5-1974

Implementation of Previous Research on Competency-Based Practicum in Special Education at USU

Clifton W. Jenkins

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IMPLEMENTATION OF PREVIOUS RESEARCH ON COMPETENCY-BASED PRACTICUM IN SPECIAL EDUCATION AT USU

by

Clifton W. Jenkins

A report submitted in partial fulfillment of the requirements for the degree of

MASTER OF EDUCATION

in

Special Education

(Learning Disabilities)

UTAH STATE UNIVERSITY
Logan, Utah

1974
Acknowledgments

An acknowledgment of love and appreciation is given to my wife, Veretta, and our children, Dean, David, and Melissa, for their patience and never ending support.

Second, sincere appreciation is extended to Dr. Hyrum S. Henderson, my Committee Chairman, for providing direction and support that led to the completion of this report.

An acknowledgment of appreciation is made to the members of my committee, Joan F. Thorkildsen and Lionel Brady, for their advice and support during the writing of this report.

Clifton W. Jenkins
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Introduction

There is a very real need for exploration and development of alternative approaches to special education (Lilly, 1971). Some have questioned the necessity of teachers receiving preservice training at teacher education institutions (Popham, 1971). Schwartz (1971) suggested that teachers need special training before being placed in a diagnostic-prescriptive teaching situation.

The recent trend is to integrate the special student into the regular classroom. This requires that special educators be trained to perform specialized assessment and provide remedial instruction for a variety of exceptional children in a way that is compatible with regular classroom routine and procedure (Burrello, Tracy, and Schultz, 1973).

Statement of the Problem

In expressing their dissatisfaction with teacher preparation institutions, Bausell and Moody (1973) charged that if held accountable at all they are evaluated solely on "in house criteria." One example of this criteria is the number of faculty publications. They felt this criteria was irrelevant to the primary purpose of the institution.

Not all publications originating in teacher preparation institutions can be considered irrelevant to their primary purpose. A competency-based practicum training program was developed in 1973 by Dale LeFevre to train special educators in specific diagnostic, prescriptive and self-monitoring
skills. It provided monitoring and observational procedures to aid the college supervisor in determining levels of competency achieved by practicum students.

This research grew out of a department where competency-based teacher education was a pertinent concern. That concern influenced the undertaking of the research to create the program as well as to develop the program itself. The benefits of the program were recognized and implemented. That resulted in one instance where a dissertation was relevant to the primary purpose of the institution.

When the present study was begun no attempt had been made to study or evaluate the implementation of that program.

**Purpose of Study**

It was the purpose of this study to determine to what extent the research by LeFevre has been adapted to the student practicum in special education and to examine the implications of its implementation and operation. A comparison was made between the LeFevre model and the program implemented in student practicums, and the results of evaluations of its implementation and operation were made.

**Assumptions and Definitions**

1. The LeFevre model is the one developed by Dale LeFevre (1973) in his dissertation, "The Development and Validation of a Competency Based Practicum in Clinical Teaching."
2. The clinical teaching model is that implemented in Student Practicums in Special Education at Utah State University.

3. For the purpose of this paper, the term "change" will be defined as results from evaluation recommended by the evaluator in the program.

4. The scope of LeFevre's study included the following terms often seen in literature: Competency-based Teacher Certification (CBTC), Competency-based Teacher Education (CBTE), and Competency-based Clinical Teaching (CBCT). Performance was found to be used interchangeably with competency in these terms. The general purpose relating to these terms is to train and certify teachers with proven ability to teach, not to merely successfully complete a given number of college courses.

Limitations

The research was limited to determining the extent of implementing evaluation and change evolved since the implementation of LeFevre's model at U.S.U.
Review of Literature

In his Doctoral dissertation LeFevre (1973) developed and validated a competency-based practicum in clinical teaching. The objective was to use competency-based methods in a practicum situation to better prepare preservice teachers for inservice teaching.

A review of literature was conducted to determine what competencies were identified as needed for certification and at what level they should be developed by teacher education institutions, and to determine the format, content, and process of competency-based programs, their development, implementation, operation and results. In an effort to obtain information supporting the needs, format and procedure of such a program three areas of review were selected: competency-based teacher certification, competency-based teacher education, and competency-based clinical teaching.

