.5
Review of audio tapes	150	55.8	88	32.7	26	9.7	5	1.9
Review of videotapes	170	63.4	86	32.1	12	4.5	0	0.0
Observation through a one-way mirror	219	83.3	36	13.7	8	3.0	0	0.0
Written reports of sessions	24	8.9	64	23.8	135	50.2	46	17.1
Provide written evaluative feedback	12	4.4	85	31.4	130	48.0	44	16.2

Note: The n's do not compute to 275 due to missing data.

Table 24

Supervisory Roles

Supervisory Role	Never		Rarely		Often		Always	
	n	%	n	%	n	%	n	%
Consultant	5	1.8	21	7.7	173	63.8	72	26.6
Counselor	15	5.6	97	35.9	133	49.3	25	9.3
Teacher	7	2.6	9	3.3	63	60.4	91	33.7
Evaluator	10	3.7	60	22.5	148	55.4	49	18.4
Administrator	32	12.0	78	29.2	105	39.3	52	19.5

Note: The n's do not compute to 275 due to missing data.

supervisees less than once a month. The supervisors reported that on average, the length of the typical supervision session is one hour (n = 138, 50.2%) or less (n = 103, 37.5%). The majority of supervisors (n = 144, 52.4%) reported that they routinely document supervision sessions.

The supervisors were also asked to report how frequently they employed a variety of supervision methods (Table 23). The majority of the supervisors indicated that they often (64.7%) or always (21.0%) utilized the supervisee's self-report of counseling sessions as a supervisory method. The use of supervisee's written report of counseling sessions was the second method that the majority of supervisors often (50.2%) or always (17.1%) utilized. The majority of the

supervisors also reported that they always (16.2%) or often (48.0%) provide written evaluative feedback to supervisees. Live observation with the supervisor present in the counseling session was a supervisory method often (42.5%) utilized by the supervisors, although the majority of the supervisors indicated that that they rarely (41.5%) or never (10.0%) used this method. The majority of supervisors also indicated that they rarely (51.1%) or never (26.5%) role played counseling sessions with supervisees. The supervision methods that the majority of supervisors reported that they never utilized were the review the supervisees counseling sessions on audio (55.8%) or video (63.4%) tapes, or observation of supervisees counseling sessions through a one-way mirror (83.3%).

Finally, the field-based supervisors reported that they assume a variety of roles in the supervision relationship (Table 24). The role of teacher was most frequently reported with 33.7% of the supervisors indicating that they always assumed this role in the supervision relationship, and 60.4% indicating that they often do so. The field-based supervisors also always (26.6%) or often (63.8%) assumed the role of consultant. Although the role of evaluator is assumed less frequently that that of teacher or consultant, the majority of supervisors (73.8%) indicated that they often or always assumed this role with supervisees. The supervisors reported that they were less likely to assume the roles of administrator and counselor. Although 19.5% of the supervisors indicated that they always assumed the role of administrator, 29.2 % indicated that they rarely assumed this roll and 12.0% indicated that they never assumed the administrator

role. Similarly, while the role of counselor is often (49.3%) or always (9.3%) assumed by the majority of the supervisors, others indicated that they rarely (35.9%) or never (5.6%) assumed this role.

Additional Analyses

In order to determine the CRCs (N = 774) opinions regarding the establishment by the CRCC of specific experience and training requirements for clinical supervisors, descriptive statistics (frequencies and percentages) were computed for items 12 and 13 in section two of the RCSI (see Appendix B). As indicated in Table 25, the majority of CRCs support the establishment of both experience (N = 534, 70.5%) and training (N = 512, 67.5%) requirements for clinical supervisors by the CRCC.

Table 25

Experience and Training Requirements for Supervisors

Variable	N	Valid %
Experience Requirements for clinical supervisors		
Yes	534	70.5
No	223	29.5
Training Requirements for clinical supervisors		
Yes	512	67.5
No	247	32.5

Note: The Ns do not compute to 774 due to missing data.

Chapter 5

DISCUSSION

The primary purpose of this study was to begin the inductive process of identifying the supervisory knowledge and skill areas that are important for effective field-based clinical supervision of rehabilitation counselors and to determine if perceptions of importance differed in relation to the demographic characteristics or professional experiences of CRCs. A Delphi study was employed as the initial step in identifying a pool of supervisory knowledge and skill areas. This process resulted in the identification of the 95 supervisory knowledge and skill areas that were utilized in the RCSI. In defining what constitutes an important knowledge or skill area, an a priori criterion level ($\geq$ 2.00) was established to denote at least moderate importance for a knowledge or skill item or group of items. A review of the mean scores of the items demonstrated that the CRCs in the national study perceived 94 of the items to be of at least moderate importance and only one item to be slightly less than moderately important. In addition, the CRCs, on average, considered all six of the empirically derived supervisory knowledge and skill areas important in relation to the a priori criterion level (Table 25). These results were consistent with those found in the Delphi study and lend empirical support for the use of this methodology and further validates the knowledge and skill items identified.

Perceptions of Relative Importance

The results indicated that although CRCs as a group regarded each of the

Table 26

Importance and Preparedness Factors Mean Scores

	Factor Mean Score	
Factor	Importance	Preparedness
1. Ethical and Legal Issues	3.20	2.26
2. Theories and Models	2.64	2.14
3. Intervention Techniques and Methods	2.97	2.34
4. Assessment and Evaluation	2.89	1.99
5. Rehabilitation Counseling Knowledge	3.26	3.01
6. Supervisory Relationship	2.73	2.24

six supervisory knowledge and skill factors to be of at least moderate importance, perceptions of relative importance for each factor did vary in relation to one or more demographic or professional characteristics. It is interesting to note that no significant differences in perceptions of importance were identified according to the CRCs supervisory experience, number of years of post CRC work experience, professional identity or academic major in relation to any of the factors.

For three of the factors, Ethical and Legal Issues, Intervention Techniques and Methods, and Rehabilitation Counseling Knowledge, perceived importance varied only as a function of the gender of the respondent with females perceiving

these factors to be significantly more important than males. In relation to the Supervisory Relationship factor, perceived importance differed only in relation to the degree level of the CRC. Although CRCs with masters degrees did not differ from those with doctorates or bachelors degrees in this area, CRCs with bachelors degrees did perceive this factor to be significantly less important than those with doctorate degrees.

Assessment and Evaluation

Although all CRCs, regardless of employment setting, perceived the Assessment and Evaluation factor to be of at least moderate importance, CRCs employed in colleges or universities perceived this factor to be significantly more important than those employed in private proprietary settings. Neither group, however, differed significantly from CRCs employed in any other field-based setting. Females also perceived this factor to be significantly more important than males.

Theories and Models

The majority of differences in perceived importance were identified in relation to the Theories and Models factor. Females also perceived this factor to be significantly more important than males. As with the Supervisory Relationship factor, CRCs with doctorate degrees perceived this factor to be more important than bachelor level CRCs although neither differed significantly from masters level CRCs in this area. Although CRCs employed in colleges or universities perceived this factor to be significantly more important than those employed in state-federal rehabilitation or private proprietary settings, no significant

differences were noted between CRCs who were not employed in college university settings. Job title was also found to impact the perceptions of some of the CRCs in relation to the relative importance of this factor. Although all CRCs, regardless of job title, perceived this factor to be of at least moderate importance, counselor specialists did perceive this factor to be significantly more important than rehabilitation counselors. Finally, CRCs with supervision training perceived this factor to be significantly more important than those without training.

In summary, these findings demonstrate that there is a substantial body of supervisory knowledge and skills that are perceived by CRCs to be important for the effective field-based supervision of rehabilitation counselors. Relatively few significant differences in the perceived importance of the six factors were identified. It is of particular interest that the perceived relative importance of each factor was generally consistent for the master's level, field-based CRCs. These results suggest that CRCs, regardless of their demographic or professional characteristics, would concur with Maki and Delworth's (1995) contention that clinical supervision in rehabilitation counseling is a distinct intervention, requiring specific knowledge and skills in multiple domains.

Although each of the six factors were perceived to be of at least moderate importance, it is interesting to note that CRCs rated the Rehabilitation Counseling Knowledge factor as being most important for the effective field-based supervision of rehabilitation counselors (Table 25). These results suggest that CRCs believe it is important that supervisors are proficient in the knowledge and skills that are unique to rehabilitation counseling in order to effectively supervise

more novice rehabilitation counselors. The findings also seem to indicate that CRCs would concur with Bernard and Goodyear (1998) that supervision should be provided by a senior member to a junior member of the same profession.

