

ABSTRACT

Title of dissertation: SUPERVISORY STYLES, SUPERVISION OUTCOME AND COUNSELOR SELF-EFFICACY OF ADDICTION TREATMENT PROFESSIONALS

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Due to the paucity of research in the addictions treatment field regarding supervision, this research study sought to examine the style, type and outcome of supervision of addictions treatment professionals and how it relates to supervisee self-efficacy. Thus, the primary purpose of this study is to quantify the addictions treatment professional's supervision outcome in relation to other variables including supervisory style, supervisory type, and demographic variables. The research questions of the present study are as follows: 1. What do addictions treatment counselors perceive as the overall supervisory style of their clinical supervisors? 2. Does the supervisory style of clinical supervisors of addictions treatment counselors predict the outcome of supervision? 3. What type of delivery style of supervision do addictions treatment counselors receive? 4. Is there a significant relationship between supervision outcome and specific demographic characteristics of addictions treatment professionals (e.g., age, years of experience, recovery status, gender, formal education)? 5. What is the relationship between perceived addictions treatment counselor self-efficacy and perceptions of supervision outcome? 6.

Can supervision outcome be predicted from addiction treatment counselor perceived supervisory style and perceived self-efficacy?

This study discussed the definition of supervision, types and techniques of supervision, models, and mechanisms. The supervisory relationship, supervision outcome, and supervision effectiveness were discussed in relation to other areas of mental health counseling. When discussing these areas in terms of the addictions treatment field, the lack of empirically valid research was noted. The many different types of supervision (e.g., individual, group, peer, etc.) and different styles were also discussed. Though styles have been variously defined, this research study used the supervisory styles as defined by Friedlander & Ward (1984) which include the Attractive, Interpersonally Sensitive, and Task Oriented subscales.

The methodology included a pilot study to refine the instruments that were ultimately used for this study. Several changes were made to the original instruments and these changes focused mainly on defining terms used in rating supervisors. The three instruments that were used include the Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984), The Supervision Outcome Questionnaire (SOQ; Worthington and Roehlke (1979) and the Counselor Self-Efficacy Scale (COSES; Melchert, et. al., 1996). A demographic questionnaire was included to gather information regarding demographic variables and supervisory style.

The results indicate that supervisees have a fairly positive overall perception of the supervisory style of their supervisors. Supervisory style was found to be predictive of supervision outcome with a positive linear relationship. The delivery style of supervision for this sample was noted. There were no demographic variables that

predicted type of supervision. Counselor self-efficacy was found to be not statistically significant relative to supervision outcome. A linear relationship was found between supervision style, counselor self-efficacy, and supervision outcome such that when overall supervision style increases and self-efficacy decreases slightly, then supervision outcome can be predicted.

Finally, the implications for training of supervisors in the addictions treatment field was discussed as well as the implications for future research. The study's limitations were also discussed.

SUPERVISORY STYLES, SUPERVISION OUTCOME AND
COUNSELOR SELF-EFFICACY OF ADDICTION TREATMENT
PROFESSIONALS

By

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DEDICATION

This document and all the work it took to make it happen is dedicated to my best proof-reader, friend and husband. Without his encouragement, this opus would not have come to fruition.

The author would also like to acknowledge the effort of Dr. Anita Marchesani. She kept me focused and on track despite the many distractions offered by life and motherhood.

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CHAPTER ONE

INTRODUCTION

While clinical supervision has long been regarded as a significant part of the counseling profession, the importance of effective clinical supervision in the addiction treatment process has gained increased attention over the past twenty years (Culbreth, 1999; Junhnke & Culbreth, 1994; Powell, 1989). There is new interest among addictions professionals regarding the prevention of counselor burnout, the maintenance of addictions counselors' credentials, and the efficacy of treatment for clients (Borders & Leddick, 1987; Powell, 1993). As the profession of addictions counseling grows and matures, it becomes even more critical that counselors acquire more advanced clinical skills. As such, addictions counseling professionals have focused a great deal of attention on clinical supervision or "in-house" supervision of addictions counselors.

A variety of definitions for clinical supervision exists. Powell (1993) focused primarily on issues regarding the efficient management of responsibilities. Valle (1984) described supervision as a process enabling the supervisee to be more effective in the performance of duties. While Kutzik (1977) described supervision as one's position in an organizational structure, Loganbill, Delworth and Hardy (1982) defined supervision as "an intensive, interpersonally focused, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person" (p. 4). This definition incorporates three essential components of supervision which include: 1) highly individualized, personal attention designed around the unique personal and professional traits of the supervisee; 2) the central aspect of the supervisory relationship; and 3) the administrative authority to hold the supervisee accountable. This

definition also incorporates the four basic functions of the supervisory process: monitoring client welfare, enhancing growth within developmental stages, promoting transition from stage to stage, and evaluating the supervisee.

Unfortunately, the supervision of addictions counselors has been fragmented, vague, or non-existent (Valle, 1984). This is evidenced by the paucity of research and literature written on the topic of addictions treatment supervision (Juhnke & Culbreth, 1994). And as a result, there has been a significant lack of support or direction for supervision of addictions treatment professionals.

Addictions treatment is a unique specialty within the field of counseling. Perhaps one of the most notable aspects of this specialty is the issue of recovering versus non-recovering counselors (Culbreth & Border, 1999). Historically, there has been a strong bias within the addictions treatment field in favor of recovering counselors, based on the belief that chemically dependent clients will listen only to recovering counselors who have had their own experiences in overcoming an addiction. The recovery issue is somewhat confounded by a second aspect of the field, variations in the professional training of addictions treatment counselors. State certified addictions treatment counselors with only a high school diploma may work side by side with practitioners who have graduate degrees in counseling. Educational training levels often parallel recovery status with non-recovering counselors more likely to have graduate degrees (Valle, 1979). Consideration of the increasing number of graduate level non-recovering counselors entering the field has made supervision ever more critical. For this reason, examining the type and style of supervision as well as supervision outcome and counselor efficacy is crucial.

Need for Study

Despite increased numbers of addictions treatment programs, addictions supervision has been virtually neglected. Not until recently, has there been a focus on the unique characteristics and idiosyncrasies of addictions counseling. Unlike other counseling specialties, the addictions counseling field consists of a significant number of paraprofessionals who have not fulfilled the educational requirements for a masters degree in counseling or any other human service field. Paraprofessionals in some states are required to have little more than a high school diploma or equivalent and pass a state certification examination. As a result, many paraprofessionals lack the fundamental counseling skills and organized sequence of practica and internships found in counselor education programs. Therefore, the need for a more systematic focus on the supervision of addictions counselors is warranted.

Likewise, most addictions counselors and paraprofessionals are in-recovery and believe that one must be in-recovery to provide effective treatment (Powell, 1993). In essence, many in the addictions field espouse a “recovery-only” position about who should be addictions treatment providers. These two factors, (1) unfulfilled educational requirements and (2) “recovery-only” position among addictions counselors, complicate the issue of supervision in the addictions counseling field and creates resistance among many addictions counselors in-recovery and non-recovering supervisors.

While supervision may be more complicated in addictions treatment settings, many addictions counseling professionals perceive clinical supervision as the key to improved staff retention and turnover, job satisfaction, reduced counselor burnout, and the quality of care delivered to addictions clients (Powell, 1991). As such, there has been

more emphasis placed on the supervisory process, supervision outcomes, and supervision effectiveness among addictions counselors. Therefore, it is critically important for addictions supervisors to establish supervision practices that are most effective for positive client outcomes. Also, it is imperative that addictions supervisors better understand the supervisory relationship and process when working in the addictions counseling setting. Research that explores the unique types of supervision that are occurring in addictions treatment facilities and the counselors' perceptions of supervisors' style and outcomes would help further the field's knowledge and understanding of addictions supervision.

Statement of Problem

The present study seeks to extend the empirical understanding of addictions supervision by examining the following research questions.

1. What do addictions treatment counselors perceive as the overall supervisory style of their clinical supervisors?
2. Does the supervisory style of clinical supervisors of addictions treatment counselors predict the outcome of supervision?
3. What type of delivery style of supervision do addictions treatment counselors receive?
4. Is there a significant relationship between supervision outcome and specific demographic characteristics of addictions treatment professionals (e.g., age, years of experience, recovery status, gender, formal education)?
5. What is the relationship between perceived addictions treatment counselor self-efficacy and perceptions of supervision outcome?

6. Can supervision outcome be predicted from addiction treatment counselor perceived supervisory style and perceived self-efficacy?