Competency-based Teacher Certification (CBTC)

Literature was reviewed for this present paper regarding CBTE to find what was being done toward developing CBTE programs. By identifying skills required, levels of competency expected and methods of measurement used, it could be determined by comparison if those developed by LeFevre were compatible with those required by CBTE programs.

At this time there is much interest in CBTE. The certifying agencies feel it is necessary to insure the preparation of competent teachers. Stiles
(1969) pointed out that in certifying teachers the state functions the same as it does in licensing professionals in other fields because it attests to the professional competency of the various types of educational personnel. "Certification should distinguish levels of competency and responsibility." (Edelfelt, 1968)

"The profession itself must become more directly responsible for the certification of teacher competence." (Stiles, 1969)

Vail (1973) said it is nonsense to think "that certification guarantees competency as a teacher." In a speech to the Vermont State Continuing Education Division, he said, "The top priority for us in this division in the years ahead is to improve the quality of instruction provided the boys and girls." Quality instruction is provided by competent teachers. Certification does not guarantee competency.

It is desirable then that CBTE be based first upon teacher education or teacher preparation, and second upon evaluation of experienced teachers. However, the review of literature revealed no agreement on the skills a competent teacher should have, the level of competency in a given skill, or how competency should be measured. There must be agreement in these areas before teachers can be trained in the required skills and their level of competency determined.

Competency-based Teacher Education (CBTE)

Literature regarding CBTE was reviewed to determine format, content, and process used to determine programs at other CBTE institutions,
especially those using modular programs. These programs could then be used in comparison with LeFevre's to identify its pertinent characteristics.

There has been dissatisfaction expressed regarding teacher education programs in that most of them have long periods of preparation for teaching with little or no actual teaching practice until near the completion of the program (Delp, 1968).

Bausell and Moody (1973) expressed their dissatisfaction particularly with teacher competency and teacher preparational institutions. They felt that colleges of education, if held accountable at all, are evaluated solely on "in house" criteria. Examples of "in house" criteria are: the number of faculty publications, ability to attract federal or private funding, course evaluation by students, or possibly the number of trained teachers graduated per year. The problem with "in house" criteria is that they are irrelevant to their institution's primary purpose which is to prepare competent teachers.

They reported further:

We later demonstrated that children taught by students who had completed practice teaching and their required courses in instructional methods and materials did not learn significantly more than children taught by students who had done neither. Since a teaching practice effect has been established using these same materials, the conclusion is inescapable: the teacher preparation as provided by colleges of education does not result in increased student achievement. (Bausell and Moody, 1973, p. 299)

Popham expressed similar concern:

Experienced teachers are not particularly skilled at bringing about specified behavior changes in learners.
We should not be surprised that they are not skilled goal achievers. Certainly they have not been trained to be: teacher education institutions rarely foster this competence. Nor is any premium placed on such instructional skills after the teacher concludes preservice training.

This is a totally unacceptable state of affairs. Every profession worthy of its name derives its professionalism precisely from the fact that its members possess a special expertise not present in non-members of the profession. (Popham, 1971, p. 601)

While not disproving the findings of Bausell and Moody (1973), Turner disagreed with their methods, particularly the experimental design used in their study:

By the usual standards of experimental design, none of the studies on which Bausell and Moody premise their contention can be regarded as dependable. Moreover, Bausell and Moody's "inescapable conclusion" for them is not only merely escapable, it is irrational.

Popham's study is not a fair trial of the hypothesis that there is no relationship between teacher preparation/experience and student performance.

Neither Popham nor Bausell and Moody have produced studies from which dependable information about teacher education can be extracted. (Turner, 1973, p. 299)

The disagreement between Turner, Popham, and Bausell and Moody do not challenge the need or objective of CBTE. It does place the responsibility on educators to examine more closely their methods of educating teachers. They should be continually searching for better methods of teacher preparation (Tyler, 1973). Somehow in our press to get someone resembling a well prepared teacher into the school or college classroom, we overlook our first obligation: to prepare children for maturity according to the best educational
principles (Goldstein, 1959). To do this, it is necessary to determine the method or program most efficient at teacher training.