It is also interesting that CRCs perceived the Supervisory Relationship factor to be less important than all but the Theories and Models factor given that the supervisory relationship has often been identified as the most critical and fundamental element necessary for effective and productive supervision (Bernard & Goodyear, 1998; Borders et al., 1991; Carroll, 1995; Ellis, 1991; Holloway, 1995). In reviewing the means and standard deviations for items contained in this factor (Table 11, p.72) it is important to note that the five items with the lowest mean scores and highest standard deviations are those pertaining to diversity related issues and power issues in supervision. The importance of understanding and addressing potential relationship variables, specifically those pertaining to diversity issues, that may affect the supervisory relationship have been identified as essential for the development and maintenance of an effective supervisory relationship (Bernard & Goodyear, 1998; Cook, 1994; Leong & Wagner, 1994; Turner, 1993). These findings seem to suggest that some CRCs are either unaware or place limited importance on the potential impact of diversity issues in the supervisory relationship.

Perceived Preparedness of CRCs

The second purpose of this study was to identify the perceived preparedness of CRCs relation to the six supervisory knowledge and skill areas and to determine if perceptions of preparedness differed in relation to the

demographic characteristics or professional experiences of CRCs. Three a priori criterion levels were established to differentiate levels of perceived preparedness: High perceived preparedness ($\underline{M} \geq 3.00$), moderate perceived preparedness ($\underline{M} = 2.00 - 2.99$), low perceived preparedness ($\underline{M} \leq 1.99$). These criterion levels will be used in discussing perceived preparedness of CRCs in relation to each supervisory knowledge and skill factor.

CRCs reported high level of preparedness only in relation to the Rehabilitation Counseling Knowledge factor. Low moderate levels of preparedness were reported in relation to the remaining five factors (Ethical and Legal Issues, Theories and Models, Intervention Techniques and Methods, Assessment and Evaluation, Supervisory Relationship. Table 25 provides the mean importance and preparedness scores for each supervisory knowledge and skills factor. In comparing the importance and preparedness scores, it is evident that that with the exception of the Rehabilitation Counseling Knowledge area, there is a relatively large discrepancy between the importance and the perceived preparedness of the CRCs in relation to five of supervisory knowledge and skill areas.

Perceptions of Preparedness According to Characteristics of CRCs

In reviewing how perceptions of preparedness differed in relation to the demographic characteristics or professional experiences of the CRCs, several interesting findings were identified. Although gender influenced perceived importance in relation to the majority of supervisory knowledge and skill areas, it did not significantly influence perceived preparedness in relation to any of the

factors. The academic major of the CRCs did not influence either perceived importance or perceived preparedness.

Years of Post CRC Work Experience

Given the professional movement towards establishing experience requirements for supervisors, it is interesting that no significant differences in perceptions for preparedness were identified in relation to number of years of post CRC work experience for any of the supervisory knowledge or skill areas. These results indicate that perceptions of preparedness are not of function of the CRCs years of experience as a counselor. In other words, respondents with four year or less post CRC counseling experience perceived themselves to be prepared at a similar level for each supervisory knowledge and skills factor as CRCs with 15 or more years of counseling experience.

Supervision Training

In contrast, CRCs with supervision training perceived themselves to be significantly more prepared than those without training in relation to all of the supervisory knowledge and skill areas except Rehabilitation Counseling Knowledge. It is interesting to note, however, that although significant differences were identified in relation to the perceptions of preparedness for the Ethical and Legal Issues, Theories and Models, Intervention Techniques and Methods, and Supervisory Relationship areas, all CRCs, on average, perceived themselves to be moderately prepared in these areas. Only in relation to the Assessment and Evaluation area did CRCs without supervision training perceive themselves to be less than moderately prepared. These results suggest training

in clinical supervision increases CRCs confidence in their supervisory related knowledge skills, particularly in relation to the Assessment and Evaluation area. It also interesting however, that all CRCs regardless of whether or not they have received clinical supervision training perceive themselves to be moderately prepared, on average, in relation to the majority of the supervisory knowledge and skill areas. These findings may lend support to Bernard and Goodyear's (1998) contention that many counselors assume that their experiences as counselors and as supervisees provide sufficient preparation for the supervisory role.

Supervisory Experience

Experience as supervisors also significantly impacted perceptions of perceived preparedness. Although all CRCs, on average, perceived themselves to be moderately prepared in the Ethical and Legal Issues, Theories and Models, Intervention Techniques and Methods, and Supervisory Relationship areas, the results indicated that perceived preparedness of CRCs with supervision experience was significantly higher than those without similar experience in these factors. As occurred with supervision training in relation to the Assessment and Evaluation factor, the perceived preparedness of CRCs with supervision experience was significantly higher than the perceived preparedness of CRCs without supervision experience in these areas. Only in relation to this factor did CRCs without supervision experience indicate a less than moderate level of perceived preparedness. No significant differences in perceived preparedness were identified in relation to Supervisory Relationship factor. The perceived

preparedness of CRCs with clinical supervision experience was also significantly higher than those without experience in relation to the Rehabilitation Counseling Knowledge factor. CRCs with clinical supervision experience perceived themselves to be highly prepared in this area while those without experience reported moderate levels of preparation. These findings are interesting in that they can not be easily explained. As will be discussed later, the results of this study indicate that CRCs who provide supervision are more likely to have received training in clinical supervision. As a result, it is difficult to determine if perceptions of preparedness pertaining to both supervision experience and supervision training are related or independent functions.

Educational Level

The educational level of the CRCs was found to impact perceived preparedness for all of the factors. CRCs with doctorate degrees had significantly higher levels of perceived preparedness than CRCs with bachelors degrees in relation to Ethical and Legal Issues, Theories and Models, Intervention Techniques and Methods, Rehabilitation Counseling Knowledge, and Supervisory Relationship factors. CRCs with doctorate degrees also had significantly higher levels of perceived preparedness than CRCs with masters' degrees in relation to the Theories and Models, Intervention Techniques and Methods and Assessment and Evaluation factors. The perceived preparedness of the masters and bachelors level CRCs did not differ significantly in relation to any of the factors. CRCs with masters' degrees reported less than moderate levels of preparedness only in relation to Assessment and Evaluation factor.

CRCs with bachelors degrees reported less than moderate levels of preparedness in relation to the Ethical and Legal Issues, Theories and Models, and Assessment and Evaluation factors. It is not surprising that CRCs with doctorate degrees have at least moderate levels of perceived preparedness in relation to all of the factors.

Job Title

Rehabilitation educators had significantly higher levels of perceived preparedness than CRCs with a variety of other job titles in relation to the Theories and Models, Intervention Techniques and Methods, and Assessment and Evaluation. No significant differences were found for any of these factors between the CRCs who reported what could be considered field-based job titles. Moderate levels of preparedness, on average, were reported in relation to the Intervention Techniques and Methods factors across all job titles. In relation to the Theories and Models factor, moderate levels of perceived preparedness, on average, were reported by all job titles except the other rehabilitation specialists who reported less than moderate preparedness in relation to this factor. Although significant differences were not found between CRCs with field-based job titles, the level of perceived preparedness did diverge in relation to Assessment and Evaluation factor. Rehabilitation educators, rehabilitation counselors and administrators, on average, reported moderate levels of perceived preparedness. Less than moderate levels of perceived preparedness in relation to this factor were reported by CRCs who reported their job titles as being supervisors, other rehabilitation specialists, case managers, social

workers, other counseling specialists and CRCs with other job titles. These results indicate that, for the most part, the job title of the field-based CRCs do not significantly impact their level of perceived preparedness in relation to the majority of the factors. Given the previously discussed findings, it is not surprising that perceptions of preparedness varied most in relation to the Assessment and Evaluation factor.

Employment Setting

Relatively few significant differences in perceived preparedness were related to the employment setting of the CRCs. In relation to the Theories and Models factor, the perceived preparedness of CRCs working at a college or university was significantly higher than the perceived preparedness of CRCs employed at state-federal rehabilitation settings. No significant differences were found for this factor between the CRCs who were employed in field-based settings. CRCs employed in all but the other employment setting category reported moderate levels of preparedness, on average, in relation to this factor. CRCs employed in other settings indicated less than moderate levels perceived preparedness. The perceived preparedness of CRCs employed in colleges or universities was significantly higher than those employed in other employment settings in relation to the Intervention Techniques and Methods factor. All CRCs, regardless of job setting reported moderate levels of preparedness in relation to this factor. These findings suggest that their employment setting does not significantly effect perceptions of preparedness for the majority of CRCs employed in field-based settings in relation to any of the factors.