Design and Organization of Study

This study used the Supervision Outcome Questionnaire (SOQ) which is based on the work of Worthington and Roehlke (1979). This instrument gathered data on contribution of supervision to improved counseling. The Supervisory Styles Inventory (SSI) developed by Friedlander and Ward (1984) was used to gather data on addiction treatment professionals' style of supervision. The Counselor Self-Efficacy Scale (COSES) developed by Melchert, et.al. (1996) was used to measure counselors' confidence in their counseling ability. A demographic form is also included to gather information on supervisee's highest degree obtained, recovery status of both the addictions treatment professional and of their supervisor, gender, ethnicity, case load, years of experience in the addictions treatment field, frequency of supervision (both currently receiving and ideally would like to receive), and type of supervision received. The survey was hand carried to several Community Service Boards (CSB) in Northern Virginia.

The Supervision Outcome Questionnaire (SOQ) is based on the work of Worthington and Roehlke (1979). It consists of three questions measuring satisfaction with supervision, supervisor competence, and contribution of supervision to improved counseling. The Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984) was used to measure the supervisor's style, defined as the manner in which a supervisor approaches and responds to counselors and how she or he implements supervision within the supervisory relationship (Holloway & Wolleat, 1981). The SSI is a 33-item measure of

the degree to which a supervisor or supervisee endorses behaviors that represent each of the three factorially derived dimensions of supervisory style: Attractiveness (friendly, flexible, supportive, open, positive, warm; 7 items), the Interpersonally Sensitive (perceptive, committed, intuitive, reflective, creative, resourceful, invested, therapeutic; 8 items), and Task-Oriented (goal-oriented, concrete, explicit, practical, structured, evaluative, prescriptive, didactic, thorough, focused; 10 items). The Counselor Self-Efficacy Scale (COSES) is based on the work of Melchert, et. al. (1996). It consists of 20 items indicating the degree of agreement regarding the respondent's *confidence* in their counseling abilities.

Definitions of Terms

The following terms have been defined relative to the context of this study:

Addiction Treatment Professional

The NAADAC, The Association of Addiction Professionals, (previously known as National Association of Alcohol and Drug Abuse Counselors) (1995) defines the 'professional alcoholism and drug abuse counselor' or addictions treatment professional as "professionals dedicated to the treatment of alcohol and drug dependent clients and their families..." (p. 1).

Administrative Supervision

An organizational position which is responsible for time sheets, personnel management, administration of leave and sick days, program management, and other business management details.

Clinical Supervision

Loganbill, Delworth and Hardy (1982) define clinical supervision as "...an intensive, interpersonally focused, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person" (p. 4). Bernard and Goodyear (1998) also offered the following definition of clinical supervision, "This relationship is evaluative, extends over time, and has the simultaneous purposes of enhancing the professional function of the more junior person(s), monitoring the quality of professional services offered to the clients...and serving as a gatekeeper of those who are to enter the particular profession" (p. 6).

For the purposes of this study, both of the previous definitions will be used to guide this study and the consequent definition is used as part of the demographic survey: one who assists the development of therapeutic competence in another person with an evaluative component to enhance their professionalism, monitor the quality of services offered to clients, and serve as a gatekeeper for the profession.

Counselor Self-Efficacy

A counselor's beliefs or judgments about his/her abilities to effectively counsel a client in the near future (Larson & Daniels, 1998). Counselor self-effectiveness has been shown to relate to counselor performance, counselor anxiety, and the supervision environment (e.g., Friedlander, 1986; Larson, et. al., 1992).

Supervisee

One who is in a supervisory relationship with another person.

Supervision Effectiveness

Ronnestad and Skovholt (1993) concluded that there was reasonable validity to the perspective that what is good supervision depends on the developmental level of the

supervisee. Supervisors of beginning supervisees should provide high levels of encouragement, support, feedback, and structure. The relationship with advanced supervisees is typically more complex since these supervisees tend to vacillate between feeling professionally insecure and professionally competent. The supervisor should take responsibility for creating, maintaining, and monitoring the relationship which serves to provide structure and a mediating role while supervisees are in turmoil. Thus, supervisors of experienced supervisees serve in a well-defined role of patient teacher with an emphasis on structure and instruction (Loganbill, et. al., 1982). As supervisees acquire experience, the need for instruction diminishes and it is the supervisory relationship which provides a supportive context as advanced supervisees assess and reassess their professional competencies and personal qualifications.

Supervision Outcome

Since there is no clear definition from the literature, supervision outcome can be defined by delineating the characteristics, roles, and labels given to effective supervision and thereby, to supervision outcomes. Characteristics of effective supervision outcome are provided by Bradley and Ladany (2001). They include self-reflection and self-monitoring of the interpersonal process associated with the supervisor-supervisee interactions, along with the ability to move between identifying with and observing the experiences of both the supervisee and the clients. When supervisees have been surveyed to indicate the characteristics of effective supervisors, they include expertise, trustworthiness, interpersonal attractiveness, tolerance of supervisee mistakes in an atmosphere of safety, openness to feedback about their own style of relating, and a significant investment of time (White & Russell, 1995). This should also include

increasing counselor self-efficacy as supervisees' accurate self-evaluation of work with clients has been identified as an important outcome of successful clinical supervision (Steward, et al., 2001).

Supervisory Relationship

The definition of a supervisory relationship that will be used for the context of this research is from Dye (1994) and states that the supervisory relationship is a reference to the manner in which supervisee and supervisor are connected as they work together to meet goals. Some of these goals are common across supervisory relationships and some goals are idiosyncratic. There has been some discussion of the working alliance and this is not technically different from the supervisory relationship in the context of this paper. Bordin (1979) suggested that the working alliance is a collaboration to change and is common across all techniques of therapy and thus supervision. The three elements composing this collaboration include the bond between the individuals involved, the extent to which they agree on goals, and the extent to which they agree on tasks. Chen and Bernstein (2000) broke supervision down into both a process and a relationship much like Loganbill, et. al., (1982) who noted two perspectives of the supervisory relationship. As a process, supervision, is concerned with the interaction of supervision participants, who reciprocally negotiate, shape and define the nature of their relationship. As a relationship, supervision functions as the context within which the supervisor-supervisee interactions unfold. The emphasis of supervision is on a purposeful, task-oriented learning process within the bidirectional nature of the supervision relationship (Efstation, Patton, and Kardash, 1990). That is, the relationship moves both upwards (e.g., supervisee to supervisor) and downwards (e.g., supervisor to supervisee) and is based on

mutual influence. This mutual influence broadens the perspective of power even though the supervisor continues to have greater possibility to influence the supervisee (Bernard & Goodyear, 1992). Another factor effecting this two-way interaction is the supervisee's belief or judgment about their own abilities (Larson & Daniels, 1998).

Supervisory Style

Supervisory style as defined by Friedlander and Ward (1984), is the different approaches that supervisors use, in combination with their distinctive manner of responding to supervisees and includes the following factors: attractiveness, interpersonally sensitive, and task orientation. Supervisory style also refers to the supervisor's distinctive manner of approaching and responding to supervisees and of implementing supervision (Friedlander & Ward, 1984). Steward, Breland, and Neil (2001) further defined supervisory style as the manner through which supervisors exhibit attractiveness, task orientation, and interpersonal sensitivity within the supervisory dyad.

Techniques of Supervision

Behaviors that accomplish the work of supervision. There are three general functions of supervision techniques (Borders, et. al., 1991): assessing the learning needs of the supervisee; changing, shaping, or supporting the supervisee's behavior; and evaluating the performance of the supervisee. The majority of the supervision application falls into the second function while the other functions are constantly being monitored. Although techniques of supervision are often associated with a particular degree of structure, it is the supervisor's use of the technique that will determine the level of structure (Rigazio-Digilio & Anderson, 1994)

CHAPTER TWO

REVIEW OF THE LITERATURE

INTRODUCTION

This chapter will provide an overview of the literature in the counseling supervision field, as well as in ancillary fields applicable to counseling and that is relevant to the supervision of addictions treatment professionals. The chapter will begin with a definition of supervision, including supervision in the addictions treatment field. A discussion of the types of supervision including individual, group and peer will follow. Then, techniques used in supervision will be addressed. Models of supervision will ensue and will include several models as well as an addictions treatment model. After that, the mechanisms of supervision will be discussed, followed by supervision effectiveness. The supervisory relationship with special attention to the supervisory relationship within addictions treatment will then be addressed. And finally, a review of the literature pertaining to supervisory styles and supervision outcomes will take place. Factors unique to supervision of addictions treatment professionals will be discussed throughout this review as part of each relevant section.

