

Clinical Supervision and Professional Development of The Substance Abuse Counselor Part 3: A Review of the Literature

Treatment Improvement Protocol (TIP) Series

52

Contents

Section 1—A Review of the Literature

Section 2—Annotated Bibliography

Section 3—Bibliography of Available Literature



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Contents

- Section 1: A Review of the Literature 1-1**
 - Overview of the TIP 1-1
 - TIP Organization 1-1
 - Introduction..... 1-2
 - Definitions of Clinical Supervision 1-3
 - Unique Issues in Supervision for Substance Abuse Counselor 1-4
 - The Current Status of Clinical Supervision for Substance Abuse Counselors..... 1-5
 - Models of Clinical Supervision..... 1-7
 - Modalities of Supervision..... 1-9
 - Supervisory Styles and Contributing Factors..... 1-10
 - Cross-Cultural Supervision 1-11
 - Legal and Ethical Issues in Supervision..... 1-12
 - Supervisor Training and Supervision 1-13
 - Administrative Issues in Supervision 1-13
 - References 1-14

- Section 2: Annotated Bibliography 2-1**
 - Research-Related Studies..... 2-1

- Section 3: Bibliography of Available Literature 3-1**

Section 1: A Review of the Literature

Overview of the TIP

This Treatment Improvement Protocol (TIP) is designed to assist **clinical supervisors** who are either new to this position or wish to improve their skills and **administrators** interested in establishing a new system of clinical supervision or improving an existing one. In the substance abuse treatment field, clinical supervision is a necessary and essential element in improving client care and contributing to the professional development of clinical staff.

The lack of clinical supervision is one of the factors named in the Substance Abuse and Mental Health Services Administration's (SAMHSA's) 2007 report on workplace development. High turnover rates among staff are a major problem in the substance abuse treatment field, and "the support of a supervisor" is considered one of the remedies (Hoge, Morris, Daniels, Stuart, Huey, & Adams, 2007, p. 18). Many leaders in the behavioral health field are approaching retirement age and will need to cultivate strong candidates to replace them as clinical supervisors. It is hoped that this TIP will offer encouragement and practical help to those wishing to become supervisors or to start supervision programs within their organization.

The literature on clinical supervision is primarily descriptive and prescriptive, rather than empirical. Excellent textbooks and curricula in the field abound. To the extent they exist, research studies are represented in this literature review. Because the literature on clinical supervision of substance abuse treatment counselors is extremely limited, this review includes material on clinical supervision in a number of fields.

TIP Organization

This TIP is divided into three parts. Parts 1 and 2 are bound together, and Part 3 is available only on the Internet.

Part 1: *Clinical Supervision and Professional Development of the Substance Abuse Counselor.* Part 1 is for substance abuse counselors and consists of two chapters:

- Chapter 1 discusses the basic issues facing clinical supervisors. It provides basic recommendations along with guidelines for new supervisors on practical, legal, and ethical issues, models of supervision, how counselor performance is measured, methods and techniques, administrative supervision, and resources.
- Chapter 2 presents eight representative vignettes that portray how clinical supervisors might address a variety of situations and challenges. Comments from a "master supervisor" and how-to notes shed additional light on the dialog and provide step-by-step directions for using specific techniques.

Part 2: *Clinical Supervision and Professional Development of the Substance Abuse Counselor: A Guide for Administrators* contains two chapters:

- Chapter 1 provides a rationale for clinical supervision and discusses the major issues for administrators involved in establishing and overseeing a supervision program, including legal, ethical, diversity, and cultural competence issues; the development and implementation of a model for the program; and the provision of support and professional development opportunities for supervisors.
- Chapter 2 includes tools that can be adapted for use in your supervision program.

Printed copies of Parts 1 and 2 can be obtained from SAMHSA's National Clearinghouse for Alcohol and Drug Information (www.ncadi.samhsa.gov). Electronic copies can be downloaded from www.kap.samhsa.gov.

Part 3 Clinical Supervision and Professional Development of the Substance Abuse Counselor: A Review of the Literature. This section is a literature review on the topic of clinical supervision for substance abuse treatment counselors, clinical supervisors, and administrators. Part 3 consists of three sections: a review of the recent literature, an annotated bibliography of the literature most central to the topic, and a bibliography of other available literature. It includes literature that addresses both clinical and administrative concerns. To facilitate ongoing updates, which will be performed every 6 months for up to 5 years from first publication, the literature review will only be available online at www.kap.samhsa.gov. The review is not intended for academics. Rather, it is written for clinical supervisors, counselors, and administrators who are seeking to apply this TIP in their work.

The following topics are addressed in **Part 3**:

- Review of the literature pertaining to clinical issues discussed in Part 1 of this TIP.
- Information about the methodology used to perform the literature search (see Appendix A).
- An annotated bibliography of 19 core sources and a general bibliography.

This literature review is organized as follows:

Introduction

Definitions

Unique Issues in Supervision for Substance Abuse Counselors

The Current Status of Clinical Supervision for Substance Abuse Counselors

Models of Clinical Supervision

Supervisory Styles and Contributing Factors

Cross-Cultural Supervision

Legal and Ethical Issues in Supervision

Supervisor Training

Administrative Issues in Supervision

Introduction

Most writing on clinical supervision begins by lamenting the dearth of research on the topic. This will be no exception. The literature on clinical supervision for mental health providers is more extensive than that for substance abuse treatment providers, and some of the former can also be applied to substance abuse treatment. The existence of substance abuse counseling as a distinct discipline is comparatively new, dating from the 1970s. An understanding of the importance and benefits of clinical supervision is also relatively new in the substance abuse field. There are very few books available on clinical supervision in alcohol and drug abuse counseling. There are no periodicals specific to supervision and substance abuse. Given this, the field can benefit from the experiences of the other mental health disciplines.

Although there are articles in substance abuse counselor periodicals about clinical supervision, this literature tends to be descriptive, rather than research-based. The focus has been on the current status of clinical supervi-

sion, models of supervision, organizational and administrative issues related to supervision, stylistic differences, and methods for teaching supervision skills.

To the extent that the literature is research-based, many of the studies use surveys of supervisors and supervisees to answer fairly narrow research questions. Unfortunately, many of the surveys have response rates of less than 50 percent and no estimates of how these low rates bias the study results. (See reviews of conceptual and empirical publications regarding supervision in several counseling disciplines in Shulman and Safyer, 2005.)

In recent years, signs of growing interest in and appreciation for the importance of clinical supervision for substance abuse counselors have appeared. This TIP is one example. SAMHSA/CSAT's *Competencies for Substance Abuse Treatment Clinical Supervisors* (TAP 21-A; CSAT, 2007) is another. One of the recommendations from the Center for Substance Abuse Treatment stakeholders for "strengthening professional identity" is to "develop, deliver and sustain training for treatment and recovery support supervisors, who serve as the technology transfer agents for the latest research and best practices" (CSAT, 2006, p. 37).

Curricula on clinical supervision have been published by the Addiction Technology Transfer Centers (ATTCs; e.g., the Mid-Atlantic ATTC and the Northwest Frontier ATTC). The American Counseling Association (ACA) revised its code of ethics, including the section on supervision, training, and teaching, in 2005 (ACA, 2005). The Association for Addiction Professionals' Code of Ethics is available on its Web site (naadac.org). One of the most extensive research projects on clinical supervision in the substance abuse field, entitled Project MERITS, is funded by the National Institute on Drug Abuse (NIDA) and conducted by the University of Georgia (Eby, McCleese, Baranik, & Owen, 2007).

Definitions of Clinical Supervision

The most prominent definitions of clinical supervision have many common elements, although their emphases may be somewhat different.

A social influence process that occurs over time, in which the supervisor participates with supervisees to ensure quality clinical care. Effective supervisors observe, mentor, coach, evaluate, inspire, and create an atmosphere that promotes self-motivation, learning, and professional development. They build teams, create cohesion, resolve conflict, and shape agency culture, while attending to ethical and diversity issues in all aspects of the process. Such supervision is key to both quality improvement and the successful implementation of consensus- and evidence-based practices (CSAT, 2007, p. 3).

Clinical supervision is a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive (Powell & Brodsky, 2004, p. 11).

Supervision is an intervention that is provided by a senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the clients that she, he, or they see, and serving as a gatekeeper of those who are to enter the particular profession (Bernard & Goodyear, 2004, p. 8).

Clinical supervision is an interpersonal tutorial relationship centered on the goals of skill development and professional growth via learning and practicing. Through observation, evaluation, and feedback, supervision enables the counselor to acquire the competence needed to deliver effective patient care while fulfilling professional responsibilities. (Durham, 2001).