Professional Identity

Finally, significant differences were found in relation to the professional identity of the CRCs for two factors. In relation to the Theories and Models factor, CRCs who reported their professional identity as being counseling perceived themselves to be significantly more prepared than CRCs who reported their professional identity as being both rehabilitation and counseling. CRCs who reported their professional identity as being both rehabilitation and counseling however, perceived themselves to be significantly more prepared in the Rehabilitation Counseling Knowledge area than those who reported their professional identity as being counseling only. Neither group differed significantly from CRCs with any other reported professional identity in relation to these or the other four factors.

In summary, although CRCs believe all of the supervisory knowledge and skill areas to be of at least moderate importance, these results suggest that CRCs do not perceive themselves to be highly prepared in any of the supervisory knowledge and skill areas that are not specific to rehabilitation counseling knowledge. It is interesting to note that although the CRCs perceived themselves to be moderately prepared in the Ethical and Legal Issues factor, they reported less than moderate levels of preparedness in relation to the Assessment and Evaluation factor given that these areas are so closely intertwined. The assessment and evaluation of the counselors competency, provision of appropriate services, and ethical treatment of clients are the primary

ethical (Bernard & Goodyear, 1998) and legal (Sutton, 1998) responsibilities of the supervisor.

Given the professional movement towards the establishment of experience requirements for clinical supervisors, it is interesting that years of counseling experience did not significantly impact perceived preparedness in relation to any of the factors. It is also interesting, given the professional movement towards the establishment of training requirements for supervisors, that in relation to the majority of supervisory knowledge and skill factors, CRCs with supervision training had significantly higher levels of perceived preparedness than those without training. It should be remembered however, that perceptions of preparedness do not necessarily equate to actual preparedness. It is also interesting that although significant differences were found in relation to the CRCs job title and employment setting, the results suggest that the differences in perceptions of preparedness varied primarily between the field-based CRCs and the university based CRCs.

Supervisors Characteristics and Practices

Supervisor Characteristics

The third purpose of this study was to provide base-line information about the demographic and professional experiences of CRCs who have provided field-based supervision. Approximately 35% of the CRCs in this study indicated that they had provided field-based supervision within the last five years. In examining the demographic characteristics of the supervisors, it was revealed that although the majority of supervisors were female, 43.3% of the supervisors were male.

This is interesting given that only 36% of the full sample were male. The age range of the supervisors was comparable to those of the CRCs.

The masters' degree was the highest earned degree for almost 90% of the field-based supervisors. These results support the contention that the majority of field based supervision in rehabilitation counseling is provided by masters' level counselors. Rehabilitation counseling was the most frequently reported academic major, followed by other counseling specialties and other majors.

In contrast to the full sample of CRCs (44%), the majority (66%) of supervisors indicated that they held at least one additional credential. Licensure as a professional or rehabilitation counselor (LPC/LRC), other non-listed credentials, and Certified Case Manager were the most frequently cited additional credentials. The most frequently reported professional identity for the supervisors was both rehabilitation and counseling followed by rehabilitation.

The most frequently reported job titles for the field-based supervisors was rehabilitation counselor, followed by supervisor, and administrator. These findings are interesting in that they suggest that although they do not hold the formal title of supervisor, rehabilitation counselors may often assume the role and responsibilities of a supervisor for more novice rehabilitation counselors. The percentage of supervisors employed in each of the job setting basically reflected the distribution of the CRCs with the most frequently reported settings being private proprietary, state - federal rehabilitation, and private non-profit rehabilitation facility.

Although the majority of field-based supervisors indicated that they typically supervised only one individual at a time, others indicated that they supervised 20 or more individuals at any given time. The type of individuals most frequently supervised in the last five years were employees or subordinates followed by internship, and practicum students.

The supervisors reported that prior to providing clinical supervision for the first time, 34% had five or more years of post CRC work experience, 38.4% had two to four years of experience, and 27.5% had one year or less years of experience. It is interesting to note that while 29% of the CRCs in the full sample reported formal training in clinical supervision, 49% of the supervisors indicated that they had received formal training in clinical supervision. These results suggest that approximately half of the supervisors have either independently sought supervision related training or it has been available (or perhaps even required) at their employment setting.

Supervisory Practices of Field-Based Supervisors

The final purpose of this study was to identify the supervisory practices that characterize the work of CRCs who provide field-based clinical supervision. The supervisors reported that they utilize a wide variety of practices in their interactions with supervisees. The majority supervisors indicated that met frequently with their supervisees and typically on a one-to-one basis. The majority of supervisors also indicated that they routinely document supervision sessions and often provide written evaluative feedback to the supervisees. These

findings suggest that the majority of supervisors are accessible, actively involved with the supervisees and their cases, and monitor their supervisees closely.

Although many supervisors indicated that they do observe the supervisees in their counseling sessions with clients, the majority of supervisors reported that they rely on the written and self-reports of supervisees interactions with clients as their primary methods of supervision. These results suggest that the majority of supervisors may rely most heavily on what could be considered indirect methods of supervision, that is they are not actively observing the counselor's interactions with the client. This may be the result of time constraints, the counseling skills of the supervisee, the nature of the counselors job duties, or the expectations for supervisors by their employers.

The supervisors reported that they assumed a variety of roles in their relationship with supervisees with teacher and consultant being the most frequently assumed. The field-based supervisors also reported that they always or often assumed the roles of consultant and evaluator. The supervisors reported that they were less likely to assume the roles of administrator and counselor. These results seem to indicate that the supervisors would support Bernard and Goodyear's (1998) contention that supervisors must assume a variety of roles in order to meet the needs of the counselors they supervise.

Experience and Training Requirements for Supervisors

Additional analyses were conducted to examine opinions regarding the establishment by the CRCC of specific experience and training requirements for clinical supervisors. The results indicated that the majority of CRCs would

support the establishment of specific experience requirements for CRCs who provide clinical supervision. These findings are interesting given that the counseling experience level of the CRCs in this study did not significantly impact perceptions of importance or preparedness in relation to any of the supervisory knowledge or skill areas. These findings seem to indicate that CRCs believe that proficiency as a rehabilitation counselor is acquired over time and that proficiency and experience as a rehabilitation counselor are necessary for the effective supervision of more novice counselors.

The majority of CRCs also support the establishment of training requirements for clinical supervisors. In light of the previously discussed findings of this investigation, these results seem to have several implications. Although CRCs, on average, indicated that they perceive themselves to moderately prepared in the majority of supervisory knowledge and skill areas, these findings seem to suggest that they are cognizant of the limitations of their supervisory related knowledge and skills. These findings might also indicate that CRCs, perhaps as a result of their experience as supervisors or supervisees believe that supervisory training is necessary for effective supervision, and perceive clinical supervision to be a distinct intervention requiring training in a unique body of knowledge.

Assumptions and Limitations

The primary assumption underlying this study is the validity of using self-report methods. It was assumed that CRCs have the prerequisite skills, abilities, and professional judgment necessary to accurately and honestly assess the

supervisory knowledge and skills that are essential for the effective clinical supervision of pre and post-graduate rehabilitation counselors. It is further assumed that CRC's accurately and honestly assessed their preparedness to provide clinical supervision and to describe their current supervisory practices.

A second assumption of this study concerns the generalizability of the results. Since under current CRCC and CORE guidelines, all CRCs are considered qualified to provide clinical supervision, a random sample of CRCs was drawn for this study. It is therefore assumed that given the 53% response rate and the similarities between the demographic characteristics of the sample and the population that the CRCs in the study are representative of all CRCs. A limitation is recognized, however, that it is possible that only those CRCs in the sample who had a significant interest in the area of clinical supervision may have responded.

A limitation is also recognized in relation to the data collection instrument developed for use in this study. The RCSI was constructed over a six-month period, primarily through the use of a Delphi Study and a review of the literature. While the development efforts were rigorous and extensive, it is recognized that that certain supervisory knowledge and skill areas may not have been identified and therefore not subjected to analysis.

Finally, although it is assumed that the CRCs responded honestly to each item on the questionnaire, there is a question as to whether some CRCs may have confused supervised counseling experiences with supervision training.

Implications for the Rehabilitation Profession

The results of this investigation appear to have several potential applications for the rehabilitation counseling profession. Although several authors (Herbert, 1995; Maki & Delworth, 1995; Maki & Riggar, 1997; Stebnicki, Allen, & Janikowski, 1997) have proposed the adoption of Bernard and Goodyear's (1992) definition of clinical supervision, a definition of clinical supervision has not yet been formally adopted by the rehabilitation counseling profession. The supervisory knowledge and skill areas found to be important in this study could be utilized for the development or endorsement of a single unified definition of clinical supervision for the rehabilitation counseling profession. Currently, there are no standards of practice for rehabilitation counseling supervisors. These results could serve as a forum for discussion regarding the development of standards of practice for supervisors specific to rehabilitation counseling or the adoption of the "ACES Standards for Counseling Supervisors" (Dye & Borders, 1990).