Definition of Supervision

Although supervision is a term known to most counseling professionals, its precise meaning is elusive and difficult to define (Chen & Bernstein, 2000). The American Heritage Dictionary of the English Language (1992) described supervision as directing and inspecting (work or workers or the operation of an organization). Confusion regarding the meaning of supervision results from different uses of the term in different settings such as schools, hospitals, community agencies (Valle, 1984). For example, supervision in schools might be more administrative in nature while in

hospitals, the supervision might include more focus on the medical model. The focus here will be on clinical supervision to distinguish it from other types of supervision even though the literature doesn't often make such distinctions. Loganbill, Delworth and Hardy (1982) define clinical supervision as "an intensive, interpersonally focused, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person" (p. 4). Clarification of this definition incorporates three essential components. First, the phrase "one-to-one" identifies with the belief that supervision requires highly individualized, personal attention designed around the unique personal and professional traits of the supervisee. Second, since counseling is essentially an interpersonal process, so too, should supervision. In other words, the relationship between the supervisor and supervisee is central. Finally, administrative authority must be held by someone who is responsible and can hold the supervisee accountable. If this power dynamic is not part of the process, then the interaction cannot be called supervision.

Those who perform supervision are necessarily in contact with those whom they supervise and, therefore, some sort of relationship exists (Dye, 1994). In its broadest sense of the term, relationship merely refers to the manner in which supervisor and counselor are connected and interact as they work together to meet their goals, some of which are common and some of which are idiosyncratic. Part of the meaning of clinical supervision implies a superior-subordinate relationship as defined by one's position in an organizational structure (Kutzik, 1977). Another meaning of supervision implies an equalitarian relationship where advice is sought and the decision to accept or reject advice is left to the helper (Valle, 1984). Henderson (1994) states that supervisory relationships

are characterized by mutual respect, two-way interactions, and a collaborative spirit. This relationship between supervisor and supervisee also mirrors the counseling relationship in certain aspects. This has been termed “parallel process” and refers to the dynamics in the supervisory relationship that replicate those experienced by the supervisee in the clinical counseling relationship (Durham, 2002). The value of recognizing such parallels is the potential insight the supervisee gains by becoming aware of how he or she is expressing the client’s problem in supervision. This parallel process must be worked through or both the supervisory and the therapeutic relationship will suffer (Sumerel, 1994). However, the supervisory relationship is still more important than techniques, knowledge, and the training of the supervisor or of the supervisee (Sternbach, 1993). Finally, the relationship between supervisor and supervisee must reflect an adherence to ethical guidelines. Ladany, et. al (1999) found that supervisees who report that their supervisors exhibited a greater obedience to supervisor ethical guidelines indicate a stronger supervisory relationship. Thus, the supervisory relationship, whether egalitarian or superior-subordinate, is an integral part of the definition of supervision.

Some definitions (e.g., Kutzik, 1977; Powell, 1993; and Valle, 1984) regard supervision as focusing primarily on issues regarding the efficient management of responsibilities, while others view the process as enabling the supervisee to be more effective in the performance of duties. Worthington (1987) regards the process of supervision as a slow shift of focus from the supervisee learning the theory of the supervisor to the supervisor adapting his or her methods to work within the theoretical framework of the supervisee. This shift slowly occurs as supervision progresses and the supervisee gains experience. According to another definition of supervision (Bradley &

Gould, 1994), there is the supervisee's acquisition of professional role identity through the modeling of the supervisor and the supervisor's evaluation of the supervisee's performance. The definition of supervision also incorporates four basic functions or foci of the supervisory process (Loganbill, Delworth and Hardy, 1982): monitoring client welfare, enhancing growth within stages, promoting transition from stage to stage, and evaluating the supervisee. Monitoring client welfare refers to the fact that this must be the primary ethical responsibility of the supervisor. In cases where the primary function of the client's welfare conflicts with an intervention that would be most beneficial to the learning of the supervisee, the client's welfare must come first and it is up to the supervisor to continuously monitor the client's welfare.

Supervision can also be viewed as a highly structured process with roles and expectations clearly defined, or as an experiential process (Valle, 1984). Worthington (1987) describes the process as being either proactive or reactive. When the process is proactive, the agenda is clearly planned with goals clearly identified, and interventions are usually initiated by the supervisor. If the process is reactive, then the goals are still identified but the supervisor awaits critical incidents and intervenes when those incidents arise without initiating his or her agenda. Worthington (1987) also discusses whether or not the process may change as supervisee's gain experience. Changes will occur, but the nature of the change depends on whether the supervisor believes in a content-specific or process-specific theory of supervision. The process of change can be enhanced by the help of a guide who facilitates the relationship within the context of a learning environment that is individualized to fit the unique needs of each supervisee (Durham, 2001).

One of the major differences between counseling and supervision is the evaluative aspect of supervision (Bernard, 1979; Bernard & Goodyear, 1992; Dye & Borders, 1990; Loganbill, Delworth and Hardy, 1982). The supervisee is, by definition, practicing counseling under the direction and inspection of someone with greater qualifications. This aspect is the defining difference between counseling and supervision of counseling/clinical supervision.

Evaluation of the supervisee is the distinguishing component of supervision (Loganbill, Delworth and Hardy, 1982). The authoritative nature of supervision is in that one person of the pair who holds the other accountable for his/her actions. This is one of the main aspects marking the supervisory relationship as different from the therapeutic one. This evaluation may be directed primarily to outside sources and often includes technical components. The supervisor may need to assign a letter grade, may need to recommend to a licensure board, or may need to report to administrators. This is quite different from providing the supervisee feedback within a supervisory session. Feedback is chosen for its facilitative value to the supervisee while an evaluation may also include more difficult information.

Loganbill, Delworth and Hardy (1982) also point out that this function may be working in opposition to enhancing supervisee's growth within stages and transitioning supervisees from stage to stage since it is more judgmental in nature rather than growth enhancing. There are several ways that supervisors try to deal with this dilemma, from denying the evaluation's reality to discussing it only when forced to. An alternative is to encourage an ongoing dialogue involving the effects of the evaluation upon the relationship in order to continuously monitor for its effects on the relationship.

Consultation may also be easily confused with supervision (Benshoff, 1994). As a matter of fact, the term “peer consultation” is often used interchangeably with the term “peer supervision” while “case consultation” is often used instead of the term “supervision.” Consultation is different from supervision in that it offers only information or advice to another without providing guidance for growth. Consultation also does not take into account the primary concern of supervision: the client (Benshoff, 1994). Therefore, peer consultation and peer supervision, though they share the same non-hierarchical ideals, are not necessarily the same. Also, case consultation, as a form of supervision is not strictly a model. It will, however, be discussed as an option frequently employed by supervisees using supervision as a means toward licensure.

Supervision in Addictions Treatment

To date, there has been little research into supervision process or the supervisory relationship in the addictions treatment field (Culbreth & Borders, 1999). With virtually no empirical studies to date, a significant lack of support or direction has resulted (Juhnke & Culbreth, 1994). A few articles do, however, delineate supervision within the addictions treatment field separately from supervision in the general mental health field. (e.g., Allen, Szollos, & Williams, 1986; Bernard & Goodyear, 1992; Culbreth & Borders, 1997, 1999; Culbreth, 1999; Powell, 1991, 1993). For instance, Valle (1984) notes that supervision in alcoholism treatment facilities reflects the diverse experience and training of both the counselor and supervisor. However, he then goes on to state the three components included in all types of supervision (managerial, educational, and clinical) without distinguishing it from any other type of supervision in the mental health field. Culbreth (1999) also notes that the recovery status and educational level of counselors

and supervisors in the addictions treatment field influences supervisory practices. Again, he does not elaborate on how this happens.

Some resources note issues other than the supervisory relationship that are believed to be important with addictions treatment counselors in particular. These include desired personality characteristics of clinical supervisors (Powell, 1991), clinical responsibilities of the addictions treatment supervisor (Machell, 1987), and specific supervision techniques for working with addictions treatment counselors (Valle, 1984).

First, clinical supervisors in addictions treatment do share common personality characteristics (Powell, 1991). These include emphasis on cooperating with others to carry out tasks (being good team players) and bringing others into alliance to accomplish results. Though these characteristics were found to be common by Powell (1991), there was no subsequent empirical support showing their importance in supervising addictions treatment counselors.

It was suggested by Machell (1987) that professionals promoted into a supervisory capacity do not always realize their new obligations. Thus, the hypothesis goes, some supervisory responsibilities are neglected while the supervisor remains client oriented rather than organization oriented. There was no empirical support found to suggest the clinical responsibilities of the addictions treatment supervisor impair clinical supervision.