Supervision is a process whereby a counselor with less experience learns how to better provide services with the guidance of a counselor with more experience and skill. It is distinct from teaching in that the “curriculum” is individually determined by the supervisees and their clients (Bernard & Goodyear, 2004). Although there is some variation in the literature about the therapeutic nature of the supervisory relationship, based on the supervisor’s theoretical orientation in the substance abuse field, it is generally agreed that supervision is not therapy for the counselor. In fact, a clear boundary must exist between supervision and counseling. Although the supervisee’s behavior is under scrutiny, therapeutic interventions are provided for the purpose of improving the supervisee’s ability to provide services, not for any broader reason (Bernard & Goodyear, 2004).

Unique Issues in Supervision for Substance Abuse Counselors

Clinical supervision for substance abuse counselors differs from supervision for other healthcare providers in several important ways.

1. Historically, many substance abuse treatment providers were themselves in recovery, with 38 percent of counselors (and 30 percent of supervisors) self-reported in recovery (Eby et al., 2007). The field has traditionally supported individuals in long-term recovery with appropriate training as counselors. They are eligible for a variety of certifications and/or licenses, according to a certifying body or the laws of the State in which they practice. Counselors without professional preparation are valued for their life experience as well as for the skills they bring to an organization. For these counselors who are also recovering from substance use disorders, relapse could be an issue that a supervisor would need to monitor (Culbreth & Borders, 1999). In a survey, one study compared recovering with nonrecovering counselors. There were no between-group differences in satisfaction with supervision; however, both recovering and nonrecovering counselors were significantly more satisfied with supervision when their supervisors had the same recovery status (Culbreth & Borders, 1999; Eby et al., 2007). Eby showed that “counselors not in recovery report significantly lower job satisfaction, organizational commitment, perceived organizational support and higher turnover intentions than those personally in recovery” (p. 40). Nonrecovering counselors say they have significantly lower professional commitment, but believe they have better employment options in other counseling fields.
2. Eby et al. (2007) report that substance abuse counselors and clinical supervisors are only moderately satisfied with the supervisory relationships, and generally dissatisfied with both their pay and opportunities for promotion within their organizations. The average response to one’s perceived organizational support for their work is well below average when compared to published data from employees in other mental health disciplines. Counselors and supervisors report moderate stress levels and client/case overload. Between 35 and 40 percent of substance abuse counselors and 22 percent of clinical supervisors report a strong intention to leave their current job. High turnover rates contribute to job stress for many clinical supervisors in the substance abuse treatment field.
3. Historically, many substance abuse counselors finished their formal education in high school and lack the graduate degrees of others. Traditionally, they may have less supervised practice and less theoretical background. However, this picture is changing, as an increasing number of master’s-trained clinicians are entering the field, with 60–80 percent of the counselors now having at least bachelor’s degrees, and almost 50 percent have master’s degrees (CSAT, 2003; Eby et al., 2007). Substance abuse treatment administrators find it difficult to recruit academically trained staff due to the low salaries offered for these types of positions compared with similar positions in other mental health disciplines (CSAT, 2003). Thus, in some instances, long-term clinical supervisors without formal academic training are supervising master’s level counselors. The new entrants into the field, with master’s degrees and experience in being clinically supervised, are presenting interesting challenges to organizations and long-term supervisors without formal academic training (Eby et al., 2007).

4. The nature of substance use disorders themselves makes counseling and clinical supervision unique. In addition to their chronic, relapsing nature, they are often accompanied by co-occurring mental disorders; suicidal thoughts and behaviors; and problems with interpersonal relationships, housing, employment, and the criminal justice system (Kavanagh, Spence, Wilson, & Crow, 2002). Clients also have to deal with the social stigma attached to substance abuse and to seeking treatment for mental health and substance abuse disorders. Substance abuse counselors are increasingly being asked to treat clients whose illnesses are medically and psychiatrically severe (Minkoff, 2001).
5. Finally, Eby et al. (2007) states that the “quality of the clinical supervisory relationship is clearly important to counselors. . . . [A]s the clinical supervisory relationship is viewed more favorably by counselors, job satisfaction, organizational commitment, and perceived organizational support increase” (p. 6).

The Current Status of Clinical Supervision for Substance Abuse Counselors

SAMHSA recognizes clinical supervision as an important part of workforce development. It “provides support for practitioners struggling with the day-to-day pressures of the job and enhances clinical skills and professional growth” (Whitter, Bell, Gaumont, Gwaltney, Magana, & Moreaux, 2006, p. 38). At the same time, SAMHSA recognizes the need for supervisor training, as counselors are often promoted to supervisory positions with little or no training (CSAT, 2003).

In the substance abuse treatment field, some organizations do not offer clinical supervision or inappropriately ask administrators without clinical training to take on this role (Roche, Todd, & O’Connor, 2007). This places those acting as supervisors as well as the agency at considerable legal risk. In other organizations clinical supervision may not address counselors’ needs, be provided on an irregular basis, or resemble more a social encounter than a planned, purposeful interchange. According to Eby et al. (2007), the average number of hours per week providing clinical supervision (as reported by the clinical supervisor) is 2.6. One-on-one discussions are the primary model of interaction between supervisors and counselors (90 percent reported), with group clinical supervision second (60 percent). Other forms of interaction include email (56 percent), written messages (41 percent), and telephone (52 percent). The primary modes of supervision include:

- Observing individual counseling sessions (18%).
- Observing group counseling sessions (29%).
- Reviewing case notes (70%).
- Reviewing audio/video tapes (11%).
- Listening to case reviews/presentations by counselors (70%) (Eby et al., 2007).

Salaries remain a significant issue for counselors and clinical supervisors. According to Eby et al., the mean starting salary for a substance abuse counselor nationwide is \$34,705 and for clinical supervisors \$52,308, with significant variation depending on the region of the country (\$46,167 in the South; \$57,774, in the East), years in the behavioral health field (1–5 years, \$39,230; more than 10 years, \$54,586), and educational level (\$44,358 with some college, to \$77,714 with a Ph.D. or M.D.). There is no significant difference in salaries by licensure or certification (Eby et al., 2007; CSAT, 2003).

Generally, counselors are only moderately satisfied with the overall quality of their supervisory relationship. Clinical supervisors are somewhat more satisfied than are counselors. Supervisors and counselors report feeling lukewarm as to whether the supervisory relationship is meeting their specific needs. Generally, counselors and supervisors report perceived role overload, emotional exhaustion, and stress at work. It is important to point out that any significant level of burnout and exhaustion may have a detrimental effect on client care, job turnover, and employee satisfaction (Eby et al., 2007). These data are at variance with other studies. Another

survey of substance abuse counselors' job satisfaction indicated that they are "very satisfied." The primary predictors of this rating were the number of hours of supervision during a week, the length of time the supervisor had been a clinical supervisor, the supervisor's degree level, and whether or not the supervisor was also the counselor's administrative supervisor (Evans & Hohenshil, 1997). Caution should be exercised, however, when comparing data compiled in 1997, given the significant changes that have occurred in the substance abuse treatment field in recent years.

There are unique barriers to implementing clinical supervision programs and to improving the overall quality such programs where they exist.

In a survey of substance abuse counselors, 30 percent reported that they did not receive supervision (Culbreth, 1999). The situation has doubtless changed since this study was completed, as indicated by the Eby et al. (2007) data. Of those receiving supervision, respondents preferred weekly supervision sessions but had no preference for the gender of the supervisor (Culbreth, 1999). Other studies indicate that supervisees prefer same-sex supervisors (Alderfer, 1991). Culbreth (1999) and CSAT (2003) indicate that slightly more than half of the supervisors were male. Eby et al. (2007) states that 43.7 percent of counselor-clinical supervisory dyads were cross-sex dyads and 45 percent were cross-race dyads. Although the group as a whole had no preference for whether the supervisor was in recovery, counselors without graduate-level training preferred supervisors in recovery over nonrecovering supervisors, according to Culbreth (1999).

It is important to ask whether clinical supervision for substance abuse counselors is effective in improving their counseling skills. Although some studies approach this question for other groups of clinicians, Eby is the only one who has explored it with substance abuse counselors. Most of the former studies are not typically randomized controlled trials, have small sample sizes, and use measures of unknown reliability and validity (Kavanagh, Spence, Wilson, & Crow, 2002). There is some evidence that supervision is helpful in teaching new clinical skills in allied mental health workers (Kavanagh, Spence, Strong, Wilson, Sturk, & Crow, 2003).

A survey of members of the National Association for Addiction Professionals (NAADAC) with 3 years or less experience in the field indicated that "on-the-job supervision" is of "great or very great utility" for more than 80 percent of this group (NAADAC, 2003). However, again a note of caution: Eby et al. (2007) demonstrated a key factor in satisfaction on the job and in clinical supervision is the not-for-profit vs. for-profit status of the organization, with significantly higher ratings of the supervisory experience in nonprofit entities. Perhaps this result might be attributed to generally higher rates of compensation in for-profit organizations. Arguably, an even more important question is the degree to which quality clinical supervision translates into improved clinical skills and client outcomes.