Implications for Education

These results indicate that the training needs of clinical supervisors include but also extend beyond the standards of preparation for rehabilitation counselors. Currently, there are no specific guidelines or published curriculums for training masters level, field-based CRCs in the rehabilitation counseling literature or within the certification and accreditation standards established by the CRCC and CORE. The results suggest that training has a positive impact on

perceptions of preparedness, especially in relation to assessment and evaluation issues. The findings of this study could be examined and utilized for the development of specific standards of preparation for rehabilitation counseling supervisors. In addition, the results of this study could also be employed to prioritize and address the immediate training needs of CRCs who are currently providing supervision through the development of in-service and continuing education of educational models and curriculum. The results of this study could also serve as a forum for discussion within the rehabilitation counseling profession as to when, how, and who should provide supervision training.

The results of this study indicate that CRCs would support the establishment of training requirements for CRCs who provide field-based clinical supervision. It should be noted however, that the issue of providing and/or requiring clinical supervision training for CRCs is complex. Although CRCs support the establishment of training requirements for supervisors, less than 30% of the full sample of CRCs reported they had received any training in clinical supervision and only approximately 50% of supervisors reported that they had received training. In addition, the majority of CRCs are supervising employees or subordinates. The motivation to secure clinical supervision training may therefore be tied for many CRCs to opportunities for promotion within the workplace. Given that CRCs are typically not paid for providing field-based practicum, internship or licensure supervision, there is a question as to what will motivate the CRCs who provide these essential services to secure additional training.

Implications for Future Research

Field-based clinical supervision has been considered a critical component in the professional development process of novice rehabilitation counselors for more than 20 years. This study is the first effort to empirically investigate the supervisory knowledge and skills, preparation and practices of CRCs who are currently or could in the future provide supervision. It is hoped that this investigation will serve as a stimulus for future research in this critically important area of professional practice.

Because of the inductive nature of this study, the results can not be considered exhaustive. Future research will therefore be needed to determine whether there are any yet unidentified knowledge and skills areas that are essential for effective field-based supervision. Research is also needed to determine if perceptions of importance of specific supervisory knowledge and skill areas vary as function of the type of supervision (e.g. practicum, internship, licensure, and employee/subordinate) provided. In addition, the results of this study indicate that perceptions of importance but not preparedness vary as a function of gender. Given that the majority of CRCs are female, future research is needed to investigate the impact of gender on the supervisory beliefs and experiences of both supervisor and supervisees.

The findings of this study suggest that training in clinical supervision has a positive effect on perceived preparedness. Research will need to be conducted to determine the types of preparation and training that is most effective in enhancing the supervisory knowledge and skills of CRCs. In addition, it must be

remembered that perceived preparedness does not necessarily equate to actual competency. Future research is needed to develop instruments and techniques to measure demonstrated competency in clinical supervision.

This study collected only minimal baseline information about the current supervisory practices of CRCs. Future research is needed to comprehensively investigate the practices and functions of explemplary field-based supervisors, specifically those who provide practicum and internship supervision, in order to determine best practices. Finally, and most importantly, research is needed to identify the impact of clinical supervision on client outcomes.

Conclusions

This investigation is the first to empirically determine that CRCs believe that there are specific supervisory knowledge and skills and preparation that are important for the field-based clinical supervision of rehabilitation counselors. The identified knowledge and skill areas include, but are also uniquely different from the knowledge and skills that are required for effective rehabilitation counseling practice. These findings indicate that clinical supervision is a distinct intervention requiring training and preparation in a distinct body of knowledge.

This study also sought to establish a base line of knowledge of the characteristics and supervisory practices of CRCs who have provide field-based supervision within the last five years. The results suggest that approximately one third of the CRCs have had experience as a supervisor. The demographic characteristics of the supervisors mirrored those of the CRCs. It is therefore not

surprising that the majority of field-based supervision is provided by masters' level CRCs in all of the field-based employment settings.

Given the movement within the counseling profession for the establishment of minimum experience requirements for supervisors, it is interesting to note that the majority of supervisors had less than 5 years of post CRC counseling experience prior to providing supervision for the first time. These results have several possible implications for both supervisors and supervisees. The findings indicate that the majority of supervisors would not have been eligible for the new adjunct designation for clinical supervisors offered by the CRCC prior to providing supervision for the first time. In addition, the majority of supervisors did not have the minimum of five years of experience required by many state licensure regulations and recommended in "The 1994 ACA Model Legislation for Licensed Professional Counselors" (Glosoff, Bensoff, Hosie, & Maki, 1995). These findings suggest that as novice CRCs attempt to secure licensure, they may be required to locate someone other than their immediate supervisor to provide the state mandated supervision. This may result in some CRCs being supervised by individuals who meet their state's experience and training criteria for supervisors, but may not be employed in the same setting and/or not a CRC.

Given the current professional movement toward the establishment of training requirements, it is interesting to note that almost 50% the supervisors indicated that they had received training in clinical supervision. It is also interesting that CRCs support the establishment of training requirements for

supervisors. These combined findings lend further support that CRCs believe supervision to be a distinctly different from counseling as an intervention and requires specific training.

It is hoped that these findings will provide valuable information to the rehabilitation counseling profession as it continues its professionalization process.

APPENDICES

Appendix A

Delphi Round 3: Supervisory Knowledge and Skill Areas

Delphi Round 3: Supervisory Knowledge and Skill Areas

(Note: Provided below are the items as they appeared on Round 3 of the Delphi study, the means and standard deviations for each item, and the decision to drop, retain or revise each item in the final instument)

Scale: 0 = Not Important 1 = Little Importance 2 = Moderately Important 3 = Highly Important 4 = Very Highly Important

Knowledge of:	Mean	Standard Deviation	Item Retention Decision
1. Influence of the supervisor's counseling orientation on the supervisory relationship	2.67	.72	Retain item
2. Impact of various supervisory styles and approaches on the supervisory relationship	3.53	.64	Retain item
3. Implications of culture/ethnicity similarities/differences between the supervisor and the supervisee	2.80	.86	Retain item
4. Implications of gender similarities/differences between the supervisor and the supervisee	2.40	.74	Retain item: Sufficient empirical and theoretical support for the retention of this item
5. Implications of age similarities/differences between the supervisor and the supervisee	2.20	.77	Drop: Mean blow 2.50 Rounds 2 &3, Insufficient empirical or theoretical support for retention of the item
6. Implications of sexual orientation similarities/differences between the supervisor and the supervisee	2.20	.86	Retain item: Strong theoretical support for the retention of this item (B& G, 1998)
7. Implications of spirituality similarities/differences between the supervisor and the supervisee	2.20	.94	Drop: Mean blow 2.50 Rounds 2 &3, Insufficient empirical or theoretical support for retention of the item
8. Implications of disability similarities/differences between the supervisor and the supervisee	2.53	.99	Retain item
9. Rapport building in supervision	3.80	.41	Retain item
10. Trust issues in the supervisory relationship	3.80	.41	Retain item
11. Supervisory working alliance	3.53	.64	Retain item
12. Power issues in supervision	3.00	.84	Retain item
13. Importance of both control and creativity in the supervisory relationship	2.87	.83	Drop item: Not a knowledge area
14. Sources of conflict in the supervisory relationship	3.27	.59	Retain item

Scale: 0 = Not Important 1 = Little Importance 2 = Moderately Important 3 = Highly Important 4 = Very Highly Important			
Knowledge of	Mean	Standard Deviation	Item Retention Decision
15. Transference and countertransference issues on the supervisory relationship	3.40	.51	Retain item
16. Stress related to supervision	3.13	.74	Drop: Redundant with item 47
17. Parallel process issues in supervision	3.23	.60	Retain item
18. Operational definition(s) of clinical supervision	3.13	.64	Retain item
19. Similarities and differences between clinical and administrative supervision	3.00	.65	Retain item
20. A variety of models and theories of supervision (e.g. Developmental, Discrimination, etc.)	3.07	.80	Retain item
21. Research pertaining to theoretical models of supervision	2.47	.74	Drop: Mean blow 2.50 Rounds 2 &3
22. Stages of clinical skill development (e.g. novice through master counselor)	3.47	.52	Retain item
23. Changing needs of supervisees over the course of supervision	3.73	.46	Retain item
24. Multiple supervisory roles (e.g. teacher, counselor, consultant, evaluator)	3.20	.77	Retain item
25. Models and theories of supervisor development	2.60	.63	Retain item
26. Impact of social role models in supervision	2.28	.82	Drop: Mean blow 2.50 Rounds 2 &3
27. Adult learning theories	2.60	.51	Retain item
28. Systems theories	2.43	.65	Drop: Mean blow 2.50 Rounds 2 &3
29. Leadership theories	2.36	.63	Drop: Mean blow 2.50 Rounds 2 &3
30. Group supervision process and techniques	3.27	.59	Drop: Redundant with item 59
31. Issues in group supervision	3.27	.59	Drop: Redundant with item 59
32. Rehabilitation counseling supervision literature	3.07	.59	Retain item
33. Generic counseling supervision literature	3.07	.70	Retain item
34. Teaching as a supervision technique	3.33	.49	Retain item
35. Consultation as a supervision technique	3.33	.49	Retain item
36. Counseling techniques in supervision to facilitate supervisee awareness and change	3.53	.52	Retain item
37. Use of video/audiotapes in supervision	2.93	.88	Retain item
38. Case presentation method of supervision	3.47	6.4	Retain item