Finally, specific supervision techniques for working with addictions treatment counselors were suggested by Valle (1984). However, when looking critically at the descriptions of supervision methods provided, no significant difference was noted between clinical supervision for the general mental health field and addictions treatment. In other words, the suggested supervision processes for addictions treatment counselors

were not significantly different from those of other mental health practitioners. It is therefore concluded that the supervisory relationship is of primary importance when looking at supervision outcome in the addictions treatment field. The supervisory relationship will be considered following a discussion of the types, techniques, and models of supervision.

Types of Supervision

Individual Supervision

Though little has been written strictly about individual supervision, it is still considered the cornerstone of professional development (Bernard & Goodyear, 1998). Most articles assume that the supervision they are discussing regards individual supervision unless otherwise stated. Both group and peer supervision are specialized forms of supervision which will be discussed later. Techniques of supervision (e.g., IPR, SAS, etc.) should not be confused with types of supervision (e.g., individual, group, etc.) and they will be discussed separately.

Although most supervisees will experience some form of group supervision in their training and will have the opportunity to experience some form of peer supervision, virtually all supervisees will experience individual supervision sessions (Bernard & Goodyear, 1998). Whether these individual sessions will produce insights that will linger long enough into the supervisees' career or will frustrate or bore them has something to do with the supervisor's skill in choosing and using a variety of supervision methods or techniques which will be discussed later in this section. There are many different techniques from which a supervisor can choose to use when conducting an individual session.

One general task of supervision is simultaneously both supporting and challenging the supervisee. Blocher (1983) argued that effective supervision will offer a balance of both support and challenge. Challenge can have several forms, including confrontation as well as the encouragement to stretch and try new behaviors. Support also has several forms including encouragement and feedback. The difficulty lies in providing enough challenge to move the supervisee forward without overwhelming him/her. Another difficulty lies in providing enough support to the supervisee so that he/she can meet the presented challenges without overindulging the supervisee or conveying the belief that they are too fragile or inept to handle the work. To offer this balance of challenge and support is an ongoing task of supervisors (Bernard & Goodyear, 1998). Its particular form will change as the supervisee develops. If the supervisor successfully models a balanced delivery of challenge and support, the supervisee will adopt and respond to these effective norms.

Finally, the supervisor's conceptual model will affect the form that both the challenge and support take in supervision (Bernard & Goodyear, 1998). Another factor affecting the form of challenge and support given in supervision will be the supervisee's developmental stage. For example, as supervisees gain experience, the need for instruction diminishes and it is the supervisory relationship which provides greater supportive context as advanced supervisees assess and reassess their professional competencies and personal qualifications (Loganbill, et. al., 1982).

One study found that understanding the supervisee's behavior in supervision can have psychodynamic overtones (Cooper & Gustafson, 1985). Supervisees may have adopted patterns of interaction from earlier family interactions and transferred them to the

supervision experience. The quality and form of at least some of their behavior might be understood as responses that occur outside their awareness. These include difficulties in handing inordinate authority over oneself to the supervisor out of unconscious respect for one's parents. This speaks of old family loyalties. Old family sacrifices also affect interactions and may, for example, cause a supervisee to react negatively to feedback of a personal nature that comes from an authority figure due to the supervisee's suffering from humiliation in their family of origin.

Although techniques of supervision are often associated with a particular degree of structure, it is the supervisor's use of the technique that will determine the level of structure (Rigazio-Digilio & Anderson, 1994). For example, individual supervision based on audiotape may be directed by the supervisor and follow the supervisor's instructional agenda or the use of audiotape may be requested by the supervisee to reflect on the moment in a counseling session that had special meaning for the supervisee. Structured supervision sessions are supervisor directed and involve a reasonably high amount of supervision activity (Bernard & Goodyear, 1998). Unstructured interventions may be supervisor or supervisee directed and require more discipline on the part of the supervisor to allow learning to take place without directing it. The great majority of supervisees will benefit from both types of interventions at different stages in their professional development.

Another area considered by researchers is that of social learning theory and its interface with supervision (Cobia & Pipes, 2002). Of course, the broader area of learning itself has applicability to supervision in general in that any opportunity for learning is by definition a context for seeing learning in action. Supervision has been directly linked to

social learning theory by Hosford and Barmann (1983). The social context of learning is common across all theories of social learning and is the cornerstone for how supervision is then affected. Social learning theory has focused on many constructs including, but not limited to, behavioral capability (knowledge and skill necessary to perform a behavior, implies skills training as appropriate process to enable learning to take place), expectancies (values placed on a given outcome), observational learning (modeling), and emotional coping responses (Cobia & Pipes, 2002).

From the context of social learning theory, this behavioral capability implies that skills training, directed by the supervisor, is appropriate to supervision. Supervisee expectancies are clearly an important area of supervision in valuing a certain kind of outcome. Observational learning is also an important element in many supervision sessions. Bandura's work (1977) highlighted the role of models (observational learning) in the transmission of behavior. Supervisors verbally model, through information sharing, what they would do if they were involved in the counseling circumstances being discussed. They also model ethical behavior in the context of the supervisory relationship and actively engage in ethical decision-making when the need arises, to the extent that supervisors assist supervisees in problem solving and stress management regarding emotionally charged situations, the constructs of social learning theory are being used to create planned interventions (Cobia & Pipes, 2002).

In summary, social learning theory offers a set of constructs that seem to specifically address the processes used in supervision. In particular, the role of the supervisor is highlighted in the learning process and the learning that is assumed to take place is embedded in a social context.

Group Supervision

There are three major approaches to the use of groups in supervision: group supervision, peer group supervision, and the peer consultation team (Richard & Rodway, 1992). Group supervision was seen by Kadushin (1985) as the use of a group by the supervisor to implement responsibilities for education, support, and administration. The focus here will be on the clinical aspects of group supervision. The goals of increasing autonomy and fostering personal growth are emphasized (Loganbill, Hardy, & Delworth, 1982).

Holloway and Johnston (1985) defined group supervision as a process in which supervisors oversee a supervisee's professional development in a group of peers. Group supervision can also include the fact that it is a regular meeting of a group of supervisees with a designated supervisor (Bernard & Goodyear, 1998). Their purpose is to further their understanding of themselves as clinicians, of the clients with whom they work, and/or of service delivery in general. The supervisees are assisted in this endeavor by their interaction with each other in the context of the group process. There has been no research on the best size of a supervision group, however (Bernard & Goodyear, 1998).

Group supervision is unique in that growth is aided by the interactions occurring between group members (Werstlein, 1994). Counselors do not function in isolation, so the group becomes a natural format to accomplish professional socialization and to increase learning in a setting that allows an experience to touch many members. Supervision in groups provides an opportunity for counselors to experience mutual support, share common experiences, solve complex tasks, learn new behaviors, participate in skills training, increase interpersonal competencies, and increase insight

(MacKenzie, 1990). The supervision process assists students in self-discovery, critically evaluating their own work, and assists supervisees in effective use of techniques used in therapy (Loganbill, Hardy, & Delworth, 1982).

Collaborative learning may be a pivotal benefit according to another author (Hillerband, 1989), with the supervisees having opportunities to be exposed to a variety of cases, interventions, and approaches to problem solving in a group . By viewing and being viewed, actively giving and receiving feedback, the supervisee's opportunities for experimental learning are expanded; this characterizes group supervision as a social modeling experience. From a relational perspective, group supervision provides an atmosphere in which the supervisee learns to interact with peers in a way that encourages personal responsibility and increases mutuality between supervisee and supervisor.

Groups allow members to be exposed to the cognitive processes of other counselors at various levels of development, according to Hillerband (1989). This exposure is important for the supervisee who learns by observing as well as speaking. Finally, hearing the success and the frustrations of other counselors gives the supervisee a more realistic model by which they can critique themselves and build confidence (Werstlein, 1994).

Advantages of group supervision frequently suggested and delineated in the literature are discussed here (Bernard & Goodyear, 1998; Carroll, 1996; Riva & Cornish, 1995). They include economy of time, money, and expertise since one supervisor can provide supervision for several supervisees in the same amount of time as an individual supervision session and for relatively the same cost. There is minimized supervisee dependence. In other words, hierarchical issues between supervisor and supervisee are

diminished by encouraging more input from other supervisees in case analysis. Also, opportunities for vicarious learning are plentiful and include personal learning as well as normalizing feelings, etc. The supervisee is exposed to a broader range of clients and the feedback for the supervisee in greater quantity and diversity with a variety of perspectives from group supervision not possible with only one supervisor. Not only is the quantity of supervision greater, but feedback for the supervisee is of greater quality. When someone becomes an expert in their domain, they are less likely to be able to describe, in layman's terms, the actual cognitive processes. So, other supervisees may be better able to explain what the supervisor meant. Another advantage is seeing a more comprehensive picture of the supervisee; seeing the supervisee in different roles gives a broader picture of him or her. The facilitated risk taking with the group interaction may encourage relatively increased risk taking. Here, the supervisor must ensure it is not beyond the capabilities of the supervisees. There is also greater opportunity to use action techniques. And, the final advantage is the ability to mirror the supervisees' intervention (this is specific to supervision of group therapists) which is a type of parallel process.