A second question is whether supervision is reflected in better client outcomes. It appears that there is no empirical evidence on this question regarding supervision for substance abuse counselors. Freitas (2002) reviewed ten studies of psychotherapy supervision and concluded that the research was generally of poor quali-

Barriers to Implementing Clinical Supervision

- Managers place a low priority on supervision or lack the time and energy to develop a program.
- Counselors place a low priority on supervision or lack the time to participate in developing a program.
- Supervisors lack adequate training to perform this job well.
- Too few individuals are adequately qualified and available.
- The roles of clinical and administrative staff are blurred, creating conflict.
- A common language and conceptual framework is lacking among supervisors, supervisees, and administrators.
- Funding is scarce; resources need to be used directly for client care.
- The belief that when the supervisor and supervisee are of different cultures, the practical benefits of clinical supervision may be limited.
- The belief that to express a need for clinical supervision indicates an inability to do the job.

Source: Roche, Todd, & O'Connor, 2007, p. 244; Powell & Brodsky, 2004, xxiii, 320

ty. Psychometric information for the measures used was lacking in most. No statistical controls were in place for Type I and Type II errors,¹ and clients were not randomly assigned to therapists. Freitas points out that even defining and measuring client outcomes is fraught with difficulty. When the supervisor–supervisee relationship is added, it is not surprising that the effects of supervision are obscured. However, anecdotal evidence and common sense both lead one to believe that clinical supervision is of value and that some elements of client outcome may be attributable to it.

Research on these issues is extremely complex, which has doubtless prevented many from undertaking it. Efficacy studies are now accepted as the standard of evidence-based practices, but clinical supervision does not easily lend itself to this type of study. For the most part, it is not prescriptive, standardized, or manualized. Differences among supervisors are enormous. Criteria for effectiveness and client outcomes are elusive, and comparisons are difficult, if not impossible to make (Bernard & Goodyear, 2004).

Models of Clinical Supervision

It makes intuitive sense that supervisors and counselors progress through what could be described as stages as they become more expert in their fields. Developmental models of counseling are not new (see Delaney, 1972; Hess, 1986; Hogan, 1964; Loganbill, Hardy, Delworth, 1982; Skovholt & Rønnestad, 1992). The **Integrated Developmental Model** (IDM) was developed by Stoltenberg, McNeil, and Delworth (1998) and is not specific to substance abuse counselors. It is perhaps the best known approach of several developmental models, which assume that a counselor matures and becomes more self-confident and skilled over time. With experience, the counselor undergoes a shift in awareness from self (“how am I doing?”) to client (“how is the client feeling?”) and from dependence (“what should I do in this case?”) to autonomy (“how is the therapeutic relationship progressing?”). Effective supervision should be matched to the counselor’s developmental level and therefore use different techniques at different times (Falender & Shafranske, 2004a; Northwest Frontier ATTC, 2005a; Powell & Brodsky, 2004).

Level 1 counselors are new to the field, highly motivated, and highly anxious. Supervision for these people should include direct observation, skills training, and support. According to Stoltenberg, McNeill, and Delworth (1998), a counselor with 1–5 years of experience in the field might be expected to be in Level 1. Level 2 counselors have 6–9 years’ experience and are able to show empathy toward their clients, but have uneven success in practicing their skills (they are usually aware of this). In supervision, they need support, empathy, and constructive feedback but are ready to begin processing personal issues, such as self-awareness and defensiveness. At Level 3, counselors are fairly autonomous and have gained professional identity. They typically have been in the field for more than 10 years and have a high level of insight into their functioning. They benefit from supervision that is more collegial and can discuss the supervisor–supervisee relationship and countertransference (Falender & Shafranske, 2004a; Northwest Frontier ATTC, 2005a; Powell & Brodsky, 2004; Stoltenberg et al., 1998). Stoltenberg et al. also indicate that supervisors go through similar stages of development, from Levels 1–3, over the course of their career.

In their review, Falender and Shafranske (2004a) conclude that while developmental models are appealing, there is no empirical support for them. However, it makes sense to conclude that individuals can learn to become better supervisors and that in the process, they become increasingly confident and less dependent on more experienced supervisors.

To reiterate the above statement, Watkins (1993), among others, has proposed that supervisors similarly progress through stages as they become more competent, autonomous, identified with their role as supervisors, and self-aware. They begin in “role shock” and progress through role recovery/transition and role consolidation to role mastery. As their experience grows, they come to have greater confidence in their supervisory skills;

¹A Type I error is a false positive or when a difference tests statistically as significant and in fact it is not. A Type II error is a false negative or when a difference tests statistically as not significant and in fact it is.

more insight about their effect on supervisees; a clearer, more integrated theoretical basis for their supervisory style, and a consolidated, well-elaborated sense of professional identity (Bernard & Goodyear, 2004; Campbell, 2000; Watkins, 1993).

Psychotherapy-based or philosophically based models provide an excellent opportunity for supervisors to model the behaviors they wish to teach. They have been developed for the major theoretical orientations of therapists, including cognitive–behavioral, psychodynamic (Ekstein & Wallerstein, 1972; Greben & Ruskin, 1994), psychoanalytic (Caligor, Bromberg, & Meltzer, 1984; Kugler, 1995; Lane, 1990; Nelson, Gizara, Hope, Phelps, Steward, & Weitzman, 2006), and client-centered approaches. Most models begin with a specific psychotherapeutic model or philosophy of treatment, especially in the marriage and family therapy field (Liddle, Breunlin, & Schwartz, 1988; Minuchin & Fishman, 1981). It has been estimated that 90 percent of the literature on clinical supervision grows out of a specific psychotherapeutic model (Powell & Brodsky, 2004).

Discrimination models or social role models attempt to identify the variety of roles the supervisor assumes and the supervisory foci that are addressed under each role (Bernard & Goodyear, 2004). The roles used most frequently by theorists are teacher, counselor, and consultant. They also include monitor, evaluator, therapist, facilitator, and administrator. The foci in Bernard and Goodyear’s **Discrimination Model** are intervention, conceptualization, and personalization. Others foci include counseling skill, professional role, emotional awareness, supervisory relationship, and therapist’s process (Bernard & Goodyear, 2004). Although social role models may provide a useful tool for supervisors, empirical evidence does not support their “adequacy,” according to Falender and Shafranske (2004a, p. 18). However, the Discrimination Model is especially valuable to supervisors to differentiate what role they are adopting at a particular time in supervision, and with individual supervisees. Variations on the Discrimination Model are the **Competency-Based Approach** (Falender & Shafransky, 2004b), the **Contextual Model** (Holloway, 1995), the **Task-Oriented Model** (Mead, 1990) and the **Interactional Model** (Shulman, 1993).

The Blended Model (Powell & Brodsky, 2004) is the only model specific to substance abuse supervisors. The model has a number of essential elements:

1. Self. Each supervisor develops an idiosyncratic style of supervision, largely based upon his or her personality profile and model of counseling.
2. Philosophy of counseling. Supervisors articulate their philosophy or model of counseling, describing what they do in counseling, what models and techniques they use, and at what times and/or circumstances.
3. Descriptive dimension. The blended model uses a version of Bascue and Yalof’s Descriptive Dimensions (1991).
4. Stages of counselor development. This model adapts the IDM model of Stoltenberg et al. (1998) and other developmental approaches to clinical supervision.
5. Contextual factors. The blended model uses the work of Holloway (1995) and other contextual models of clinical supervision, addressing factors affecting supervision, such as age, race, gender, ethnicity, recovery–nonrecovery, disciplines, academic background, and the like.
6. Affective–behavioral axis. The model views supervision along a continuum, blending affective and behavioral changes for the counselor in supervision.
7. Spiritual dimensions. In addition to addressing cognitive, skills, affective, and latent issues in supervision, a supervisor may address “spiritual” issues. The first four components aid a counselor in understanding “how” to counsel. The spiritual dimension focuses on “why” issues: why a counselor does what he or she does.

Modalities of Supervision

Individual supervision is, historically, the typical modality of supervision most clinicians receive. It provides the supervisor the opportunity to develop a closer relationship with the supervisee and to tailor the process to the unique needs of that person. Culbreth's survey (1999) found that over 50 percent of substance abuse counselors who responded received primarily individual supervision, although their ideal preference would be a combination of individual and group supervision.

Several formats are possible in individual supervision. Live supervision includes bug-in-the-ear (where the supervisor provides feedback via an earphone in the supervisee's ear), phone-ins, and consultation breaks. Each method is distracting to one degree or another (Bernard & Goodyear, 2004). Co-facilitation, where the supervisor sits in on the individual or group session led by the supervisee, allows the supervisor to share the experience of the group. In this format, the supervisor can intervene directly if the session become countertherapeutic (Powell & Brodsky, 2004). For substance abuse counselors, postsession debriefing is most common. The supervisee brings a case or a problem that arose during a session to the supervisory session for discussion. This type of self-report, although convenient, is problematic, particularly for inexperienced counselors who may miss important details and nuances in a clinical situation (Bernard & Goodyear, 2004; Powell & Brodsky, 2004).