Research conducted by Sybouts (1973) supported the advantages of CBTE. While early results were inconclusive, the data point rather clearly to two major findings: teacher education students like PBTE better than the traditional instructions, and youngsters taught by PBTE learn more.

A study of 180 students, 90 taught by PBTE teachers and 90 taught by traditional teachers, showed that those taught by PBTE teachers received mean scores of .739, while those taught by traditional teachers received mean scores of .687 on posttest after both groups were taught the same concept.

To meet these objectives it is necessary to have some method which would allow students a practical way of obtaining better supervised experience and would permit the college to observe and evaluate the quality of teaching (Delp, 1968). This program or method is identified by Vail (1973) as performance-based teacher education.

Care must be exercised not to expect too much from PBTE programs. We might expect a PBTE approach to rest on an empirically derived theory which would in turn enable highly accurate deductions to be made for the purpose of planning teacher training. At this time it is questionable whether PBTE is any better off in this respect than any other approach (Kennedy, 1973).

Some deductions applicable to PBTE have already been made as to what is needed to improve teacher education. Orlosky (1973) emphasized that teacher competencies must be delineated in order to prepare competent teachers.
Pitman (1973, p. 26) specified more than what the learner must do when he said, "In a performance or competency based system one must clearly specify what the learner is to do, the degree or level of performance or competency expected, and the evaluation procedure to be used." In emphasis of this, Haring (1969) said one of the most important responsibilities of the educator is the evaluation of what the learner has learned.

The present review made no attempt to list all teacher education institutions presently utilizing competency-based teacher education. However, eight institutions were noted which had complete programs in operation. Many others had partial programs or programs under development. Two of these programs were representative of most in outline of content, format, and method.

The Association of Teacher Educators described content and method:

A teacher education program based upon clearly stated behavioral objectives and organized in terms of performance modules provides the means for maximum flexibility and individualization. Each module consists of a diagnostic pretest, a unit of instruction through which the desired behavior may be acquired, and a posttest by which performance is demonstrated. Knowledge of the behavioral objective of each module enables the student to evaluate his own progress as he moves ahead. At the same time it assists him in determining what he needs to do in order to perform as specified. (Association of Teacher Education, 1973, p. 15)

Wyoming University, Laramie College of Education (1973) described the format and content of a CBTE program in terms of:

1. Individualized and personalized instructions.

2. Modular instructions.
3. Clinical experience.

4. Simulated laboratory experience.

5. Research oriented structure.

Each of these areas is discussed individually. Clinical experience is discussed last and is included in the Competency-based Clinical Teaching section.

Individualized instructions. This is the method whereby the program is adapted to the student. It should allow the student to progress at his own rate and by his own method. The rate and method are outlined in Guide to Clinical Experiences in Teacher Education:

The emphasis upon individuality is not intended to suggest that each student will have complete control of his own program and be free to make indiscriminate choices of favored activities. It does mean, however, that means are available for providing clinical experiences on an individual basis, for demonstration of proficiency, and for progress determined by evidence of personal growth and professional maturity rather than by completion of a mandated series of assignments. (Association of Teacher Educators, 1973, p. 15)

There are limits to individualization, particularly in the rate of progress. It is not possible for CBTE programs to be completely self-passing. If they are carried out over more than one quarter, problems are created when staff change course responsibility at which time the supervising staff member must assess the partial progress of students still in the program and relay this evaluation to his successor (Kennedy, 1973).

Modular instructions. Tyler (1973) identified a major advantage of modular instructions in that it allowed one to reduce a selected area of
instructions to a particular set of skills or subskills, thus increasing the probability that each trainee will be able to demonstrate his mastery of each skill.

Tyler went on to describe the steps in planning a package program and identified the required content of the packages in such a program:

First, instructional objectives should be stated behaviorally, in light of the overall goals of the training package. All learner outcomes and desired responses should be observable and available for critique and review.

Second, active learning experiences should be planned to meet each objective. Accordingly, each learner experience should have a point for point correspondence with each training objective, which will provide immediate feedback regarding the appropriateness of each response.