Though these advantages of group supervision are many, there are also several limitations to be noted. These include the following five suggestions (Carroll, 1996):

1. The group format may not allow individuals to get what they need—if supervisees are carrying a heavy caseload they may not get the supervision time they need, if a group is heterogeneous in skill level the more skilled practitioners may not get what they need, the learning may be too diffuse to be worthwhile, there may a distinct minority that is offered virtually nothing by this structure.

2. Confidentiality concerns—these concerns are not only about the clients who are the focus of supervision but also for the supervisees.
3. The group format is not similar to individual counseling—parallel process may not be as obvious in this format.
4. Certain group phenomena can impede learning—competition and scape-goating, for example need to be carefully monitored by the supervisor.
5. The group may focus too much time on issues not of particular relevance to or interest for the other group members—again, something for the supervisor to be watchful.

Some interpersonal processes that occur during group supervision that must also be carefully monitored include competition among supervisees and support from the group (Bernard & Goodyear, 1998). Some competition between supervisees is inevitable. It can even be useful to stimulate group members into stretching beyond their comfort zones. However, the supervisor must be vigilant to channel that competition and acknowledge that it exists so that it can be put into the proper perspective. Group cohesiveness must also be fostered to provide support for the individual supervisee. Yalom (1985) suggested that this cohesiveness is the group equivalent of empathy.

Though there are several models of group supervision, ranging from Bernard and Goodyear (1992) to Borders (1991), there are many similarities. However, there are no articles describing a group supervision model that accounts for the relationship between the levels of mastery of relevant counseling behaviors by both the supervisee and supervisor, individual and developmental characteristics of the supervisee and supervisor, and the sequence of concerns in group development (Bradley & Ladany, 2001). With that

said, Bernard and Goodyear (1992) summarized the typical foci of group supervision: didactic presentations, case conceptualization, individual development, group development, organization issues, and supervisee/supervisor issues. Models for conducting group supervision detail experiential affective approaches designed to increase the supervisee's self-concept and ability to relate to others, and/or cognitively focused activities, such as presenting cases which broadens the supervisees ability to conceptualize and problem-solve. While the literature provides information on how to conduct these activities, less obvious are the reasons why certain activities are selected and when the activities are most appropriate to use.

Groups of all types have relatively predictable stages through which they move (Tuckman & Jensen, 1977). These authors have developed a widely recognized model of group development. This model suggests that groups move through five stages, each with characteristic goals for the members:

1. Forming—members work together to become comfortable with one another;
2. Storming—members work together to resolve issues of power;
3. Norming—members work to set norms for within-group behavior;
4. Performing—this is the stage at which members tackle work-related tasks, it is the group's most productive stage; and
5. Adjourning—members work to say good bye to one another.

Borders (1991) offers a model that details suggested activities with the reasons for using them. Groups may be used to increase feedback among peers through a structured format and assignment of roles while reviewing tapes of counseling sessions. "Role-

taking” encourages supervisees to assume more responsibility in the group as feedback is offered from several viewpoints.

The group supervision format requires that supervisors be prepared to use their knowledge of group process (Werstlein, 1994). Group supervision is based on the recognition of parallel processes in supervision and therapy as well as influences that the supervisory relationship can have on the therapeutic relationship has long been recognized (cf., Bernard, 1979; Bernard & Goodyear, 1992; Borders, et. al., 1991; Juhnke & Culbreth, 1994; Leddick 1994; Valle, 1994). The purpose of supervision is to provide a learning experience in a safe environment which allows examination of therapeutic relationships (Steadman & Harper, 1995). The supervision process builds on itself and learning is cumulative; it implies an ongoing relationship that uses different instructive and consultative methods to inform the work of the group therapist by examining a group event (Ettin, 1995). There are various levels of the supervisory process (Steadman & Harper, 1995). At the level of the therapeutic system, the focus needs to be on the content of what happened in the therapy session, the interventions used by the therapist, and the process of the therapeutic group. At the level of the supervision system, the focus needs to be on the therapist’s countertransference to the client, how the supervision group parallels the client group, and the countertransference of the supervisors. The focus changes depending on which level of interaction and which components will serve to shed the most light on the presenting problem.

One of the purposes of supervision is to provide therapists an opportunity to share and explore what happened in the therapy group session (Steadman & Harper, 1995). As such, Ettin (1995) describes the process as beginning with a structured description of the

group being presented and a formulation of an initial question, a primary process enhancement phase wherein members of the supervision group respond freely to what they have heard and experienced (without offering advice or diagnoses), a reassociation phase where the presenter reacts to the supervisory group's input by sharing associations and adding any other pertinent information or addressing questions that have arisen during the group's brainstorming, and finally, a dynamic formulation and intervention strategy phase where the group impasse is reconsidered in light of the parallel process, mirroring responses, subjective and objective countertransference reactions and projective identifications which were uncovered by the supervision group members. The result of this process accounts for what happened in the group and gives the supervisee an opportunity to reflect.

Other goals of supervision include the mastery of theoretical concepts, skill development, personal growth, and the integration of the supervisee's knowledge, skills, and attitudes as effective counseling tools (Bradley & Ladany, 2001). Mastery of theoretical concepts is most often met through some academic component and is usually not a major goal of supervision. The exception is, of course, in the addictions treatment field where there are many paraprofessionals in the role of therapist. This will be addressed further in later sections. Secondly, skill development is the most frequent goal for supervision. The group format provides a forum for supervisees to develop their counseling skills through analysis and practice of the individual skills. However, when group supervision is used to address individual concerns one at a time, the unique characteristics of the group setting are not utilized (Wilbur, et. al., 1991). Thirdly, the goal of personal growth, though not empirically shown to improve the efficacy in

supervisees' functioning, group supervision retains some of this early emphasis on the facilitator role in supervision (Holloway & Johnson, 1985). Finally, skill integration may be the most important goal of supervision (Bradley & Ladany, 2001). The experience within a group, of situations illustrative of actual psychodynamic as well as group dynamic issues, helps supervisees to make important connections between their academic knowledge and clinical practice. Group members promote each others' learning by modeling, by offering explanations of information processing, and through increasing each others' motivation. This is an example of how peers influence each other in positive ways. More of peer supervision will be explored in the next section.

Peer Supervision

Arrangements in which peers work together for mutual benefit are referred to as peer supervision (Benshoff, 1994). Peer consultation may, however, be the more appropriate term to describe a process in which critical and supportive feedback is emphasized while evaluation is de-emphasized (Bernard & Goodyear, 1992). However, the terms peer supervision and peer consultation can be used interchangeably and often are used to describe similar nonhierarchical relationships in which participants have neither the power nor the purpose to evaluate one another's performance.

The basic premise underlying peer consultation is that individuals who have been trained in basic helping skills can use these same skills to help each other function more effectively in their professional roles. Peer consultation experiences can offer a number of benefits to counselors (Benshoff & Paisley, 1993), including:

- decreased dependency on "expert" supervisors and greater interdependence of colleagues;

- increased responsibility of counselors for assessing their own skills and those of peers and for structuring their own growth;
- increased self-confidence, self-direction, and independence;
- development of consultation and supervision skills;
- use of peers as models;
- ability to choose peer consultant; and
- lack of evaluation.

In contrast to traditional models of counseling supervision, the emphasis in peer consultation is on helping each other to reach self-determined goals rather than on evaluating each other's counseling performance (Benshoff, 1994). In other words, each individual sets their own goals rather than setting them with group or supervisor direction. This lack of evaluation and the egalitarian, nonhierarchical relationship that is created between peer consultants offers opportunities for different types of experiences than may be had with designated supervisors. Peer consultants must assume greater responsibility for providing critical feedback, challenge, and support to a chosen colleague. In so doing, however, they also must assume greater responsibility for examining and evaluating their own counseling performance (Benshoff, 1994). Often, there is a greater sense of empowerment stemming from setting one's own goals, making the process of peer consultation work, and finding structure and direction for themselves within the framework of the model (Benshoff & Paisley, 1993).