The advantages of individual supervision are that confidentiality can be better preserved, counselors may feel more safe and comfortable in a one-on-one experience, individual needs can be better addressed, and greater depth and honesty may be established. The disadvantages of individual supervision are that it is time consuming and therefore expensive, particularly if a supervisor has several supervisees. It also increases opportunities for miscommunication among staff, and does not provide counselors with opportunities to learn from each other.

Distance supervision (individual and group), by telephone or email has also been used. A current, and largely unmonitored and regulated system is cyber supervision, where the supervisor observes a counseling session through the Internet. A number of States have cyber supervision programs in place. Key issues about this medium remain to be addressed: confidentiality of information, scrutiny and oversight by regulatory bodies, credentialing of cyber supervisors, and other legal and ethical concerns (Derrig-Palumbo & Seine, 2005; Powell, 2006; Kraus, Zack, & Stricker, 2004).

Group, dyadic, and triadic supervision, in which two or more supervisees meet with a supervisor, is widely used with substance abuse counselors. The advantages of group supervision are similar to those of group therapy. The primary advantage is that it saves time and money; more counselors can receive supervision with less time spent. The group can provide feedback to supervisees from a variety of perspectives and the team can learn from each other. Dependence on the supervisor is lessened in group supervision, while supervisees enjoy mutual support and have greater opportunities for learning (Bernard & Goodyear, 2004). These modalities furnish more opportunities for team-building, role-playing, and simulations (Powell & Brodsky, 2004). On the other hand, individual supervisees may not get what they need in a group, and shame and embarrassment can result from self-disclosure to peers. Supervisors have to be attuned to group process and dynamics. Competitive, challenging behavior can occur between peers. However, for substance abuse supervision, group seems to be an ideal medium to maximize the limited time available for clinical supervision (Powell & Brodsky, 2004).

Research has generally supported the effectiveness of group supervision (e.g., Wilbur, Wilbur-Roberts, Hart, Morris, & Betz, 1994). In tracking a six-person group, interviews by Christiansen and Kline (2000) indicate that group processes operate in this modality. "Participation anxiety" related to group members' perceptions of risk changed qualitatively as the group matured. Over time, group members came to recognize the anxiety as a helpful motivator to their learning. Trust increased, and feedback was perceived as less evaluative and more informative.

Several surveys show a limited preference among supervisees for individual supervision. No studies of substance abuse counselors' preferences for one modality were found in Eby et al.'s research (2007). Ray and Altekruise (2000) compared four modalities of supervision used with master's level counseling students. Eighty-one percent ranked individual supervision the most or second most helpful experience, while 45 percent ranked group supervision equally highly. Newgent, Davis, and Farley (2004) compared group, individual, and triadic (supervisor and two supervisees) modalities of supervision for doctoral-level counselor education students (n = 15). These students preferred individual supervision in terms of their satisfaction, their perception of its effectiveness, and their belief that it better met their needs. Again, the data are sparse, with relatively small sample sizes not specific to the substance abuse field.

Supervisory Styles and Contributing Factors

Supervisory styles have been categorized into three main types (Friedlander & Ward, 1984), as shown below. The categories have little research to support the differentiation and/or effectiveness of supervisory styles.

Fernando and Hulse-Killacky's survey of master's level counseling students (2005) indicated that both attractive and interpersonally sensitive styles contribute to supervisees' satisfaction with supervision, and the task-oriented style contributes to their self-efficacy.

Supervisors' self-disclosure is often used in clinical supervision, but differently with different supervision styles (Ladany & Lehrman-Waterman, 1999). Supervisors who use the attractive style are more likely to self-disclose in general and specifically to relate neutral counseling experiences. Those who use the interpersonally sensitive style disclose fewer neutral counseling experiences. Supervisors' perception of their style is related to the perception of their supervisory working alliance (Ladany, Walker, & Melincoff, 2001). The supervisors who saw themselves as more self-disclosing were more likely to use attractive and interpersonally sensitive styles and have a stronger emotional bond in supervision. Those who used a task-oriented style were likely to have a mutual agreement on the tasks of supervision with their supervisees.

The appropriate supervisory style may be based on the counselor's level of experience (Stoltenberg et al., 1998). Level 1 counselors may likely need more practical information and work on clinical skills (task-oriented style). Level 2 and 3 counselors, who may be dealing with complex countertransference issues, for example, might benefit from an interpersonally sensitive style (Powell & Brodsky, 2004). Supervisory styles are also related to

Categories of Supervisory Style		
Category	Role	Description
Attractive	Consultant	<ul style="list-style-type: none"> • Open • Warm • Friendly • Flexible • Supportive
Interpersonally sensitive	Counselor	<ul style="list-style-type: none"> • Invested • Therapeutic • Committed • Perceptive
Task oriented	Teacher	<ul style="list-style-type: none"> • Goal oriented • Practical • Focused • Structured

Source: Friedlander & Ward, 1984

the supervisor's theoretical orientation, with interpersonal sensitivity more characteristic of supervisors with a psychodynamic orientation and task orientation being related to cognitive-behavioral orientation (Friedlander & Ward, 1984).

Finally, in a survey of supervisors of substance abuse counselors, no gender differences were found for how supervisors report working with male and female supervisees (Reeves, Culbreth, & Greene, 2001). Supervisors under age 50 were less likely than those over 50 to decide on the topics discussed in supervision, less likely to require adherence by supervisees to directives, and more comfortable in self-disclosure. Certified clinical supervisors were more likely to use the attractive and interpersonally sensitive styles than the task-oriented style. Younger supervisors and those with more education appeared to be more flexible in supervision (Reeves et al., 2001).

Cross-Cultural Supervision

One's culture is generally viewed as a strength that, during treatment or supervision, should be validated (Garcia, 1998). Clinical supervision must address gender, racial, ethnic, and cultural concerns. Particularly when the client and counselor (or counselor and supervisor) are of different cultures, this disparity can have a significant impact on the therapeutic alliance and the effects of treatment (Holloway, 1995). Supervisors can have a positive effect on their supervisees by providing a climate in which discussion of these issues is encouraged and by modeling appropriate behaviors.

Some of the skills included in cultural competence include "awareness, openness, and sincere attention to cultural and racial factors, guidance and explicit discussion of culture-specific issues, being vulnerable and sharing [supervisors'] own struggles, and providing opportunities for multicultural activities" (Inman, 2006, p. 74; see also Borders and Brown, 2005). Supervisors have a responsibility to initiate discussions on:

- Their own cultural background and that of the supervisee.
- The ways the values and traditions of the culture can affect counseling and supervision expectations and goals.
- Their own multicultural strengths and weaknesses and those of the supervisee.
- Racial identity models described in the literature.
- The ways their level of racial or cultural identity influence their counseling or supervising (Daniels, D'Andrea, Kim, & Soo, 1999).

Racial, ethnic, and cultural issues will arise when supervisor and supervisee are of different cultures. Whether the supervisor is responsive to these concerns or not can make a difference in the quality of the supervisory relationship. One group of researchers defined cultural responsiveness in supervision as:

Responses that acknowledge the existence of, show interest in, demonstrate knowledge of, and express appreciation for the client's and supervisee's ethnicity and culture and that place the client's and supervisee's problem in a cultural context (Burkard, Johnson, Madson, Pruitt, Contreras-Tadych, et al., 2006, pp. 288–289).

Using consensual qualitative research, Burkard et al. examined culturally responsive and unresponsive events that occurred in supervision with culturally mismatched dyads. European American supervisees and supervisees of color had generally positive reactions to the supervisors' culturally responsive events and felt their supervisory relationship improved afterward. In events that left negative feelings, supervisors of color avoided discussing cultural concerns with their European American supervisees. Supervisees of color, in contrast, reported that their European American supervisors actively dismissed their cultural concerns. Both groups expressed negative feelings as a result of these events, including anger, frustration, and disappointment (Burkard et al., 2006).

Legal and Ethical Issues in Supervision

In today's environment, legal and ethical issues in supervision, as in counseling, have become more numerous and complex. Clinical supervisors have an obligation to know the relevant State laws that apply to their practice and to ensure that their supervisees also have this knowledge. Malpractice and liability claims related to clinical supervision include cases involving situations where supervisors failed in their duty to properly supervise counselors and oversee cases. Legal issues include vicarious liability, by which a supervisor is responsible for the supervisee's behavior; duty to warn and to protect, which for substance abuse counselors involves supervisory guidance; and malpractice. A good defense against malpractice is consultation with colleagues and documentation of when supervisory sessions took place and what was discussed (Powell & Brodsky, 2004). Thorough discussions of legal issues are in most supervision texts (Falvey, 2002; Reamer, 2001, 2003).