Third, a packaged program should include explicit instructions on how to implement the program. These instructions should cover such items as (a) the target population involved, (b) directions on how to organize and manage the group, (c) ways to arrange the physical setting, and (d) specific directions in the use of equipment and materials.

A final consideration should be the type of evaluation given the package. Ideally, evaluation should include not only the performance of teachers during training but also the ultimate criterion--change in the behavior or performance of children. Evaluation may include verbal, nonverbal, or written responses which can be recorded and charted. In addition, it is helpful to set up a performance criterion for each participant, as well as the total group, such as 90 percent attainment of all program objectives.

It is strongly recommended that simulated practice exercise be built in so that first-time trainees can gain experience in presenting the package to others. (Tyler, 1973, p. 405)

The use of modules in CBTE has created problems that educators must solve to obtain maximum effectiveness from the program. Getz noted two
problems that are of considerable concern:

Competency-based models frequently specify only those competencies that can be easily identified and measured. However much training in improved teaching behavior requires complex learning activities and complex creative evaluations. Until higher order competencies are specified in instructional packages, competency-based programs will remain subject to the charge of content simplicity.

A competency-based program produces special problems for evaluation. Appropriate tools must be used to determine competency levels. (Getz, 1973, p. 300)

While discussing the Wilkits used at Weber State College in their teacher education Program, Burk (1972) said, relevant to the evaluation of module programs, "A good teacher education system demonstrates theory in practice," and "A good teacher education system exists on the merits of its accomplishments."

This does not solve the problem of how to measure the level of competency in the skill developed by the training in the module. That problem must be dealt with on the basis of each skill and the level of competency required.

Simulation. Situations created with the intent of being similar to in-service teaching and often using the student teachers' peers as pupils constitutes simulation.

These experiences fill a very real need in teacher training. They provide an opportunity for the first-time trainee to gain experience in presenting the packages to others. They provide some experience before the trainee actually appears before the class (Tyler, 1973). Simulations may be that "Integrative Stem" we have sought so long which will wed theory and practice (Cruickshank, 1966).
Research oriented structure. A CBTE program must be research oriented and utilize research to determine its accomplishments. A good teacher education system exists on the merits of its accomplishments (Burk, 1972). Research must evaluate accomplishments and determine needs and methods of improvement.

It may also be necessary to orient research to CBTE. Educational research, as it is traditionally conducted, is not organized to answer questions commonly asked by decision makers planning teacher education training programs (Performance-based Teacher Education, 1973).

If, as Popham (1971) stated, "The chief reason for the teacher's existence is to promote beneficial change in the learner," there must be a system of evaluation. This system must evaluate the preservice teacher by the same measure as the inservice teacher. "Performance based teacher education will rise or fall on our ability to evaluate performance in relation to agreed upon standards." (McKenna, 1973, p. 3) However, that agreement has not been reached.

Vail (1973) reported, "pupil progress on some standardized test is the only way to measure teacher effectiveness." Performance-based Teacher Education (1973) reported "Do not use student learning measures for evaluating individual teachers." Sybouts (1973) stated, "The effectiveness of teaching must ultimately be measured in terms of achievement demonstrated by those being taught."
Standardized tests are not the only means of evaluation. Kennedy (1973) reported on another method used when he said, "Assessment of performance in teacher training usually involves observation as a major part of the assessment procedure, and reliability of observations thus becomes an important variable."

Popham (1971) challenged the reliability of observations: "The problem with the observation approach is that it is so process focused that the observer rarely moves to the logical follow-up question: 'What happens to pupils as a consequence of the teacher's using these processes?'"

Haring and Fargo tell us that evaluation of student teacher skills is possible. They reported the procedure used in one program:

The teacher was evaluated from the responses he exhibited while (a) assessing the child's skills, (b) assisting a teacher in setting up a remedial program for a child new to the class, (c) assisting a teacher in assessing the performance of a child with a learning problem who was not new to the class and (d) assisting a teacher in assessing a child with a learning problem who was new to the classroom. (Haring and Fargo, 1969, p. 159)

At this point all would agree with Getz (1973) when he said, "A competency-based program produces special problems for evaluation." The special problems involved in measuring teacher behavior, student behavior, and determining levels of competency and criteria need to be included, not viewed as disagreements.