Scale: 0 = Not Important 1 = Little Importance 2 = Moderately Important 3 = Highly Important 4 = Very Highly Important			
Knowledge of	Mean	Standard Deviation	Item Retention Decision
39. Role play exercises in supervision	3.27	.59	Retain item
40. Verbal feed-back as a supervisory method	3.80	.41	Retain item
41. A variety of live supervision techniques	3.60	.51	Retain item
42. Modeling counseling as a supervision technique	3.53	.52	Retain item
43. Co-counseling as a supervisory method	2.80	.77	Drop: Co-counseling is a live supervision technique (item # 41)
44. Use of self-disclosure as a supervision technique	2.73	.70	Retain item
45. Humor as a supervision technique/intervention	3.00	.75	Retain item
46. Metaphor as a supervision technique	3.00	.75	Retain item
47. Sources of anxiety and stress for novice counselors	3.53	.52	Retain item
48. Sources of role-strain for supervisees	3.33	.62	Retain item
49. Methods to assist supervisees who are not adequately progressing	3.93	.26	Retain item
50. Intervention techniques to deal with a resistive supervisee	3.73	.46	Retain item
51. Methods to accommodate supervisees with disabilities	3.27	.70	Retain item
52. A variety of counseling theories and techniques	3.40	.63	Retain item
53. Career development theories	2.67	.62	Drop: Item included within item # 86
54. The effectiveness of specific counseling strategies with a variety of client populations	3.40	.63	Retain item
55. Application of theoretical knowledge to real world situations	3.80	.41	Retain item
56. Models of why and how people change	3.47	.52	Retain item
57. Crisis intervention techniques	3.87	.35	Retain item
58. Sources of resistance to change	3.73	.46	Retain item
59. Group counseling theories and techniques	3.20	.68	Retain item
60. A variety of case conceptualization techniques	3.27	.59	Retain item
61. Power dynamics/issues in counselor-client relationship	3.40	.51	Retain item

Scale: 0 = Not Important 1 = Little Importance 2 = Moderately Important 3 = Highly Important 4 = Very Highly Important			
Knowledge of	Mean	Standard Deviation	Item Retention Decision
62. CRCC Code of Professional Ethics for Rehabilitation Counselors	3.73	.46	Retain item
63. ACA Code of Ethics	3.26	.46	Retain item
64. ACES Ethical Guidelines for Clinical Supervisors	3.47	.52	Retain item
65. Ethical decision making models	3.60	.63	Retain item
66. Ethical dilemmas specific to supervision.	3.80	.56	Retain item
67. Ethical responsibilities of the supervisor to the client	3.87	.35	Retain item
68. Ethical responsibilities of the supervisor to the supervisee	3.87	.35	Retain item
69. Legal responsibilities as a supervisor to the client	3.60	.51	Retain item
70. Legal responsibilities as a supervisor to the supervisee	3.53	.52	Retain item
71. Issues pertaining to informed consent in supervision	3.73	.46	Retain item
72. Confidentiality issues in supervision	3.73	.46	Retain item
73. Dual relationship issues in supervision	3.60	.51	Retain item
74. Vicarious liability in supervision	3.36	.50	Retain item
75. Due process rights of the supervisee	3.33	.72	Retain item
76. Legal and ethical issues pertaining to determining supervisee competency	3.60	.51	Retain item
77. Ethical issues in group supervision	3.53	.63	Retain item
78. Self appraisal of supervisory competencies	3.13	.52	Retain item
79. Self appraisal of counseling competencies	3.47	.52	Retain item
80. Self appraisal of training needs as a supervisor	3.47	.52	Retain item
81. Philosophy of Rehabilitation Counseling	3.13	.74	Retain item
82. Scope of Practice for Rehabilitation Counseling	3.60	.51	Retain item
83. Rehabilitation systems and how to interact with them	3.33	.62	Retain item
84. The rehabilitation process from assessment through job placement	3.53	.64	Retain item
85. Disability related issues (e.g. physical, psychological, medical, social, legal)	3.67	.49	Retain item
86. Vocational counseling and consultation services	3.07	.70	Retain item

Scale: 0 = Not Important 1 = Little Importance 2 = Moderately Important 3 = Highly Important 4 = Very Highly Important			
Knowledge of	Mean	Standard Deviation	Item Retention Decision
87. Program evaluation and research	2.07	.28	Drop: Mean blow 2.50 Rounds 2 &3
88. Case management and service coordination	3.33	.62	Retain item
89. Family gender and multicultural issues	3.07	.59	Retain item
90. Foundations of rehabilitation counseling	2.93	.88	Retain item
91. Workers compensation related issues	2.60	.83	Drop: Item related to specific setting
92. Environmental and attitudinal barriers for individuals with disabilities	3.40	.51	Retain item
93. Assessment interpretation and evaluation techniques	3.33	.49	Retain item
94. Legislation related to employment of persons with disabilities	2.93	.70	Retain item
95. Personal beliefs about how rehabilitation counselors should be trained	2.67	1.29	Drop: Item is not a Knowledge or Skill area
96. Techniques to assess the pre-supervision developmental level of supervisees	3.47	.52	Items can be considered identical, combine to reduce possible redundancy
97. Techniques to assess the pre-supervision counseling skill level of supervisees	3.47	.52	
98. Methods for identifying the supervisory learning style of supervisees	3.33	.49	Retain item
99. Communication issues related to providing supervision feedback	3.71	.47	Drop: Item redundant with items 100. 101
100.Methods for providing effective, appropriate feedback to supervisees	3.93	.26	Retain item
101.Methods to reduce supervsiee anxiety about the evaluative component of supervision	3.47	.52	Retain item
102.A variety of direct and indirect methods for evaluating supervisees	3.53	.52	Retain item
103.Evaluation methods associated with theoretical models of supervision	2.33	.82	Drop: Mean below 2.5 in Rounds 2 & 3
104.A variety of instruments to evaluate supervisee performance	2.53	.64	Retain item: Rephrase for clarity
105.Supervisor evaluation instruments	3.47	.64	Retain item
106.Design and research issues pertaining to supervision related instruments	2.20	.56	Drop: Mean below 2.5 in Rounds 2 & 3

Scale: 0 = Not Important 1 = Little Importance 2 = Moderately Important 3 = Highly Important 4 = Very Highly Important			
Knowledge of	Mean	Standard Deviation	Item Retention Decision
107.A variety of group formats for evaluating individual progress	2.40	.63	Drop: Mean below 2.5 in Rounds 2 & 3
108.Time management techniques	3.00	.75	Retain item
109.University versus on site based expectations about supervision training goals	3.27	.70	Retain item
110.Strategies to assist supervisee to establish written goals/contract for field-based experience	3.27	.59	Retain item
111.Strategies to focus supervision sessions	3.40	.63	Retain item
112.Phases of supervision (e.g. beginning, middle, end/termination)	3.20	.56	Retain item
113.Strategies for facilitating group supervision	3.07	.59	Drop: Redundant with item #59
114.Methods for documenting supervision sessions	2.93	.70	Retain item

Additional items identified in Round 2 and included in Round 3:

1. CDMS Code of Professional Ethics for Rehabilitation Counselors	2.36	1.51	Drop: Mean below 2.50
2.. Relevant state and case law regarding supervision	3.36	.78	Include item
3. Various professional credentials and their importance for the supervisor	2.86	.69	Include item
4. Personal needs and values regarding supervision	3.28	.53	Include item

Appendix B

Rehabilitation Counselor Supervision Inventory

May 1, 1999

Dear Certified Rehabilitation Counselor:

For the past 25 years, Certified Rehabilitation Counselors (CRCs) have played a critical role in the professional development of novice rehabilitation counselors. It is through clinical experiences, supervised by CRCs, that the applied skills, knowledge, attitudes, and values of the rehabilitation counseling profession are modeled and shared with the next generation of rehabilitation counselors. Despite the significant role of CRCs in the professional preparation of rehabilitation counselors, little is known about the supervisory beliefs or practices of CRCs. The Commission on Rehabilitation Counselor Certification (CRCC) is therefore sponsoring this research to investigate these issues.