Supervisors of substance abuse counselors need to be familiar with the ACA's Code of Ethics, Section F, Supervision, Training and Teaching, and the Codes of Ethics of National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the codes of ethics of the applicable certification boards for the counselors they supervise. Ethical issues for supervisors, as for counselors, vary. Supervisors are responsible for adherence to their own discipline's code of ethics and for ensuring that their supervisees adhere to theirs.

Dual relationships occur when a supervisor has a second relationship with a supervisee, such as a social, financial, business, or workplace relationship. "Sexual or romantic interactions or relationships with current supervisees are prohibited" according to the ACA 2005 Code of Ethics (ACA, 2005, p. 14; see also Falvey, 2002).

Boundary violations are a type of dual relationship. They can occur in the structure of the supervisory relationship (e.g., having a supervisory session in one's living room or during dinner in a restaurant) or in its process (e.g., giving gifts, physical contact). A number of studies of the frequency of sexual misconduct in supervision have been conducted. Between 1.4 and 4.0 percent of supervisors have had sexual relationships with their supervisees (Falender & Shafranske, 2004c). Some boundary issues are clear; others are difficult to resolve.

The client must give **informed consent** for the counselor to discuss his or her case with the supervisor. Bernard and Goodyear (1998) suggested that informed consent should occur at three levels: client consent to treatment, client consent to supervision of their case, and supervisee consent to supervision. (For a detailed explanation of these three levels, see Falvey, 2002.)

Supervisor **confidentiality** is analogous to counselor confidentiality, which must be maintained unless clearly defined circumstances demand disclosure to protect the welfare of the client or the public at large. Supervisors must know the limits of confidentiality, at both State and Federal levels.

Over half the psychotherapy interns in one study reported at least one ethical violation by their supervisor (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999). The most common were inadequate performance evaluation, breach of confidentiality, and inability to work with alternative perspectives. The existence of these perceived violations was associated with a weaker supervisory relationship and lower satisfaction.

Several models for resolving ethical dilemmas are suggested by Falender and Shafranske (2004c). (See also Falvey, *Clinical Supervision: Ethical Practice and Legal Risk Management*, 2002, and Reamer, *Tangled Relationships: Managing Boundary Issues in the Human Services*, 2001.)

Supervision contracts or agreements are generally recommended. Besides listing the basics, including the frequency, length of sessions, and length of the course of supervision, the agreement should specify the modality and approaches to be used, along with the duties and responsibilities of all parties (Bernard & Goodyear, 2004; Campbell, 2000; Northwest Frontier ATTC, 2005b).

Supervisor Training and Supervision

Training of supervisors has become a significant concern at the State and Federal level, with increasing attention given, especially with the advent of credentialing requirements for certified clinical supervisors. A number of training models are available. An Internet search will indicate resources in addition to the following:

- Northwest Frontier ATTC, Clinical Supervision: Building Chemical Dependency Counselor Skills.
- Thomas Durham, Clinical Supervision: A 5-Day Course.
- New England ATTC, Evidence-Based Practices and Clinical Supervision.
- Mid-Atlantic ATTC, Motivational Interviewing and Clinical Supervision.
- David Powell, The Blended Model of Clinical Supervision: A 5-Day Course.
- Distance Learning Center for Addiction Studies (www.DLCAS.com), various courses on clinical supervision.

What makes a good course in supervision? When seeking training in supervision, look for the course that:

- Fulfills the training hours for credentialing as a certified clinical supervisor.
- Is approved by the single State Addiction Authority and the State credentialing body.
- Is specific to substance abuse clinical supervision, wherever possible, given the unique issues in the substance abuse field.
- Provides formal training in supervisory theory and techniques as well as a period of supervised supervision of others.
- Is both didactic and experiential, with ample opportunities for skill building and practice.
- Addresses specific, job-related concerns and issues of the trainees.

Administrative Issues in Supervision

Organizational support for supervision is essential to instilling the belief that clinical supervision is key to staff retention and workforce development. Strategies for reducing the costs involved in a supervision program include agreements with other agencies, using retired supervisors interested in part-time employment, and group supervision (Roche, Todd, & O'Connor, 2007).

Other key organizational issues include how certain organizational models and styles of management influence the process of clinical supervision and how organizational receptivity to supervision affects the outcome and effectiveness of clinical supervision. Although little research has been conducted on these issues, they remain key factors that influence the adoption of clinical supervision within an organization.

Elements in a Supervision Policy		
Element	Description	Example
Why supervision?	An explanation of the importance of supervision in this workplace	Supervision improves clinical practice, supports treatment staff, and can help improve client outcomes
Policy statements	What the organization is committed to delivering	All staff who have direct contact with clients will have access to individual or group supervision
Purpose	An overall purpose describing the supervision program's direction	Clinical supervision promotes high quality clinical practice, professional standards, and competencies
Outcome standards	The standards the organization would like to achieve in supervision	All supervision is provided by qualified and experienced practitioners; the quality of clinical practice and the professional needs of staff are identified and monitored
Evaluation	The program's evaluation protocol	An annual survey of supervisors and supervisees will be conducted to evaluate the process
Key players	Identification of key players and their roles	Supervisees, supervisors, administrators; supervisees negotiate the model of supervision that best meets their needs.
Specific clinical arrangements	The arrangements under which supervision will take place in the organization	Group supervision by an experienced facilitator
Source: Roche, Todd, & O'Connor, 2007		

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Section 2: Annotated Bibliography

Research-Related Studies

Reference: Borders, L. D. (2005). Snapshot of clinical supervision in counseling and counselor education: A five-year review. *Clinical Supervisor, 24*, 69–113.

Purpose: To review recent literature on clinical supervision for counselors and counselor trainees.

Conclusions: The topics covered in this review give insight into the issues involved in clinical supervision that are important to researchers and practitioners at this point in time.

Methodology: The authors reviewed literature from a 5-year period in journals published by the American Counseling Association or two international journals on counseling. They divide literature into quantitative studies, qualitative studies, and conceptual pieces, subdivide according to specific topics in those categories (e.g., multicultural supervision, developmental models, etc.), and provide short reviews of the literature relating to each sub-topic .

Summary of Results: Major topics of interest in clinical supervision literature during this period include concerns over the lack of clinical supervision in specific settings (or misunderstandings over what constitutes clinical supervision), the importance of the supervisory relationship, problems involved in addressing relationship issues in supervision, the role of cultural differences in multicultural supervision, the need to extend research to address a more diverse group of providers, the role of feedback in supervision, other training needs, the role of supervision in certain specialized counseling situations (e.g., schools), the viability of group supervision, developmental models for providing a framework for supervision, and the use of technology in supervision.

Reference: Burkard, A. W., Johnson, A. J., Madson, M. B., Pruitt, N. T., Contreras-Tadych, D. A., Kozlowski, J. M., et al. (2006). Supervisor cultural responsiveness and unresponsiveness in cross-cultural supervision. *Journal of Counseling Psychology, 53*, 288–301.

Purpose: To examine how cultural competence (or the lack thereof) affects supervisory relationships for supervisees of either European or non-European descent.

Conclusions: Supervisees of non-European (i.e., non-White) descent experience greater dissatisfaction with supervisory relationships as a result of culturally insensitive interactions than do supervisees of European descent. Supervisors in cross-cultural supervisory relationships (regardless of whether they are of European or non-European descent) should address with their supervisees the effects of culture on client treatment.

Methodology: The authors interviewed 26 female doctoral psychology students, 13 of whom were of European descent and 13 of whom were not (6 of these individuals were African American, 6 were Asian American, and 1 was Latina. Interviewers used a semi-structured interview protocol that was aimed at evaluating how cross-cultural supervisory relationships have affected participants. Interviewees were asked to discuss specific events in which the supervisor was and was not culturally responsive. Participants were identified through Listserv requests or by asking other students with whom the authors were already familiar (those students were also eligible for study inclusion).

Summary of Results: Respondents of both European and non-European descent had similar responses to situations in which supervisors from cultural backgrounds different than their own were culturally responsive (i.e., responded to them in a culturally competent manner). Culturally responsive interactions were ones in which the supervisor helped the supervisee become more sensitive to the role of culture in therapy. For supervisees of

European descent, such interactions made them more comfortable dealing with cross-cultural interactions in therapy, while for those of non-European descent, such interactions made them feel supported and validated their own concerns. Some respondents of non-European descent did express a level of discomfort in culturally responsive exchanges, particularly when a supervisor challenged the supervisee by suggesting that they did not focus enough on the cultural concerns of a client. Respondents, regardless of cultural background, generally felt greater satisfaction with their supervisor when the supervisor discussed cultural issues. In response to culturally unresponsive interactions (i.e., ones in which the supervisor ignored the effect of culture in the treatment of a client), supervisees of both European and non-European descent experienced a negative reaction to their supervisors and found that the event made them less satisfied with their supervisor. However, supervisees of non-European descent experienced a much greater level of dissatisfaction as a result of such events and often found themselves completely dissatisfied with the supervisory relationship afterward. Supervisees of non-European descent were also more likely to report experiencing culturally unresponsive interactions with supervisors. While respondents of European descent typically felt that their relationship to their supervisor was good prior to the culturally unresponsive event, those of non-European descent did not.