Another barrier to understanding and differentiating peer supervision from the myriad other types of supervision has been that researchers and scholars often have confounded supervision with training (Goodyear & Bernard, 1998). Neither of the two ways that mental health or addiction treatment professionals use the term "training" is consistent with the usual understanding of the meaning of supervision. The first and perhaps more common way of understanding training concerns an intervention that is

more limited in scope and focus (e.g., on such specific skills as how to offer restatements of client affect) than supervision. Also, supervision requires direct client contact, whereas training does not (Lambert & Ogles, 1997).

Though sparsely investigated or discussed in the literature, peer supervision is often found in clinical work and one of the types of supervision being investigated by this study. Peer supervision has been described as one therapist supervising another therapist (Lewis, 1988). However, neither is designated as the supervisor and each therapist is on the same hierarchical level. Such contacts occur frequently in public agencies. Peer supervision has also been defined as a process in which therapists become more effective and skillful helpers by using their relationships and professional skills with each other (Wagner & Smith, 1979). Additionally, it can be defined as one-to-one or group supervision among and led by peers (Hawkins & Shohet, 1996). The practice of peer supervision is neither hierarchical nor does it include a formal evaluation and may, therefore, be considered to be more like consultation rather than supervision (Bernard & Goodyear, 1998). Various, structured peer group supervision has been defined as a supervisor meeting with a small group of supervisees according to a structured group format in which the supervisees help each other and are helped by the group leader (Starling & Parker, 2000). However, since this type of supervision is closer to group supervision than peer supervision in its strictest sense and will, therefore, not be discussed here. However, if certain conditions are met, true peer supervision can be very useful (Lewis, 1988). The first of these conditions is limiting the use of peer supervision since other forms of supervision should receive priority. It is also important that peer supervision be defined differently and that certain limitations be set regarding how it is

conducted. These limitations would be unique to each agency but might include making clear that the session and case are the responsibility of the initiating therapist/supervisee, having peer supervision as “one shot” contacts, etc.

After meeting one’s profession’s designated criteria for supervision, clinicians often engage in peer group supervision with several and varied motives (Lewis, Greenberg, & Hatch, 1988). Among reasons noted in this article for joining peer groups were suggestions for problem cases, discussion of ethical professional issues, countering isolation, sharing information, exploring problematic feelings and attitudes toward clients, learning and mastering therapeutic techniques, support for stress in private practice, and exposure to other theoretical approaches.

Though the reasons clinicians engage in peer supervision are many and varied, the process of peer supervision groups is more informal than other types of supervision groups (Lewis, et. al., 1988). Although leaderless by definition, peer groups have realized that ignoring the issue of leadership gives rise to competitiveness (Bernard & Goodyear, 1998). Therefore, most groups rotate the leadership role with one person directing each meeting. In addition to group leadership responsibilities, the designated leader may also handle administrative tasks for that particular meeting such as keeping notes, notifying absent members of the next meeting, etc. The process of peer group supervision also includes a plan for case presentation since typically only one or two cases can be reasonably discussed within the allotted time frame. Marks and Hixon (1986) have even gone so far as to suggest that presenters come with two or three questions about the case to direct the group’s discussion and to have a process observer for each group meeting. This person would differ from the group leader in that they are solely responsible for how

the group process went, etc. However, most of the literature on peer supervision does not mention this role.

Peer supervision is also recognized as a valuable aid to the clinical supervisor (cf., Baird, 1998; Kottler & Hazler, 1997). Peers can provide a supportive environment as well as reassurance that others are experiencing similar feelings and concerns. The following suggestions for use of peer supervision are therefore offered (Bradley & Ladany, 2001). First, peer group supervision is not a substitute for a competent supervisor. Second, peer group supervision may be helpful or harmful depending on the attitude of the peer supervisor, the format of peer supervision, and the training given in peer supervision. Third, a trained supervisor should conduct peer group supervision sessions before allowing peers to supervise each other. This type of modeling can serve several valuable lessons. Fourth, peer supervision has its limits and supervisees with serious skill deficiencies and those who are extremely defensive are not good candidates for peer supervision. Finally, the expertise of a trained supervisor is necessary for supervisees to learn when and where advanced skills are required for counseling. Therefore, this type of supervision should only be used as an adjunct not primary means of supervision. Chaiklin and Munson (1983) offered two conditions that must exist if the process of peer supervision is to be successful. First, a sincere desire to improve one's clinical skills must be the primary condition. The second major condition must be administrative backing for clinicians in a mental health setting.

Starling and Baker (2000) conducted a qualitative study using only four participants and looking at peer group supervision. Though flawed for several reasons including homogeneity of participants, small number of participants, and the confounding

variable of individual supervision that study participants received at the same time of this study, there is still some value in looking at the results. The results included four general themes that emerged from the analysis of interviews. The first theme was a decrease in confusion and anxiety during the practicum experience. Another theme was that supervisees' goals became clearer. Third, supervisees experienced increased confidence. The final theme that emerged was that feedback from peers enhanced the supervision process. Other results briefly mentioned included that supervisees acquired more self-knowledge and that feedback from peers was especially important to them. These themes mirror the results of other empirical studies.

Another study looking at peer supervision among front line supervisors found similar results (Hyrkas, et. al., 2003). The major drawback of this study was that it was conducted in Finland with nurse managers. However, the procedures were well thought-out and this qualitative study used nine nurse managers in peer group supervision over a 2 year period. The study concluded that members of this peer supervision group received support from their peer group and internalized reflections which resulted in greater personal insight. Also, personal growth, finding psychological resources, and internalizing leadership characteristics were found to be areas of individual development.

Some of the advantages of peer group supervision have already been stated but include providing a supportive environment and reassurance that others are experiencing similar feeling and concerns as well as that honest and constructive feedback from peer group participants is crucial to the success of the groups (Borders, 1991). Other advantages include helping clinicians remain reflective about their work and offering clinicians options beyond their individual framework (Bernard & Goodyear, 1998).

Another advantage is that peer supervision offers the type of environment that is especially attractive to adult learners. It provides a forum for re-examination of familiar experiences (e.g., early terminations, etc.) and provides a peer review process that maintains high standards for practice, thus reducing the risk of ethical violations. These types of supervision groups provide a forum for transmitting new information, thus providing continuing education for its members as well as providing the continuity necessary for serious consultation. Peer group supervision can also provide some of the therapeutic factors often attributed to the group process including reassurance, validation, and a sense of belonging. As a result, the potential for burnout may be reduced. Clinicians may become more aware of counter-transference issues and parallel process and, because feedback is provided by peers, supervision is less likely to be compromised by conflicts with authority figures. Additional positive effects of peer group supervision include support from others, having a pool of knowledge and expertise, and a group which gives support and stimulation thus reducing isolation (Clark, et. al., 1998).

Some of the major limitations noted when members of peer supervision groups come from within-agency groups include a lack of self-disclosure and lack of trust if group members have to work with each other outside the group, an inflexible structure that cannot deal effectively with crises, and a limited amount of time for individual supervision sought by its members (Bernard & Goodyear, 1998). Other difficulties not limited to within-agency groups include competing needs of group members, difficulties in challenging each other to promote personal development and skill development, and finally, true peers are truly at the same level and there may be difficulty growing beyond that as a result (Clark, et. al., 1998). Also mentioned were the difficulties maintaining

continuity and sliding into superficiality (e.g., chat sessions). Additional pitfalls may include praising one's own superiority, intensifying powerlessness, common praising, competition, and transferred unpleasant feelings or characteristics (Hawkins & Shoet, 1996).

In contrast to traditional models of counseling supervision, the emphasis in peer consultation is on helping each other to reach self-determined goals rather than on evaluating each other's counseling performance (Benshoff, 1994). This lack of evaluation and the egalitarian, nonhierarchical relationship that is created between peer consultants offers opportunities for different types of experiences than may be had with designated supervisors. Peer consultants must assume greater responsibility for providing critical feedback, challenge, and support to a chosen colleague. In so doing, however, they also must assume greater responsibility for examining and evaluating their own counseling performance (Benshoff, 1994). Often, there is a greater sense of empowerment stemming from setting one's own goals, making the process of peer consultation work, and finding structure and direction for themselves within the framework of the model (Benshoff & Paisley, 1993).

TECHNIQUES USED IN SUPERVISION

Both rational and irrational factors will influence a supervisor's initial choice of technique. Borders and Leddick (1987) listed six different reasons for choosing different supervision techniques including the supervisee's learning goals, the supervisee's experience level and developmental issues, the supervisee's learning style, the supervisor's goal for the supervisee, the supervisor's theoretical orientation, and the supervisee's own goals for the supervision sessions. Supervision methods will need to

take into account the supervisee's stated goals and known supervision needs, as well as how far along they are developmentally. Supervision methods will reflect the supervisor's vision of supervision more than the supervisee's (Bernard & Goodyear, 1998). The issue of vision, therefore, deserves some attention before describing the unique supervision techniques.