A reason for this situation is suggested by the lack of specificity about the competencies in the teacher education curriculum and the lack of measures to establish degrees of teacher competency. These preclude consideration of
the relationship between the effects of teacher training and change in pupil behavior (Turner, 1972).

Research is needed to determine the skills in which a teacher should be competent. It is needed to determine the level of competency required to be competent and to receive certification. It must include development of measurements of these competencies. Evaluation techniques new to the trade must be forthcoming (Hunter, 1973).

**Competency-based Clinical Teaching (CBCT)**

Literature in this area related directly to LeFevre's development of a clinical practicum. Because a practicum is a simulation of inservice teaching, competency-based clinical practicum and inservice clinical teaching were reviewed. In this way reality in practicum and theory in practice could be reviewed. The objective, method and results of other programs could be compared with LeFevre's model.

Clinical experiences as they apply to the regular classroom teacher and the special education teacher are similar in some ways and different in others. Because this research is oriented to special education, those areas particular to special education are emphasized.

Bechtol (1972) said, "It appears obvious that if the aim of teaching is learning there should be evidence that preservice teachers can bring about appropriate learning in students before they assume responsibility for such learning in the classroom."
A clinical practicum serves this purpose as well as teaching the pre-service teacher additional skills and providing additional experience. A clinical practicum provides the opportunity for the trainee to bring theory and practice together, to achieve the operational objectives of a good teacher training program (Haring and Fargo, 1969). "It provides teachers with practice in doing what we want them to do." (Popham, 1971)

A good CBTE program which includes a clinical practicum should prepare teachers to systematically and successfully intervene or recommend intervention to bring about learning in students. A trainee's performance in this skill is measured on the basis of two criteria: prescriptive accuracy level and continuous baseline measurement indication of intervention success (Wyoming University, Laramie College of Education, 1973).

The clinical practicum has special meaning to the special educator because his inservice achievements will be in a clinical situation. He must be able to understand the abilities and disabilities, differences, needs, instructional strategies and welfare of the handicapped (Stiles, 1969). The special educator must lead the way in truly individualized or personalized instruction to increasingly accommodate the children who are different (Deno, 1970).

It is necessary to have a clinical practicum to allow the students a practical way of obtaining supervised experience in the use of teaching skills and to permit the college to observe and evaluate the quality of the student's teaching skills (Delp, 1968).
The review of literature has revealed considerable interest in competency-based teacher certification. Educators and administrators of teacher education institutions have taken the initiative and many have performance or competency-based teacher education programs in operation. Performance-based teacher education "is a means of making new and experienced teachers more competent in teaching children than they now are." (Vail, 1973)

A problem arises of how to determine a teacher's competency. Agreement is not common on how to measure competency, what level or degree of performance establishes competency, or in what skills competency should be determined.

Work is being done in this area and some very creative methods and processes are being used. However, much progress is needed. As Orlosky (1973) pointed out, "Teacher competencies must be delineated in order to prepare competent teachers."
Procedure

Characteristics of the LeFevre Model

Dale LeFevre's dissertation was studied to determine those pertinent characteristics of content and procedure that identify it. In conference with Dr. Alan Hofmeister, LeFevre's supervising professor, these characteristics were verified as pertinent to the identification of LeFevre's model as it existed upon completion of his dissertation. This procedure was used as a precaution to verify characteristics identified.

Characteristics of content. The forms, written instructions, and simulation exercises provided in LeFevre's model are as follows:

1. Practicum Observation Instrument:
   a. Diagnosis
   b. Prescription
   c. Monitoring and recording
   d. Reinforcement

2. Instructional Module One, Individual Pupil Diagnosis:
   a. Instructions
   b. Referral
   c. Individual Pupil Referral Form
   d. Teacher Interview
   e. Observation
f. Final Diagnosis Form

g. Critical Problems

h. Assignment

3. Instructional Module Two, Individual Pupil Prescription:
   a. Instructions
   b. Procedure
   c. Individual Pupil Prescription Exercise
   d. Individual Pupil Prescription, Ten-day Form
   e. Individual Pupil Prescription Assignment