The primary purpose of this study is to identify the supervisory knowledge, skills, and preparation CRC's believe are essential for the effective field-based supervision of novice rehabilitation counselors. In addition, we hope to develop a baseline understanding of the supervisory practices of CRCs who have provided clinical supervision. **You do not, however, need supervision experience to participate in this study!**

All Information about individual participants in this study will be held in the strictest confidence. It will be used only by people who are directly involved in this study and will NOT be discussed or released to others for any purpose. Your responses will be used ONLY when combined with those of many other respondents. You indicate your voluntary agreement to participate by completing and returning this questionnaire.

Your participation in this study is greatly needed and appreciated! It is anticipated that your total time commitment to complete the enclosed questionnaire will be less then one hour. In recognition of the importance of your participation in this study, CRCC has agreed to grant three (3) hours of continuing education credits to each CRC who completes and returns the questionnaire. Please return the completed questionnaire to CRCC in the enclosed self-addressed stamped envelope by May 26, 1999.

Thank you in advance for your participation. If you have any questions or concerns about the questionnaire or the study, please feel free to contact Virginia Thielsen at 517-394-8466 or via
e-mail at thielsen@pilot.msu.edu.

Sincerely,

Susan L. Gilpin
Chief Executive Officer

Virginia A. Thielsen, CRC, LPC
Doctoral Candidate, Michigan State University

Rehabilitation Counselor Supervision Inventory

Sponsored by

Commission on Rehabilitation Counselor Certification

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

1. Please complete the entire questionnaire (Parts I and II).
2. Read each item CAREFULLY.
3. Use only a SOFT-LEAD (#2) PENCIL to mark your responses.
4. FILL IN YOUR RESPONSES COMPLETELY.
5. Do not make stray marks or write comments in the booklet.
6. In SECTION I, each statement requires TWO (2) responses (IMPORTANCE AND PREPAREDNESS). Be certain to provide both responses for each statement before proceeding to the next statement.

WHEN YOU HAVE COMPLETED THE QUESTIONNAIRE, PLEASE RETURN IT IMMEDIATELY TO CRCC IN THE ENCLOSED SELF-ADDRESSED STAMPED ENVELOPE BY THE DATE SPECIFIED IN THE COVER LETTER.

Assurance of Confidentiality

All information about individual participants will be held in the strictest confidence. It will be used only by people who are directly involved in this survey, and will NOT be discussed or released to others for any purpose. Your responses will be used ONLY when combined with those of many other respondents. You indicate your voluntary agreement to participate by completing and returning this questionnaire.

Please note: Due to space constraints the Importance and Preparedness scale grids have been removed. For an official copy of the instrument please contact the author.

SECTION ONE: SUPERVISORY KNOWLEDGE AND SKILLS

Directions:
Listed below are knowledge areas related to field-based clinical supervision of rehabilitation counselors. Please rate each statement on a scale of 0-4 for both of the following:

1. The **IMPORTANCE** of the area or standard described in the statement for the effective field-based supervision of rehabilitation counselor supervisees:

SCALE FOR IMPORTANCE
0 = Not Important
1 = Little Importance
2 = Moderately Important
3 = Highly Important
4 = Very Highly Important

2. The degree of **PREPAREDNESS** you feel you have in each area or standard as a result of your education and training:

SCALE FOR PREPAREDNESS
0 = No Preparation
1 = Little Preparation
2 = Moderate Preparation
3 = High Degree of preparation
4 = Very High Degree of Preparation

Knowledge of or Skills in:

1.	Rapport building in supervision
2.	Trust issues in the supervisory relationship
3.	Supervisory working alliance
4.	Power issues in supervision
5.	Impact of various supervisory styles and approaches on the supervisory relationship
6.	Implications of culture/ethnicity similarities/differences between the supervisor and supervisee
7.	Implications of gender similarities/differences between the supervisor and the supervisee
8.	Implications of sexual orientation similarities/differences between the supervisor and the supervisee
9.	Implications of disability similarities/differences between the supervisor and supervisee
10.	Influence of the supervisor's counseling orientation on the supervisory relationship
11.	Sources of conflict in the supervisory relationship
12.	Transference and countertransference issues on the supervisory relationship
13.	Parallel process issues in supervision
14.	Operational definition(s) of clinical supervision

SCALE FOR IMPORTANCE
0 = Not Important
1 = Little Importance
2 = Moderately Important
3 = Highly Important
4 = Very Highly Important

SCALE FOR PREPAREDNESS
0 = No Preparation
1 = Little Preparation
2 = Moderate Preparation
3 = High Degree of preparation
4 = Very High Degree of Preparation

Knowledge of or Skills in:

15. Similarities and differences between clinical and administrative supervision
16. Personal needs and values regarding supervision
17. A variety of models and theories of supervision (e.g. Developmental, Psychotherapy theory based, etc.)
18. Stages of clinical skill development (e.g. novice through master counselor)
19. Changing needs of supervisees over the course of supervision
20. Multiple supervisory roles (e.g. teacher, counselor, consultant, evaluator)
21. Models and theories of supervisor development
22. Adult learning theories
23. Group supervision theories and techniques
24. Rehabilitation counseling supervision literature
25. Generic counseling supervision literature
26. Teaching as a supervision technique
27. Consultation as a supervision technique
28. Counseling techniques in supervision to facilitate supervisee awareness and change
29. Use of video/audiotapes in supervision
30. Case presentation method of supervision
31. Role play exercises in supervision
32. Verbal feed-back as a supervisory method
33. A variety of live supervision techniques
34. Modeling counseling as a supervision technique
35. Use of self-disclosure as a supervision technique
36. Humor as a supervision technique/intervention
37. Metaphor as a supervision technique
38. Sources of anxiety and stress for novice counselors
39. Sources of role-strain for supervisees
40. Methods to assist supervisees who are not adequately progressing
41. Intervention techniques to deal with a resistive supervisee
42. Methods to accommodate supervisees with disabilities
43. A variety of counseling theories and techniques
44. The effectiveness of specific counseling strategies with a variety of client populations
45. Application of theoretical knowledge to real world situations
46. Models of why and how people change
47. Crisis intervention techniques
48. Sources of resistance to change
49. A variety of case conceptualization techniques
50. Power dynamics/issues in counselor-client relationship
51. CRCC Code of Professional Ethics for Rehabilitation Counselors
52. ACA Code of Ethics
53. ACES Ethical Guidelines for Clinical Supervisors
54. Ethical decision making models
55. Ethical dilemmas specific to supervision

SCALE FOR IMPORTANCE
0 = Not Important
1 = Little Importance
2 = Moderately Important
3 = Highly Important
4 = Very Highly Important

SCALE FOR PREPAREDNESS
0 = No Preparation
1 = Little Preparation
2 = Moderate Preparation
3 = High Degree of preparation
4 = Very High Degree of Preparation

Knowledge of or Skills in:

56. Ethical responsibilities of the supervisor to the client
57. Ethical responsibilities of the supervisor to the supervisee
58. Legal responsibilities as a supervisor to the client
59. Legal responsibilities as a supervisor to the supervisee
60. Issues pertaining to informed consent in supervision
61. Confidentiality issues in supervision
62. Dual relationship issues in supervision
63. Vicarious liability in supervision
64. Due process rights of the supervisee
65. Legal and ethical issues pertaining to determining supervisee competency
66. Ethical issues in group supervision
67. Relevant state and case law regarding supervision
68. Self appraisal of supervisory competencies
69. Self appraisal of counseling competencies
70. Self appraisal of training needs as a supervisor
71. Philosophy of Rehabilitation Counseling
72. Scope of Practice for Rehabilitation Counseling
73. Rehabilitation systems and how to interact with them
74. The rehabilitation process from assessment through job placement
75. Disability related issues (e.g. physical, psychological, medical, social, legal)
76. Case management and service coordination
77. Family, gender and multicultural issues in rehabilitation counseling
78. Foundations of rehabilitation counseling
79. Vocational counseling and consultation services
80. Environmental and attitudinal barriers for individuals with disabilities
81. Assessment interpretation and evaluation techniques
82. Various professional credentials and their importance for the supervisor
83. Techniques to assess the pre-supervision counseling skill/developmental level of supervisees
84. Methods for identifying the supervisory learning style of supervisees
85. Strategies to focus supervision sessions
86. Methods for providing effective, appropriate feedback to supervisees
87. Methods to reduce supervisee anxiety about the evaluative component of supervision
88. A variety of direct and indirect methods for evaluating supervisees
89. Instruments to evaluate supervisee performance
90. Supervisor evaluation instruments
91. Time management techniques
92. University versus on-site based expectations about supervision training goals
93. Strategies to assist supervisee to establish written goals/contract for field-based experience
94. Phases of supervision (e.g. beginning, middle, end/termination)
95. Methods for documenting supervision sessions