The perception of supervision is generally held to mean the convictions of held by the supervisor about how supervisees become competent practitioners (Bernard & Goodyear, 1998). Regardless of its origin or validity, the supervisor's vision will inspire the process of supervision. The supervisor may or may not be aware of having a vision of supervision, but this vision will greatly influence the selection of models and techniques that derive from them. These techniques must be malleable and conducive to reaching a variety of supervision goals.

There are three general functions of supervision techniques (Borders, et. al., 1991): assessing the learning needs of the supervisee; changing, shaping, or supporting the supervisee's behavior; and evaluating the performance of the supervisee. The majority of the supervision application falls into the second function while the other functions are constantly being monitored.

One issue intrinsic to all supervision situations is the challenge to think like a supervisor (Borders, 1992). Seasoned practitioners tend to continue to look at therapy issues, thus focusing on client issues rather than the learning and developmental needs of their supervisees. Some aids suggested by Borders include analyzing a supervision session to look at the relative amount of time spent on client issues versus the time spent on supervisee behaviors. Other aids include planning for supervision by considering

learning goals for supervisees, writing case notes on supervision sessions that focus on supervisory goals and outcomes, and asking for feedback from supervisees to make certain that their supervision needs are being met. Another aid may also be for supervisors to keep in mind the supervisor intentions: assess, educate, support (Strozier, Kivlighan, and Thoreson, 1993). These intentions clearly focus on the supervision relationship and may assist in keeping the supervisor focused as well as provide a means to evaluate the session afterward.

Interpersonal Process Recall

Kagan (1980) introduced Interpersonal Process Recall (IPR) which empowers counselors to understand and act upon perceptions to which they may otherwise not attend. The goals of IPR are to increase counselor awareness of covert thoughts and feelings of the client and self, practice expressing covert thoughts and feelings in the here and now without negative consequences, and, thus, to deepen the counselor/client relationship (Cashwell, 1994).

IPR is built around the concept that counselors' selective perceptions of surface issues block their therapeutic efforts more than any other variable (Bernard, 1989). IPR is based on two elements of human behavior: that people need each other and that people fear each other. Kagan(1980) proposed that people can be the greatest source of joy for one another. However, because a person's earliest imprinted experiences are as a small being in a large person's world, inexplicit feelings of fear and helplessness may persist throughout one's life. These fears are most often unlabeled and not communicated. This combination of needing but fearing others results in an approach-avoidance syndrome as

persons search for a safe psychological distance from others. As a result, people often behave diplomatically (Cashwell, 1994).

Kagan (1980) believed the diplomatic behavior of counselors is expressed two ways: affecting of clinical naiveté or tuning out client messages. Affecting clinical naiveté, most often indicative of counselors who are unwilling to become involved with clients at a certain level, occurs when counselors act as if they did not understand the meaning behind client statements. Tuning out occurs most often among inexperienced counselors who are engrossed in their own thought process, trying to decide what to do next. The result is that the counselor misses messages from the client even if they are obvious to the supervisor. IPR is designed to help counselors become more attuned to the dynamics of the counselor/client relationship that they may be missing due to their tendency toward diplomatic behavior.

In IPR, the counseling session is re-experienced via videotape or audiotape in a supervision session that can be characterized by a supportive and nonthreatening environment. The supervisor functions as consultant, taking on the role of inquirer during the IPR session. Because the supervisee is considered to be the highest authority about the experiences in the counseling session, the inquirer does not attempt to teach the counselor or ask leading questions (Bernard, 1989), but rather adopts a learning-be-discovery philosophy and functions in an assertive and even confrontive, but nonjudgmental, capacity (Kagan, 1980).

The following steps are intended as a guideline for conducting a recall session: (Cashwell, 1994)

1. Review the tape (audio or video) prior to the supervision session. As it is not

typically possible to review the entire tape during the recall session it is important to preselect sections of the tape that are the most interpersonally weighted (Bernard & Goodyear, 1992). If it is not possible to preview the tape, ask the supervisee to preselect a section of tape for the recall session.

2. Introduce the recall session to the supervisee and create a nonthreatening environment, emphasizing that there is more material in any counseling session than a counselor can possibly attend to, and that the purpose of the session is to reflect on thoughts and feelings of the client and the counselor during the session that will be previewed (Cashwell, 1994).

3. Begin playing the tape; at appropriate points, either person stops the tape and asks a relevant lead (see below) to influence the discovery process. If the supervisee stops the tape, he/she will speak first about the thoughts or feelings that were occurring at the time in the counseling session. The supervisor facilitates the discovery process by asking relevant open-ended questions (see below). During this period of inquiry, attend to the supervisee's nonverbal responses and process any incongruence between nonverbal and verbal responses (Cashwell, 1994).

4. During the recall session, do not adopt a teaching style and teach the supervisee about what they could have done differently. Rather allow the supervisee to explore thoughts and feelings to some resolution (Bernard & Goodyear, 1992). This is often more difficult than it seems.

Questions can be worded to enhance the supervisees' awareness of their blind spots at their own level of capability and readiness (Borders & Leddick, 1987). To further an

understanding of the inquirer role, the following inquirer leads are provided from various sources (Bernard & Goodyear, 1992; Borders & Leddick, 1987; Cashwell, 1994; Kagan, 1980):

- What do you wish you had said to him/her?
- How do you think he/she would have reacted if you had said that?
- What would have been the risk in saying what you wanted to say?
- If you had the chance now, how might you tell him/her what you are thinking and feeling?
- Were there any other thoughts going through your mind?
- How did you want the other person to perceive you?
- Were those feelings located physically in some part of your body?
- Were you aware of any feelings? Does that feeling have a special meaning for you?
- What did you want him/her to tell you?
- What do you think he/she wanted from you?
- Did he/she remind you of anyone in your life?

IPR, then provides supervisees with a safe place to examine internal reactions through re-experiencing the encounter with the client in a process recall supervision session. It has consistently been shown as an effective medium of supervision. For instance, Kingdon (1975) found that clients of counselors being supervised with an IPR format fared better than clients of counselors supervised by other methods.

MODELS OF SUPERVISION

The systematic manner in which supervision is applied is called a “model” (Bernard and Goodyear, 1992). Several models of supervision will be discussed including the Carkhuff Supervisory Training Model, a developmental model developed by Stoltenberg and Delworth (1987), Bernard’s Discrimination Model (Bernard and Goodyear, 1992), orientation-specific models (e.g., psychotherapeutic, behavioral, client-centered), System’s Approach to Supervision (Holloway, 1987), and Powell’s (1991) model specifically oriented toward supervision in addiction treatment.

Models are generally defined as approximate maps of reality (Storm & Heath, 1991). These “maps” allow complex phenomena to be simplified and understood. Models are used to fit reality in a manner which fosters action and further thought and are judged according to their usefulness. Models do have some commonalities and systematically attend to a safe supervisory relationship, task-directed structure, methods addressing a variety of learning styles, multiple supervisory roles, and communication skills enhancing listening, analyzing, and elaboration (Leddick, 1994).

Carkhuff Supervisory Training Model

The Carkhuff Supervisory Training Model combines elements of the psychotherapeutic and behavioral models. It is perhaps the most well-known and thoroughly researched model (Carkhuff, 1969; Carkhuff & Berenson, 1976, 1977). It is based on a theory of helping that involves the counselor responsive conditions of empathy, positive regard, genuineness, and concreteness, and the counselor initiative dimensions of confrontation, immediacy, as well as other action-oriented skills such as problem-solving, and program development skills. The counselor responsive dimensions guide the client through a self-exploration and self-understanding process that prepares him/her for the initiative dimensions which in turn encourage directionality and constructive action. The emphasis in supervision is on teaching counselors how to offer high levels of both responsive and action-oriented skills. This is accomplished through the use of discrimination training, communication training, and training in the development of effective courses of action. The Carkhuff Supervisory Training Model integrates experiential, didactic, and modeling methods of learning in pursuit of these goals.

Developmental Model

Developmental models of supervision, however, have the underlying notion that we are each continuously growing, in fits and starts, in growth spurt patterns (Leddick, 1994). It is typical to be continuously identifying new areas of growth in a life-long learning process. Worthington (1987) reviewed developmental supervision models and noted patterns. Studies revealed the behavior of supervisors changed as supervisees gained experience and the supervisory relationship also changed. There appeared to be a scientific basis for the developmental trends and patterns in supervision.