Reference: Culbreth, J. R., & Borders, L. D. (1999). Perceptions of the supervisory relationship: Recovering and nonrecovering substance abuse counselors. *Journal of Counseling & Development, 77*, 330–338.

Purpose: To determine if counselor/supervisee and supervisor recovery status affect the nature of the supervisory relationship.

Conclusions: Substance abuse treatment counselors experience the most satisfaction when their supervisor has the same recovery status as they themselves have.

Methodology: The authors mailed surveys concerning the counselor–supervisor relationship to 566 substance abuse treatment counselors working in a State public mental health system, of which 385 were returned. The surveys included five assessment instruments intended to evaluate satisfaction with supervision, supervisory style, social influence of supervisor, working alliance with supervisor, and the core conditions for creating behavioral change within the supervisory relationship.

Summary of Results: The authors found no difference in how counselors who were and were not in recovery rated satisfaction with their supervisors. There were also no significant differences in respondents' perceptions of the nature of their relationship (as measured on the five assessment instruments) according to the client's own recovery status. However, the authors did find that counselors reported significantly greater satisfaction with their counselors when their own recovery status matched that of their supervisor (e.g., when counselors in recovery had supervisors who were also in recovery).

Reference: Culbreth, J. R. (1999). Clinical supervision of substance abuse counselors: Current and preferred practices. *Journal of Addictions & Offender Counseling, 20*, 15–25.

Purpose: To determine the current and preferred methods of supervision for substance abuse treatment counselors.

Conclusions: The majority of substance abuse treatment counselors receive clinical supervision and are satisfied with the supervision they receive.

Methodology: The authors surveyed a random selection of 400 members of the National Association of Alcohol and Drug Abuse Counselors, 134 (35 percent) of whom responded. The mailed surveys asked about demographic factors relating to the counselors and their typical clients, the current supervisory practices experienced by the counselors, and their preferred supervisory practices.

Summary of Results: Respondents had a mean age of 49, were more likely to be female (55 percent), more likely to be in recovery than not (58 percent considered themselves to be in recovery), and more likely to be White than members of other ethnic/racial groups (87 percent). Their typical clients were most likely to be male, White, and have a mean age of 32. Clinical supervision was the primary means of supervision for 58 percent of the respondents, a combination of individual and group supervision was the second most common means of supervision (34 percent). Thirty percent reported receiving no supervision. Supervisors were most likely to be male (53 percent), and most (64 percent) carried their own caseloads in addition to supervising others. Half of the supervisors, according to supervisees, had a substance abuse counselor license and 39 percent had a master's degree. The majority of respondents (82 percent) did not have a say in selecting their supervisors. Most respondents were moderately to very satisfied with their supervision (the mean rating, on a five-point Likert scale, was 3.57). When asked about the focus of their supervision, the most common responses were ethical standards, adherence to agency policies, facilitating personal growth, and improving clinical skills (in that order). When asked to consider what type of supervisory relationship they preferred, most respondents did not express either a gender preference (76 percent) or a preference as to whether the individual had personal recovery experiences (59 percent). Seventy-four percent of respondents expressed a preference for supervisors who were certified substance abuse treatment counselors, 36 percent preferred a supervisor with at least a master's degree, and 35 percent preferred someone who was a nationally certified counselor. When asked about preferred methods of supervision, 46.6 percent expressed a preference for a combination of group and individual supervision, 72.2 percent preferred that supervision be required for their position, and 35 percent wanted supervision provided by an experienced colleague or peer. Supervisees preferred that their supervisors focused on facilitating growth and awareness, followed by improving clinical skills and adhering to ethical standards. Respondents, in ranking different approaches to supervision, had the greatest preference for self-reports of sessions, followed by co-therapy with a supervisor, and live observations of a supervisor with a client. There were some differences between the preferences of counselors who were themselves in recovery and those who were not. Counselors in recovery indicated a significantly greater preference for supervisors that used more influence and support in the supervisory session, spent more time discussing legal and ethical questions, and provided more frequent supervisory sessions. They were also more likely to prefer a supervisor who was also in recovery.

Reference: Daniels, J., D'Andrea, M., & Kim, B. S. K. (1999). Assessing the barriers and changes of cross-cultural supervision: A case study. *Counselor Education and Supervision, 38*, 191–204.

Purpose: To examine how cross-cultural supervisor–supervisee relationships are complicated by cultural differences and how those differences may result in communication problems and/or interpersonal conflicts.

Conclusions: Supervisors need to be open to discussing cultural issues with supervisees who have different cultural backgrounds from their own.

Methodology: The authors use a case study to examine how problems can arise in cross-cultural supervisory relationships when issues of cultural difference are not addressed.

Summary of Results: Based on their analysis of the case study they present, the authors determine that in situations in which their supervisees have cultural backgrounds that are different from their own, supervisors need to be willing to initiate discussions about cultural issues, discuss their own roles and responsibilities in the supervisory relationship, establish guidelines for getting feedback from supervisees, and explain the ways in which culturally based miscommunication or conflict can be resolved. Supervisors from the dominant culture who are in cross-cultural supervisory situations also need to express interest in hearing supervisee's ideas about the cultural difference and how it may affect the supervisory relationship.

Reference: Eby, L. T., McCleese, C. S., Baranik, L., & Owen, C. (2007). *Project MERITS Year 1 Summary Report*. Athens, GA: University of Georgia Institute for Behavioral Research.

Purpose: To report early findings from a large, 5-year study on the relationship of clinical supervision and employee turnover/burnout for staff in substance abuse treatment programs.

Conclusions: Having positive experiences in the course of clinical supervision is associated with less burnout and less intention to leave substance abuse treatment counseling.

Methodology: The Managing Effective Relationships in Treatment Services (MERIT) Project is a 5-year study funded by the National Institute on Drug Abuse (NIDA) and drew its sample of 740 substance abuse treatment counselors and 198 clinical supervisors from 27 substance abuse treatment programs that were associated with NIDA's Clinical Trials Network. Respondents answered questions about demographics, supervisory and clinical practice, job satisfaction, positive and negative experiences with clinical supervision, and related topics.

Summary of Results: The initial round of surveys indicate that clinical supervisors and the counselors they supervise are both only moderately satisfied with their supervisory relationships, although supervisors indicate somewhat higher satisfaction than supervisees. Both supervisors and supervisees have a moderately high level of professional satisfaction and are generally satisfied with their jobs, have a moderate level of loyalty towards the programs for which they work, feel that they have a moderate level of support from their programs, are generally satisfied with the work they do and their choice of profession, and are generally dissatisfied with their pay and opportunities for advancement. Both supervisors and supervisees report a moderate level of stress and some role-related overload and job-related burnout. However, the mean level of burnout reported is no higher than that reported by other human service professionals. Supervisees do report a high level of intention to leave their current position—somewhere between 35 and 40 report such an intention as do 22 percent of supervisors. Supervisees who have more favorable responses to their clinical supervision also report greater job satisfaction, greater commitment to their employer, a greater sense of support from their employer, less role-related overload, less stress, less burnout, and less intention to leave their current place of employment. Supervisees who report greater job satisfaction, greater commitment to the organization for which they work, greater commitment to their profession, a greater sense of support from the organization for which they work, and lower levels of role-related overload also report less intention to leave their current position. The authors conclude that this preliminary research suggests that more positive experiences in clinical supervision are associated with less burnout and less intention to leave one's current position and that organizations can improve retention and decrease burnout with better clinical supervision.

Reference: Evans, W. N., & Hohenshil, T. H. (1997). Job satisfaction of substance abuse counselors. *Alcoholism Treatment Quarterly*, 15, 1–13.

Purpose: To evaluate the level and sources of job satisfaction and the relationship of job satisfaction to clinical supervision for certified substance abuse treatment counselors.

Conclusions: Substance abuse treatment counselors have a relatively high level of job satisfaction compared with other professionals, and overall they are very satisfied with their jobs. However, lack of opportunities for advancement present the biggest challenge to that satisfaction.

Methodology: The authors sent surveys to 505 substance abuse treatment counselors—365 responded and 231 responses were usable. Surveys used the Minnesota Satisfaction Questionnaire to evaluate job satisfaction and an individual information form to gather information that could be used to assess the relationship of job satisfaction to clinical supervision.

Summary of Results: According to mean scores on survey responses, counselors were “very satisfied” overall with their jobs. All respondents were at least slightly satisfied. As for specific sources of job satisfaction, social

service provided the greatest satisfaction and opportunities for advancement provided the least. The mean score for satisfaction with advancement fell in the “slightly satisfied” level. The factors that appeared to have the greatest relation to satisfaction with clinical supervision were the number of hours of supervision received per week, the length of time the supervisor had been in that role, the degree level of the supervisor, and whether or not the clinical supervisor was also the counselor’s administrative supervisor.