4. Instructional Module Three, Individual Pupil Monitoring and Record Charts:
   a. Instructions
   b. Individual Progress and Report Chart Simulation Exercise
   c. Individual Progress and Record Chart Form
   d. Individual Progress and Record Chart Experience Project
   e. Individual Progress and Record Chart Assignment

5. Instructional Module Four, Reinforcing Pupil Progress by Accelerating Positive Teacher Comment:
   a. Instructions
   b. Exercise on Collecting and Recording Data
   c. Data Sheet Form
   d. Exercise on School Performances Graph
   e. School Performance Graph Form
**Procedure.** Those operations performed by practicum students, observers, and college supervisor in LeFevre's model were:

1. Pupils participating in the Clinical Practicum were pretested using the **Wide Range Achievement Test**.
2. Practicum students then applied the diagnostic, prescriptive, and remediation procedure required in modules one, two, three and four.
3. Using the practicum observation instruments two college supervisors observed the practicum student and recorded required information.
4. Pupils participating in the Clinical Practicum were posttested using the **Wide Range Achievement Test**. Results to determine pupil change and practicum student competency.

**Characteristics of the Clinical Teaching Model**

The characteristics of the clinical teaching model at the time of implementation were those of the LeFevre model. No changes were made to the LeFevre model prior to its implementation as the clinical teaching model. All changes were made as a result of evaluation following implementation.

Characteristics of the clinical teaching model as it existed at the conclusion of this report included those characteristics of the LeFevre model which remained unchanged, and those changes made in the form of additions.

Evaluation has been ongoing and is based on feedback from practicum students. The objective of the evaluations was to meet the needs of the practicum students and improve applicability of material.
Changes

Changes have been made in content and procedure as evaluations have indicated a need determined by the objective of the ongoing evaluations. Changes in content included deletion of original items, addition of new items and the relocation of original items to a different location in procedure. Changes in procedure included deletion of original tasks, addition of new tasks and relocation of original tasks to a new location in the sequence of events.

Changes made in content and retention of the original elements of the LeFevre model as a result of evaluations during the clinical teaching practicum are as follows (see pages 18-20 for comparison):

1. Practicum Observation Instrument and Guidelines:
   a. Diagnosis, no change.
   b. Prescription, no change.
   c. Monitoring and Recording were increased to include the Data Sheet Form in module four.

2. Instructional Module One, Individual Pupil Diagnosis:
   a. Instructions were all given verbally by the university supervisor and individualized to meet the needs of the student.
   b. Referral, no change.
   c. Individual Pupil Referral Form, no change.
   d. Teacher interview, no change.
   e. Observation, no change.
f. Final Diagnosis Form was to be used for projection of the program.

g. Critical problems. Practicum students were encouraged to select the two most critical problems of each pupil on which to work.

h. Assignments were made verbally at seminar with practicum student and university supervisor.

3. Instructional Module Two, Individual Pupil Prescription:

   a. All instructions were given verbally by the university supervisor and individualized to meet the needs of the student.

   b. Procedure has been included in the instructions.

   c. Individual Pupil Prescription Exercise was not included unless determined necessary by the university supervisor. Exercise with actual pupils being worked with was used more often.

   d. Individual Pupil Prescription, 10-day form was completed 1 day in advance and no longer projected 10 days in advance. Prescription 10 days in advance was not compatible with day to day evaluation of pupil progress and prescription changes resulting from those evaluations.

   e. Individual Pupil Prescription Exercise was changed the same as c.

4. Instructional Module Three, Individual Pupil Monitoring and Record Chart:
a. All instructions were given verbally by the university supervisor and individualized to meet the needs of the students.

b. Individual Progress and Record Chart simulation were discontinued.

c. Individual Progress and Record Chart form, six additional forms, five required and one optional, were used here.

d. Individual Progress and Record Chart experience project were not included unless determined necessary by the university supervisor. Exercises with actual pupils being worked with were used more often.

e. Individual Progress and Record Chart assignment was changed the same as d.

f. When used with secondary students, contracting was used instead of Individual Progress and Record Chart.