SECTION TWO: DEMOGRAPHIC INFORMATION

1. Age: _____ **2. Gender:** ☐ Male ☐ Female

3. Race/Ethnicity:

☐ African American
☐ Native American
☐ Black/non-African
☐ Latino/a
☐ Caucasian-non Hispanic
☐ Asian American/Pacific Islander
☐ Other

4. Current Job Title (Mark only one)

☐ Rehabilitation Counselor
☐ Supervisor (Rehabilitation Personnel)
☐ Job Development/Placement
☐ Work Adjustment Specialist
☐ Administrator (Manager)
☐ Rehabilitation Nurse
☐ Rehabilitation Educator
☐ Vocational Evaluator
☐ Full time Student
☐ Social Worker
☐ Case Manager
☐ Substance Abuse Counselor
☐ Independent Living Specialist
☐ Other (Specify): _____

5. Please indicate your present employment setting (Mark only one)

☐ State-Federal Rehabilitation Agency Field Office
☐ Private Non-Profit Rehabilitation Facility
☐ Private (Proprietary) Rehabilitation Company
☐ College or University
☐ Medical Center or General Hospital
☐ Independent Living Center
☐ State Rehabilitation Agency Facility
☐ Worker's Compensation Agency
☐ Social Welfare Office
☐ Business or Industry
☐ Mental Health Center
☐ Mental Hospital
☐ Mental Retardation Center
☐ Public School System
☐ Insurance Company
☐ State Fund
☐ Correctional Institution
☐ Private Practice
☐ Other (Specify)
_____

6. Total number of years of post CRC work experience in rehabilitation: _____

7. Your core professional identity is:

☐ Rehabilitation
☐ Counseling
☐ Both Rehabilitation and Counseling
☐ Psychology
☐ Other (Specify):
_____

8. Credentials: (Mark all those that apply)

☐ CRC
☐ CCM
☐ CVE
☐ CDMS
☐ NCC
☐ Licensed Professional Counselor
☐ Limited Licensed Professional Counselor
☐ LPCS (Licensed Supervisor)
☐ NBCC Approved Clinical Supervisor
☐ CWA
☐ Licensed Psychologist
☐ Limited Licensed Psychologist
☐ Other (Specify):_____

9. Education: Highest degree earned: ☐ **Bachelor** ☐ **Masters** ☐ **Doctorate**

10. Please indicate your major area of study for your highest degree. (Mark only one)

☐ Rehabilitation Counseling
☐ Psychology
☐ Social Work
☐ Other Counseling Specialty (e.g. Substance Abuse, Agency, Mental Health, etc.)
☐ Other Rehabilitation Specialty (e.g. Vocational Evaluation, Job Placement, etc.
☐ Other (Specify):
_____

11. Have you received formal training in clinical supervision? ☐ Yes ☐ No
(If "No" please proceed to question 12)

11a. Where did you complete the clinical supervision training? (Mark all that apply)

☐ Professional workshops
☐ Supervised supervision
☐ In-service (on the job)
☐ Post -master's academic course work
☐ Master's level academic course work
☐ Other

11b. What topic areas were addressed in this training? (Mark all that apply)

☐ Roles and functions of clinical supervision
☐ Models of supervision
☐ Supervision methods and techniques
☐ Supervisory relationship issues
☐ Diversity issues in supervision
☐ Evaluation issues and techniques
☐ Ethical, legal, and professional regulatory issues
☐ Research in clinical supervision
☐ Management skills for supervision

11c. Approximately how many hours of training in clinical supervision have you received? _____

12. Do you believe CRCC should establish specific experience requirements for supervisors who provide field-based clinical supervision?
☐ Yes ☐ No

13. Do you believe CRCC should establish specific training requirements for supervisors who provide field-based clinical supervision?
☐ Yes ☐ No

14. Have you provided clinical supervision in the last five years? ☐ Yes ☐ No

PLEASE READ THE FOLLOWING BEFORE CONTINUING

If you responded "NO" to question 14, PLEASE STOP HERE!
Thank you for your time and participation in this survey.

If you responded "YES" to question 14, please proceed to question 15.

15. In which setting do you provide clinical supervision? (Mark only one)

- ☐ Community/field-based agency or facility
- ☐ University/college

16. Approximately how many years of post CRC work experience in rehabilitation had you completed prior to providing clinical supervision for the first time?

☐ Less than 1 year ☐ 1 year ☐ 2 years ☐ 3 years ☐ 4 years ☐ 5 or more years

17. Approximately how many individuals have you clinically supervised in the last five years? _____

18. When providing supervision, how many individuals do you typically supervise at one time? _____

19. Which of the following types of individuals have you most frequently clinically supervised in the last five years.? (Mark only one)

- ☐ Practicum Students
- ☐ Internship Students
- ☐ Employees/subordinates
- ☐ Licensure Applicants

20. What clinical supervision format do you most frequently use? (Mark only one)

- ☐ Individual supervision
- ☐ Group supervision
- ☐ Combination of individual and group supervision

21. On average, how often do you formally meet with supervisee(s)? (Mark only one)

- ☐ More than once a week
- ☐ Weekly
- ☐ Twice a month
- ☐ Monthly
- ☐ Less than once a month

22. On average, how long is a typical supervision session? (Mark only one)

- ☐ Less than 1 hour
- ☐ 1 hour
- ☐ 2 hours
- ☐ More than 2 hours

23. Do you routinely document your supervision sessions? ☐ Yes ☐ No

24. Which of the following roles do you assume in supervision relationships with supervisees?

	Never	Rarely	Often	Always
Consultant	0	1	2	3
Counselor	0	1	2	3
Teacher	0	1	2	3
Evaluator	0	1	2	3
Administrator	0	1	2	3

25. Which methods of supervision do you use?

	Never	Rarely	Often	Always
Self-report of counseling sessions	0	1	2	3
Live observation with supervisor present in sessions	0	1	2	3
Role playing counseling sessions	0	1	2	3
Review of audio tapes	0	1	2	3
Review of videotapes	0	1	2	3
Observation through a one-way mirror	0	1	2	3
Written reports of sessions	0	1	2	3
Provide written evaluative feedback	0	1	2	3

Thank you for your time and participation in this survey.

Please return the survey in the enclosed

self-addressed stamped envelope.

Appendix C

Demographic and Professional Characteristics of the Population and the Sample

Demographic Characteristics of the Population and the Sample

Variable	Population Percentage	Sample Percentage
Gender		
Male	34.1	36.3
Female	65.9	63.7
Race/Ethnicity		
African American and Black/non-African	4.5	4.8
Native American	.5	.9
Latino/a	1.9	1.9
Caucasian/non-Hispanic	87.7	88.4
Asian American/Pacific Islander	1.4	1.4
Other	1.3	1.8
Not Stated	2.7	.8
Degree Level		
Bachelors	7.1	6.4
Master	88.7	86.4
Ph.D.	4.0	7.2

Note: Population N = 14,487; Sample N = 774

Population and Sample Job Titles

Variable	Population Percentage	Sample Percentage
Job Title		
Rehabilitation Counselor	39.0	39.9
Supervisor	7.2	9.3
Job Development/Placement	1.4	1.0
Work Adjustment Specialist	.2	.3
Administrator (manager)	10.0	11.0
Rehabilitation Nurse	.4	.1
Rehabilitation Educator	2.4	3.1
Vocational Evaluator	1.8	2.3
Full Time Student	13.4	.6
Social worker	1.1	1.3
Physical / Occupational Therapist	.2	**
Substance Abuse Counselor	1.0	1.7
Independent Living Specialist	*	.6
Case manager	*	8.8
Other	27.2	18.9
Not Stated	.9	1.0

Notes: * = Data not collected for this job title by CRCC
** = Data not collected for this job title in this study
Population N = 14,487; Sample N = 774