Reference: Fernando, D. M., & Hulse-Killacky, D. (2005). The relationship of supervisory styles to satisfaction with supervision and the perceived self-efficacy of Master’s-level counseling students. *Counselor Education and Supervision, 44*, 293–304.

Purpose: To determine if there is a relationship between supervisors’ supervisory styles and both supervisee satisfaction and self-efficacy for masters-level students.

Conclusions: The use of an interpersonally sensitive supervisory style is associated with increased satisfaction with supervision among supervisees and the use of a task-oriented style is associated with increased self-efficacy among supervisees.

Methodology: The authors surveyed 82 students in masters-level counseling programs at six different universities and their supervisors. They administered the Supervisory Styles Inventory, the Supervisory Satisfaction Questionnaire, and the Counseling Self-Estimate Inventory.

Summary of Results: The only variable studied that was significantly related to satisfaction with supervision was the supervisor’s use of an interpersonally sensitive supervisory style. The only significant variable in predicting supervisees’ self-efficacy was the use of a task-oriented supervisory style. There was no significant relationship between ratings of self-efficacy and satisfaction with supervision among supervisees.

Reference: Freitas, G. J. (2002). The impact of psychotherapy supervision on client outcome: A critical examination of 2 decades of research. *Psychotherapy: Theory, Research, Practice, Training, 39*, 354–367.

Purpose: To review literature regarding the effects of clinical supervision on client outcomes.

Conclusions: More rigorous research is needed to understand the relationship between clinical supervision and client treatment outcomes.

Methodology: The author identified a total of ten studies published between 1981 and 1997 for detailed review.

Summary of Results: Research on this topic has had a number of potential problems such as lack of psychometric data, a failure to focus on supervisors who have a limited range of experience/professional background, and a failure to randomize clients. While this research gives some indication of how clinical supervision may affect treatment outcomes for clients, more research is needed to better understand the relation of supervision to client outcomes.

Reference: International Certification & Reciprocity Consortium/Alcohol and Other Drug Abuse (ICRC/AODA). (2000). *Clinical Supervisor of Alcohol and Other Drug Abuse Counselors Role Delineation Study*. Research Triangle Park, NC: Castle Worldwide, Inc.

Purpose: To determine roles and activities of clinical supervisors who supervise substance abuse treatment counselors.

Conclusions: ICRC/AODA clinical supervisors indicate that they spend significantly more time on activities that they view as less important (management and administration) than on that they believe is most important (professional responsibility).

Methodology: ICRC/AODA undertook a survey of roles as an initial step toward developing a credentialing program for clinical supervisors. An expert panel identified questions for the survey relating to four major domains of activity (assessment and evaluation, counselor development, professional responsibility, management and administration).

Summary of Results: The respondents were mostly between the ages of 42 and 60, held certifications in both clinical supervision and substance abuse treatment counseling, had more than 15 years of counseling experience, and had a master's degree or higher. According to the mean response, respondents granted the greatest importance to the domain of professional responsibility, followed by assessment and evaluation, and counselor development (these rankings differed from the expert panel who created the survey who considered counselor development most important). When asked to rank domains according to how much time they spent on them, respondents said they spent the most time (27 percent) on management and administration, followed by assessment and evaluation, and counselor development.

Reference: Kavanagh, D. J., Spence, S. H., Strong, J., Wilson, J., Sturk, H., & Crow, N. (2003). Supervision practices in allied mental health: Relationships of supervision characteristics to perceived impact and job satisfaction. *Mental Health Services Research*, 5, 187–195.

Purpose: To determine if supervisor characteristics have an effect on mental health treatment and staff morale. Also, to give a preliminary evaluation of a new instrument for assessing supervisory relationships, the Supervision Attitude Scale.

Conclusions: The degree to which supervisees believe their supervision affects their clinical practice is related to the amount of impact that supervision has on their discipline-related skills, their satisfaction with supervision, and the frequency of contact with supervisors who come from their own discipline. Empathy and praise from supervisors increased supervisees' satisfaction with the counseling relationship.

Methodology: The authors used a database of public mental health staff in Queensland, Australia to select 375 individuals to receive a telephone survey, 272 of whom agreed to participate. Participants were interviewed using a survey designed specifically for this study as well as the supervisor and/or supervisee versions of a new instrument developed by the authors, the Supervision Attitude Scale (SAS), designed to evaluate the positive and negative aspects of the supervisory relationship. Telephone interviews were conducted in June and July 2000.

Summary of Results: The authors found that supervisors were more likely than supervisees to state that a specific supervisory contract was in place. Supervisors were also somewhat more likely to state that discipline-specific competencies were the focus of the supervisory relationship, while supervisees were more likely to state generic practice skills were the focus. Supervisees were, on average, moderately satisfied with their supervision and most believed that supervision had a positive effect on their effectiveness as clinicians (6 percent). When evaluating the effect of different factors on the impact of supervision on clinical practice, most of the factors measured did not have a significant relationship (e.g., gender, discipline, location). The factors that were significantly related were satisfaction with supervision, positive attitudes towards supervisors, time spent on discipline-specific skills (but not time spent on generic skills) and frequency of contact (the latter only with supervisors from the same disciplinary background). They did not find any relationship between job satisfaction and amount of supervision, availability of supervisors, level of specificity in the supervisory contract, or priority of discipline specific skills. The factors that appeared to have the greatest effect on satisfaction were the perceived impact of supervision on practice, a positive attitude from supervisors, and the receipt of empathy from supervi-

sors. The only specific supervisory strategy that had a significant relationship with satisfaction was the level of praise of the supervisee's performance. Both the supervisor and supervisee version of the SAS had high internal consistency and its intercorrelations demonstrated that it measured how positive the supervisory relationship was appropriately.

Reference: Ladany, N., & Lehrman-Waterman, D. E. (1999). The content and frequency of supervisor self-disclosures and their relationship to supervisor style and the supervisory working alliance. *Counselor Education and Supervision, 38*, 143–160.

Purpose: To evaluate how counselor trainees perceive the content and frequency of self-disclosures from supervisors and how supervisor style is related to the frequency of self-disclosure.

Conclusions: The type and frequency of supervisor self-disclosures are related to supervisor style and the perceived quality of the supervisory relationship.

Methodology: The authors interviewed 105 counselor trainees (out of an original sample of 525) using four instruments (i.e., the Supervisor Self-Disclosure Questionnaire, the Supervisor Self-Disclosure Index, the Supervisory Styles Inventory, and the Working Alliance Inventory-Trainee Version) and a demographic questionnaire.

Summary of Results: On average, trainees reported 5.46 self-disclosures from their supervisors. A greater number of self-disclosures was associated with a more attractive supervisory style (as measured on the Supervisory Styles Inventory), while an interpersonally sensitive or task-oriented styles were not. Specifically, an attractive supervisory style was related to a greater likelihood of disclosing neutral counseling experiences rather than personal issues or counseling struggles. On the other hand, an interpersonally sensitive supervisory style was related to a less likelihood of disclosing neutral counseling experiences. A task-oriented style was also associated with greater likelihood of disclosing neutral counseling experiences. More frequent supervisor self-disclosures were associated with a greater perceived agreement (between supervisor and supervisee) regarding the goals of supervision and with a stronger perceived emotional bond with the supervisor. The strength of the emotional bond was associated specifically with more frequent disclosures of counseling struggles.

Reference: Ladany, N., Walker, J. A., & Melincoff, D. S. (2001). Supervisory style: Its relation to the supervisory working alliance and supervisor self-disclosure. *Counselor Education and Supervision, 40*, 263–275.

Purpose: To examine supervisor perceptions of their own supervisory styles and how it affects the supervisory relationship, especially in relation to working alliance and self-disclosure.

Conclusions: Supervisors who are flexible in regards to their supervisory style are best able to attend to all aspects of the supervisory relationship. However, supervisors who believe they use an attractive supervisory style appear to be most attentive to all primary aspects of the supervisory relationship.

Methodology: The authors interviewed 137 clinical supervisors working in a variety of counseling settings. In conducting the interviews, the authors used the Supervisory Styles Inventory, the Working Alliance Inventory-Supervisor Version, Supervisor Self-Disclosure Inventory, and a demographic questionnaire.

Summary of Results: The authors found that supervisors who identified themselves as warm, friendly, and supportive (i.e., attractive in style) were more likely to see their supervisory relationship as being mutually trusting and in agreement in regards to both the tasks and goals of supervision (i.e., the three primary aspects of the supervisory relationship). When supervisors primarily believed themselves to have a task-oriented style they perceived a high level of agreement with supervisees regarding supervisory tasks (but not supervisory

goals or a high level of mutual trust). Supervisors who saw themselves as engaging in a supervisory style that was high in empathic understanding believed themselves to understand supervisees' goals in relation to supervision. Supervisors who saw themselves as attractive in style as well as those who saw themselves as interpersonally sensitive were more likely to also perceive themselves as self-disclosing than were supervisors who saw themselves as task-oriented in style.