5. Instructional Module Four, Reinforcing Pupil Progress by Accelerating Positive Teacher Comment:

a. Instructions were discontinued.

b. Exercise on collecting and recording data was discontinued.

c. Data sheet form was moved to Practicum Observation Instruments and Guidelines.

d. Exercise on school performance graph was discontinued.

e. School performance graph form was moved to Practicum Observation Instruments and Guidelines.
Changes made in procedure of the LeFevre model as a result of evaluation during the Clinical Teaching Practicum were:

1. Pretest, no change.

2. In the Practicum, where student's application of the procedures were required in modules one, two, three, and four, module four was discontinued.

3. During observation of Practicum students, only one observer, the university supervisor, made the required observations.

4. A weekly seminar was set up with the Practicum student and university supervisor for consultation regarding material and technique. Attendance was required.

5. Posttest, no change.

Practicum Student Interview

Those students participating in the clinical teaching practicum and those available who had completed it were interviewed. Six students were interviewed and asked to respond to prepared questions. Their responses were as follows:

1. Have you used the "Individual Pupil Referral form during your Practicum? 
   Yes/No 6/0

2. Did you complete the "Final Diagnosis" form and submit it to the University Supervisor for evaluation?
   Yes/No 6/0

3. Did you maintain the Individual Progress forms, Hendersons Graph, Table A Individual Progress and Record Chart, and Points Earned Form?
   Yes/No 5/1
4. Did you write a Prescription form for each child you worked with using the "Individual Pupil Prescription" form?  
Yes/No  
6/0

5. Do you feel directions were explicit in utilization of all forms in the LeFevre Model?  
4/2

6. Do you feel time spent on required activities is justified in relation to the importance of the skill achieved?  
2/4

7. Are materials required for activities readily available to you?  
6/0

8. Do you feel completion of this program has increased your competency in diagnostic and prescriptive skills?  
4/2

9. Do you feel the required activities demonstrate theory in practice?  
4/2

Relevant observations not revealed by the responses were noted.

On question No. 3, the negative response was most likely from a Practicum student in a secondary school where contracts were used instead of individual progress forms.

Questions 5, 8, and 9 express an opinion and thus the answers explain themselves.

Question No. 6 is also an opinion; however, only two students responded "yes" to all questions and may not have expressed their opinion.
Extent of Implementation of the LeFevre Model

The extent of implementation of the LeFevre model was determined by those pertinent characteristics remaining unchanged. At the conclusion of the 1974 Spring Quarter those characteristics were:

1. Practicum Observation Instrument and Guideline.
   a. Diagnosis.
   b. Prescription.

2. Instructional Module One, Individual Pupil Diagnosis.
   a. Referral.
   b. Individual Pupil Referral Form.
   c. Teacher Interview.
   d. Observation.

3. Instructional Module Two, Individual Pupil Prescriptions.
   No characteristics remain unchanged.

4. Instructional Module Three, Individual Pupil Monitoring and Record Chart.
   No characteristics remain unchanged.

5. Instructional Module Four, Reinforcing Pupil Progress by Accelerating Positive Teacher Comment. Some content characteristics relocated. All others discontinued.

Characteristics of procedure remaining unchanged were:

Pretesting.

Posttesting.
Of the original 27 characteristics of content identified, only six remain unchanged. Of the original four characteristics of procedure identified, only two remain unchanged.
Summary and Conclusions

Summary

LeFevre's model was in fact implemented as it was originally developed. Ongoing evaluation commenced immediately upon implementation with the objective of meeting student needs and improving material applicability. Many changes have taken place as a result of those evaluations. At the conclusion of Spring Quarter, 1974, only 6 of the 27 original characteristics of content remained unchanged. Of the four original characteristics of procedure, only two remained unchanged. The clinical teaching model at the conclusion of Spring Quarter, 1974, contained only eight unchanged characteristics of the original LeFevre model. However, those characteristics that were changed did not dispel all resemblance of the LeFevre model. Many of the changes were extensive, e.g., the discontinuance of module four. Other changes were slight, e.g., the availability of optional forms.