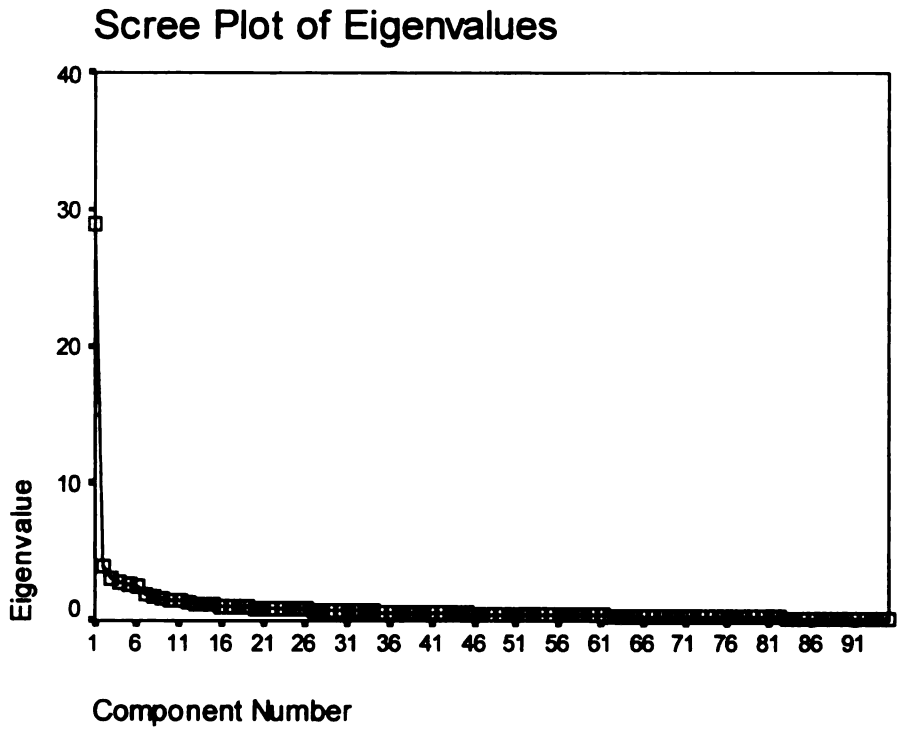
Population and Sample Employment Settings

Variable	Population Percentage	Sample Percentage
Employment Setting		
State-Federal rehabilitation agency field office	13.7	20.9
Private non-profit rehabilitation facility	9.2	9.8
Private (proprietary) rehabilitation company	21.2	17.3
College or University	8.0	6.1
Medical center or general hospital	3.6	3.5
Independent living center	.46	.1
State rehabilitation facility	4.8	2.6
Worker's compentation agency	1.7	1.4
Social welfare office	.85	1.0
Business or industry	1.1	1.6
Mental health center	3.6	3.4
Mental hospital	1.6	1.8
Mental retardation center	1.1	1.2
Public school system	1.5	1.9
Insurance company	2.5	4.0
State fund	.1	0
Correctional institution	.4	1.3
Private practice	6.9	10.2
Other	14.7	10.7
Not stated	2.7	1.2

Note: Population N = 14,487; Sample N = 774

Appendix D

Scree Plot of Eigenvalues


Scree Plot of Eigenvalues
Eigenvalue
40
30
20
10
0
1
6
11
16
21
26
31
36
41
46
51
56
61
66
71
76
81
86
91
Component Number

Appendix E

Principal Component Loadings for Importance Factors

Principal Component Loadings for Importance Factor 1

Label: Ethical and Legal Issues	Loading
57. Ethical responsibilities of the supervisor to the supervisee	.706
59. Legal responsibilities as a supervisor to the supervisee	.696
58. Legal responsibilities as a supervisor to the client	.677
56. Ethical responsibilities of the supervisor to the client	.670
55. Ethical dilemmas specific to supervision	.665
65. Legal and ethical issues pertaining to determining supervisee competency	.649
60. Issues pertaining to informed consent in supervision	.625
63. Vicarious liability issues in supervision	.608
66. Ethical issues in group supervision	.608
52. ACA code of Ethics	.596
54. Ethical decision making models	.589
53. ACES Ethical Guidelines for Clinical Supervisors	.585
64. Due process rights of the supervisee	.577
67. Relevant state and case law regarding supervision	.574
61. Confidentiality issues in supervision	.551
51. CRCC Code of Professional Ethics for rehabilitation Counselors	.546
62. Dual relationship issues in supervision	.546

Principal Component Loadings for Importance Factor 2

Label: Theories, Models and Resources	Loading
17. A variety of models and theories of supervision (e.g. Developmental, Psychotherapy theory based, etc.)	.622
23. Group supervision theories and techniques	.593
29. Use of video/audiotapes in supervision	.580
25. Generic counseling supervision literature	.569
24. Rehabilitation counseling supervision literature	.558
43. A variety of counseling theories and techniques	.533
21. Models and theories of supervisor development	.508
31. Role play exercises in supervision	.495
13. Parallel process issues in supervision	.487
49. A variety of case conceptualization techniques	.477
Transference and countertransference issues on the supervisory relationship	.461
The effectiveness of specific counseling strategies with a variety of client populations	.454
22. Adult learning theories	.439
14. Operational definition(s) of clinical supervision	.436
Counseling techniques in supervision to facilitate supervisee awareness and change	.423
18. Stages of clinical development (e.g. novice through master counselor)	.395
15. Similarities and differences between clinical and administrative supervision	.391
33. A variety of live supervision techniques	.389
92. University versus on-site based expectations about supervision training goals	.385
45. Applications of theoretical knowledge to real world situations	.352

Principal Component Loadings for Importance Factor 3

Label: Intervention Techniques and Methods	Loading
38. Sources of anxiety and stress for novice counselors	.615
40. Methods to assist supervisees who are not adequately progressing	.573
36. Humor as a supervision technique/intervention	.542
41. Intervention techniques to deal with a resistive supervisee	.542
32. Verbal feed-back as supervisory method	.512
19. Changing needs of supervisees over the course of supervision	.506
48. Sources of resistance to change	.506
39. Sources of role strain for supervisees	.502
34. Modeling counseling as a supervision technique	.426
30. Case presentation method of supervision	.414
26. Teaching as a supervision technique	.403
16. Personal needs and values regarding supervision	.402
35. Use of self-disclosure as a supervision technique	.398
42. Methods to accommodate supervisees with disabilities	.389
20. Multiple supervisory roles (e.g. teacher, counselor, consultant, evaluator)	.386
47. Crises intervention techniques	.385
46. Models of how and why people change	.380
27. Consultation as a supervision technique	.365
1. Rapport building in supervision	.362
50. Power dynamics/issues in counselor client relationship	.338
37. Metaphor as a supervision technique	.325

Principal Component Loadings for Importance Factor 4

Label: Evaluation and Assessment	Loading
90. Supervisor evaluation instruments	.666
89. Instruments to evaluate supervisee performance	.651
88. A variety of direct and indirect methods for evaluating supervisees	.646
85. Strategies to focus supervision sessions	.634
84. Methods to identify the supervisory learning style of supervisees	.601
94. Phases of supervision (e.g. beginning, middle, end/termination)	.593
95. Methods for documenting supervision sessions	.592
93. Strategies to assist supervisee to establish written goals/contract for field-based experience	.581
87. Methods to reduce supervisee anxiety about the evaluative component of supervision	.555
83. Techniques to assess the pre-supervision counseling skill/developmental level of supervisees	.551
86. Methods for providing effective, appropriate feedback to supervisees	.536
70. Self-appraisal of training needs as a supervisor	.504
68. Self appraisal of supervisory competencies	.490
69. Self appraisal of counseling competencies	.429

Principal Component Loadings for Importance Factor 5

Label: Rehabilitation Counseling Knowledge	Loading
79. Vocational counseling and consultation services	.761
74. The rehabilitation process from assessment through job placement	.699
75. Disability related issues (e.g. physical, psychological, medical, social, legal)	.681
76. Case management and service coordination	.648
81. Assessment interpretation and evaluation techniques	.624
78. Foundations of rehabilitation counseling	.613
80. Environmental and attitudinal barriers for individuals with disabilities	.607
72. Scope of Practice for Rehabilitation Counseling	.577
73. Rehabilitation systems and how to interact with them	.502
71. Philosophy of rehabilitation counseling	.481
82. Various professional credentials and their importance for the supervisor	.434
91. Time management techniques	.416
77. Family, gender and multicultural issues in rehabilitation counseling	.382

Principal Component Loadings for Importance Factor 6

Label: Supervisory Relationship	Loading
7. Implications of gender similarities/differences between the supervisor and the supervisee	.834
8. Implications of sexual orientation similarities/differences between the supervisor and the supervisee	.788
6. Implications of culture/ethnicity similarities/differences between the supervisor and the supervisee	.783
9. Implications of disability similarities/differences between the supervisor and the supervisee	.782
11. Sources of conflict in the supervisory relationship	.479
4. Power issues in supervision	.414
5. Impact of various supervisory styles and approaches on the supervisory relationship	.411
10. Influence of the supervisor's counseling orientation on the supervisory relationship	.411
2. Trust issues in the supervisory relationship	.351
3. Supervisory working alliance	.322

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