Reference: Magnuson, S., Wilcoxon, S. A., & Norem, K. (2000). A profile of lousy supervision: Experienced counselors' perspectives. *Counselor Education and Supervision, 39*, 189–202.

Purpose: To analyze the elements of poor clinical supervision.

Conclusions: Lousy supervision is one end of a continuum of supervisory practice characterized by both the absence of effective practices and the presence of harmful ones.

Methodology: The authors conducted in depth interviews with ten experienced clinical supervisors (and one with less experience) who supervised counselors/students in a variety of settings. They conducted semi-structured interviews either in person or by phone, depending on the respondent's location.

Summary of Results: From the interviews they conducted, the authors were able to discern six overarching principles that defined poor or "lousy" supervision. Such supervision was unbalanced, developmentally inappropriate, intolerant of differences, untrained, professionally apathetic, and/or poorly modeled professional/personal attributes. The authors also discuss how these overarching principles applied specifically in three general spheres: (1) the organizational/administrative, (2) the technical/cognitive, and (3) the relational/affective. So, for example, developmentally inappropriate supervision in the administrative sphere may result in a failure to assess supervisee needs, while in the relational sphere it may result in insensitivity to the supervisee's professional and developmental needs.

Reference: Magnuson, S., Wilcoxon, S. A., & Norem, K. (2000). Exemplary supervision practices: Retrospective observations of experienced counselors. *TCA Journal, 28*, 93–101.

Purpose: To determine the elements of exemplary supervision.

Conclusions: Experienced supervisors believe that exemplary supervision involves competent preparation, the ability to successfully demonstrate, the ability to elicit participation from supervisees, and the ability to stimulate supervisees.

Methodology: The authors conducted in depth interviews with ten experienced clinical supervisors (and one with less experience) who supervised counselors/students in a variety of settings. They conducted semi-structured interviews either in person or by phone, depending on the respondent's location.

Summary of Results: The authors found that respondents presented four dimensions that were involved in exemplary supervision: competent preparation, the ability to successfully demonstrate, the ability to elicit participation from supervisees, and the ability to stimulate supervisees.

Reference: NAADAC, The Association for Addiction Professionals. (2003). *NAADAC, The Association for Addiction Professionals Practitioner Services Network Year 2 Final Report: A Survey of Early Career Substance Abuse Counselors*. Washington, DC: NAADAC, The Association for Addiction Professionals. Retrieved October 27, 2008, from <http://naadac.org/pressroom/files/Year2SurveyReport.pdf>

Purpose: To better understand the education, work settings, and satisfaction of substance abuse treatment counselors who have been working in the field for 4 years or less.

Conclusions: Substance abuse treatment counselors find that on-the-job supervision is the most useful method of further educating themselves and the majority are satisfied or greatly satisfied with their current supervision.

Methodology: The NAADAC sent surveys to 662 of its members (who had previously indicated that they had 3 or fewer years working in the substance abuse treatment field) regarding their education, qualifications, work settings, personal background, and characteristics of their typical clients. The final sample of 140 respondents, however, included individuals with 4 years or less of experience in the field. The survey instrument consisted of 72 questions and is included in the report. Data from the survey were compared to information available from other sources concerning the entire membership of NAADAC.

Summary of Results: Respondents, in noting their reasons for entering the substance abuse treatment field, were most likely to state that they believed the work would be challenging or interesting, followed by having had a desire to work in a helping profession, having seen substance abuse problems in their communities, and having friends/family who had substance abuse problems or they themselves had substance abuse problems. In ranking eight sources of counselor education, participants ranked on-the-job supervision highest, followed by internships and mentoring programs (in that order), and ranked Internet materials lowest with continuing education second lowest. Almost all respondents were at least a little or somewhat satisfied with their supervision, and about 65 percent were satisfied to greatly satisfied.

Reference: Ray, D. & Altekrose, M. (2000). Effectiveness of group supervision versus combined group and individual supervision. *Counselor Education and Supervision, 40*, 19–30.

Purpose: To determine if different methods of clinical supervision are related to different ratings of counselor effectiveness for masters-level students.

Conclusions: Large group, small group, or group plus individual methods of supervision all appear to improve counseling effectiveness equally for masters-level students.

Methodology: The author randomly assigned 64 students who were enrolled in a masters-level practicum during one of two successive semesters to one of three supervisory situations: (1) combined individual and group supervision, (2) large group supervision, or (3) small group supervision. Faculty practicum supervisors for nine different practicum sections were assigned to supervise students in one of the three groups. In addition, 11 doctoral students participated as individual supervisors in the combined individual–group condition. As part of their practicum, students were assigned at least two clients who had sought help through the university’s clinic. The Counselor Rating Form-Short Version and Supervisee Levels Questionnaire-Revised were used to assess the supervisory relationship. Tapes of counseling sessions were assessed by independent raters to evaluate counselor effectiveness at the beginning and end of the semester. Students were also asked to rate their preferences regarding methods of supervision.

Summary of Results: According to independent raters, all participants improved their counseling scores over the course of the study, with no significant difference according to the method of supervision (i.e., individual plus group, large group alone, small group alone). Preferences for supervision were not related to ratings of counseling effectiveness, although participants did express a preference for individual over group supervision.

Reference: Reeves, D., Culbreth, J. R., & Greene, A. (1997). Effect of sex, age, and education level on the supervisory styles of substance abuse counselor supervisors. *Journal of Alcohol and Drug Education, 43*, 76–86.

Purpose: To better understand substance abuse treatment counselor supervisors' perceptions of their own supervisory styles and the relation of those perceptions to age, gender, and education level.

Conclusions: Younger supervisors (under the age of 50) considered themselves more flexible in some matters of supervision.

Methodology: The authors solicited participation from 171 certified clinical supervisors who had been accredited by the North Carolina Substance Abuse Professional Certification Board, 72 of whom agreed to participate. Participants completed two questionnaires intended to assess their supervisory style (i.e., the Supervisory Styles Inventory and the Supervisory Styles Index), as well as questions concerning demographics.

Summary of Results: There were no significant differences in supervisory styles according to gender. Supervisors under the age of 50 were significantly less likely than those over 50 to decide ahead of time what to discuss in supervision sessions and felt more comfortable sharing personal experiences with supervisees. Younger supervisors were also somewhat less likely to insist that supervisees adhere strictly to their direction. Overall, this group of respondents were significantly more likely to label their supervisory style as attractive or interpersonally sensitive than task-oriented.

Reference: Vespia, K. M., Heckman-Stone, C., & Delworth, U. (2002). Describing and facilitating effective supervision behavior in counseling trainees. *Psychotherapy: Theory, Research, Practice, Training*, 39, 56–65.

Purpose: To understand what factors are associated with better use of supervision by supervisees, according to both supervisors and supervisees.

Conclusions: The most important behaviors for effective use of supervision, according to both supervisees and supervisors, are demonstrating a willingness to grow, taking responsibility for the consequences of one's own behavior, actively participating in supervision sessions, demonstrating respect and appreciation for individual differences, and demonstrating an understanding of one's personal dynamics as they relate to both counseling and supervision.

Methodology: The authors surveyed both supervisees and supervisors who were involved in internship programs at universities or counseling centers. They selected some programs with which they were affiliated or familiar and selected others randomly from a list of American Psychological Association-accredited programs. Of the 335 supervisees and 61 supervisors contacted, 145 supervisees and 31 supervisors returned completed forms. Participants came from one of 13 academic programs or 10 counseling centers. All completed a survey instrument specifically designed for this study, the Supervision Utilization Rating Form (SURF), that asked respondents to rate the importance of specific behaviors for supervisees to use supervision effectively.

Summary of Results: The SURF was found to be an accurate measure of the behaviors that both supervisors and supervisees believed indicated the ability of supervisees to use supervision effectively. The items that were most often endorsed as important behaviors for good supervision by both supervisors and supervisees were demonstrating a willingness to grow, taking responsibility for the consequences of one's own behavior, actively participating in supervision sessions, demonstrating respect and appreciation for individual differences, and demonstrating an understanding of one's personal dynamics as they relate to both counseling and supervision. For most items, supervisors and supervisees did not differ significantly in the importance they granted the behaviors. However, on six items there were significant differences. On all of these items, supervisees gave a greater mean rating of importance than supervisors to the following behaviors: (1) listening attentively to the supervisor, (2) identifying one's own developmental needs, (3) inviting feedback from the supervisor, (4) demonstrating an understanding of one's personal dynamics as they relate to both counseling and supervision, (5) critiquing one's own work, and (6) discussing one's own level of development in domains such as therapy and assessment.

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