The changes may be attributed to ongoing evaluation with the objective of continual improvement. They may also be attributed to some of the apparent shortcomings of LeFevre's modules. The principle shortcoming was the absence of a "concise statement of the overall objective of the module" which has been specified by Gallagher (1973) as an essential element of module format.

LeFevre implied as a general objective:
Four specific competencies related to diagnostic-prescriptive teaching were identified. One instructional module was developed around each competency. Each module was designed to be self-instructional and to facilitate the achievement of a specific competency. (LeFevre, 1973, p. 41)

Although the foregoing appears to be a statement of general objective for the model, it was not carried through as a statement of objective in the format of each module.

There is strong indication that LeFevre's modules are subject to the charge described by Getz:

Competency-based models frequently specify only those competencies that can be easily identified and measured. However, much training in improved teaching behavior requires complex learning activities and complex creative evaluation. Until higher order competencies are specified in instructional packages, competency-based programs will remain subject to the charge of content simplicity. (Getz, 1973, p. 300)

LeFevre (1973, p. 43) stated, "Following the pretesting the practicum students were given the instructional modules, and the practicum was initiated."

Not during field testing or following has the complete module been given to the practicum student. Only the forms contained in each module have been given to the student.

LeFevre went on to state:

The skills taught with modules were based on principles of preventing failure as listed by Engleman (1969). This meant that instructional objectives were stated as specific tasks, and that diagnosis, preparation of materials, reinforcement techniques, as well as everything included in teaching, must be derived from the objective tasks. Each module consisted of instructional and assigned activities intended to facilitate the student's achievement of competency in teaching according to those principles. (LeFevre, 1973, p. 76)
LeFevre's modules do not teach "diagnosis, preparation of material, reinforcement technique, as well as everything included in teaching." These were prerequisites of the practicum to be obtained from other courses completed by the students prior to entering the practicum.

At one point LeFevre (1973, p. 43) indicated his intent to provide a practicum to display competencies in previously learned skills. At another point he indicated his intent to teach "everything included in teaching." (LeFevre, 1973, p. 76) He continued to state other goals and objectives in his dissertation which were realistic for the practicum he developed. However, his modules as self-instructional units could not attain those objectives. If they had been better designed, fewer changes may have been required after implementation.

The ongoing evaluation of the clinical teaching practicum included evaluation by the students participating in the practicum. Six of those students were available and responded to the nine questions on pages 24-25. Their response indicated they followed the program closely and were active in its ongoing evaluation. Of the nine questions asked the practicum students, they responded to four of them with all "yes" responses. Those questions related to areas concerning use of forms and availability of material. One other question dealing with the use of forms received five "yes" and one "no" responses. Three questions received four "yes" and two "no" responses. They related to the questions, "Do you feel directions were explicit?" "Do you feel completion of this program has increased your competency in diagnostic and prescriptive skills?" and, "Do you feel the required activities demonstrated
theory in practice?" One question received two "yes" and four "no" responses. It dealt with the question, "Do you feel time spent on required activities is justi-
field in relation to the importance of the skill achieved?"

Conclusions

The following conclusions were made:

1. LeFevre's Model was implemented as originally developed.

2. As a result of ongoing evaluation 23 of the original 31 pertinent characteristics were changed as LeFevre's model evolved into the Clinical Teaching Practicum.

3. LeFevre's modules did not contain a statement of specific objective as specified by Tyler (1973) and others.

4. The Clinical Teaching Practicum resulting from LeFevre's model has served and will continue to serve a very useful purpose in teacher training.

5. That the ongoing evaluation did contribute to the development of the Clinical Teaching Practicum.
Recommendations

It is recommended that:

1. The Clinical Teaching Model be continued as an entity of its own and that goals and objectives be identified.

2. The model be evaluated to determine whether it is meeting these objectives.

3. Evaluation give serious consideration to the use of self-instruction modules in the Clinical Teaching Model. These have been used with success by other teacher education institutions (Burk, 1972). However, the evaluation should attempt to determine whether modules with these format and objectives would be more effective and efficient in this program.

4. The ongoing evaluation and change of the Clinical Teaching Model be continued to update and improve the program.

5. LeFevre's modules be evaluated to determine whether they could be made more useful by adapting the format suggested by Tyler (1973). (See page 11.)
References


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