Stoltenberg and Delworth (1987) described a developmental model with three levels of supervisees: beginning, intermediate, and advanced. Within each level the authors noted a trend to begin in a rigid, shallow, imitative way and move toward more competence, self-assurance, and self-reliance for each level. Particular attention is paid to a) self and other awareness, b). motivation, and c) autonomy. For example, typical development in beginning supervisees would find them relatively dependent on the supervisor to diagnose clients and establish plans for therapy. Intermediate supervisees would depend on supervisors for an understanding of difficult clients, but would chafe at suggestions about others. Resistance, avoidance, or conflict is typical of this stage because supervisee self-concept is easily threatened. Advanced supervisees function independently, seek consultation when appropriate, and feel responsible for their correct and incorrect decisions. Each of the three levels include three processes: awareness, motivation, and autonomy. Stoltenberg and Delworth (1987) highlight eight areas of growth for each supervisee which include: intervention, skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences,

theoretical orientation, treatment goals and plans, and professional ethics. Helping supervisees identify their own strengths and growth areas enables them to be responsible for their life-long development as both therapists and supervisors.

Nevertheless, there is inadequacy with current developmental stage theories of supervision is that they are primarily stage theories rather than theories of how transitions take place between stages. They specify, although broadly, what the counselor and the supervisor experience and do during each stage. But how does the supervisor promote movement within a stage and between stages? Since there is currently no transition theory of counselor development it is difficult to tell.

Discrimination Model

Because many therapists view themselves as integrating several theories into a consistent practice (see, for example, Freeman, S.C., 1992), some models of supervision were designed to be employed with multiple orientations. One such “a-theoretical” model proposed by Bernard (Bernard, 1979; Bernard & Goodyear, 1992) is the discrimination model. It combines an attention to three supervisory roles with three areas of focus. Supervisors might take on a role of teacher when they directly lecture, instruct, and inform the supervisee. Supervisors may act as counselors when they assist supervisees in noting their own blind spots or the manner in which they are unconsciously hooked by a client’s issue. Then supervisors relate as colleagues during co-therapy, they might act in a consultant role. Each of the three roles is task-specific for the purpose of identifying issues in supervision. Supervisors must be sensitive toward an unethical reliance on dual relationships. For example, the purpose of adopting a counselor role during supervision is the identification of unresolved issues clouding a therapeutic

relationship (Leddick, 1994). If these issues require ongoing counseling, however, supervisees should pursue that work with their own therapists.

The Discrimination Model also highlights three areas of focus for skill building: process, conceptualization, and personalization (Bernard & Goodyear, 1992). Process issues examine how communication is conveyed. For instance, is the supervisee reflecting the client's emotion, did the supervisee reframe the situation, could the use of paradox help the client be less resistant? Conceptualization issues include how well supervisees can explain their application of a specific theory to a particular case--how well they see the big picture--as well as what reasons they have for what to do next. Personalization issues pertain to supervisees' use of their persons in therapy, in order that everyone involved is non-defensively present in the relationship. For example, the supervisees' usual body language might be intimidating to some clients, or they may not notice that their client is physically attracted to them.

The Discrimination Model is primarily a training model. It assumes the supervisor has habits of attending to some of the roles and issues mentioned above. When a supervisor identifies a customary practice, then the other two categories can be recalled. In this way, interventions are geared toward the needs of the supervisee instead of the supervisors own preferences and learning style.

Orientation-Specific Models

The supervision model perceived from the psychological perspective can be viewed in terms of its major types of models: orientation-specific, developmental or

integrative (Bernard & Goodyear, 1992; Borders, et. al., 1991; Boyd, 1978; Leddick, 1994; Stoltenberg & Delworth, 1987). An overview of these major models of counselor supervision follows.

Counselors who adopt a particular brand of therapy (e.g. Adlerian, solution-focused, behavioral, etc.) often believe that the best supervision is an analysis of practice for true adherence to the therapy. Psychoanalytic supervision (Leddick & Bernard, 1980) occurs in stages. During the opening stages, the supervisee and supervisor eye each other for signs of expertise and weakness. This leads to each person attributing a degree of influence or authority over the other. The mid-stage is characterized by conflict, defensiveness, avoiding, or attacking. Resolution leads to the working stage of supervision. The last stage is characterized by a more silent supervisor encouraging supervisees in their tendency toward independence.

There is strong support for the view that counselor supervision is similar to counseling and psychotherapy (Boyd 1978, Mueller & Kell, 1972). The psychotherapeutic model of counselor supervision focuses on the interpersonal and intrapersonal dynamics of the training relationship. A basic assumption in this approach is that counseling is partly an emotional experience and that processing both the inter- and intrapersonal dynamics is a crucial aspect of supervision. The counselor needs to be aware of these dynamics and of how to use them to induce therapeutic change (Boyd, 1978). The goal of psychotherapeutic supervision is for counselors to learn what is therapeutic and how to function in a therapeutic manner (Mueller & Kell, 1972). This involves becoming aware of inter- and intrapersonal dynamics, understanding the effect

of these dynamics on the helping relationship, changing these dynamics and learning how to use these dynamics for therapeutic gain (Boyd, 1978).

While there are variations within psychotherapeutic models to supervision, they are similar in their focus on relationship dynamics. The process by which this form of supervision occurs is usually unstructured in order to emphasize the dynamics of interactions between counselor and client or counselor and supervisor.

While the psychotherapeutic models are similar in that they emphasize the relationship between counselor and supervisor as being the primary source of learning, the behavioral model uses the relationship as part of the process. Once a facilitative relationship has been established, the focus shifts to evaluating each skill and then establishing learning goals to increase the counselor's performance of these skills. Assessment of the counselor's skills enables the supervision goals to be selected (Boyd, 1978; Leddick & Bernard, 1980). For these goals to have meaning, they must be selected by both counselor and supervisor and to be behaviorally specific. Problem-solving strategies including how these goals are reached, when they are attained, and how they can be evaluated are then jointly developed. Some more common methods are modeling, reinforcement, role-playing, behavioral rehearsal, and micro-counseling.

The focus of the behavioral model, however, is upon teaching counseling skills to supervisees and learning to extinguish inappropriate behaviors. It is based on the assumption that counseling skills can be behaviorally defined, measured, and taught using techniques of psychological learning theory. Behavioral supervision is specific in nature since it focuses on individual skill level and teaches supervisees how to increase their skill level. According to Boyd (1978), there are five steps used to increase skill level.

They include a) establishing a relationship between the supervisor and counselor, b) assessing the counselor's skill level, c) setting supervision goals, d) developing and implementing strategies to meet these goals, and e) evaluation of learning.

Carl Rogers (cited in Leddick & Bernard, 1980) outlined a program of graduated experiences for supervision in client-centered therapy. Group therapy and practicum were the core of these experiences. The most important aspect of supervision was modeling the necessary and sufficient conditions of empathy, genuineness, and unconditional positive regard.

Bernard and Goodyear (1992) summarized the advantages and disadvantages of orientation-specific models. When the supervisee and supervisor share the same orientation, modeling is maximized as the supervisor teaches and theory is more integrated into training. When orientations clash, conflict or parallel process issues may predominate.

There are also other deficiencies with the current theories. For example, each theory of supervision depends on a picture of counselor development that is clear in what it says but is painted with broad brush strokes. From afar, the shapes are noticeable but on further inspection there are no details. The descriptions of counselor development rest on scant research. There is no specification of what higher order counseling skills are or when each level of counseling skill rises to the fore. For example, it is generally agreed that listening skills are the building blocks of therapies and that advanced empathy, confrontation, and conceptualization, for example, are necessary to good counseling. However, when are counselors most ready to learn conceptualization? When and how

does the counselor show readiness to learn how to use the conceptualization arrived at in supervision?

Nevertheless, there is certain common ground with all these different types of theories. Models attend systematically to a safe supervisory relationship, task-directed structure, methods addressing a variety of learning styles, multiple supervisory roles, and communication skills enhancing listening, analyzing, and elaboration. As with any model, as the supervisor gains insight and experience, their personal model will grow, change, and be transforming.

System's Approach to Supervision

Holloway (1987) indicated that common factors in the supervisory process are the agents of change: supervisor characteristics and supervisee characteristics. Also common to the supervisory process are the characteristics of the client and environmental factors which are considered contextual factors. The System's Approach to Supervision (SAS) is based on these ideas. The process itself is the result of the interaction of the tasks and functions of supervision occurring within the context of these factors. Central to the supervisory process is the supervisory relationship, which, according to Holloway (1995) consists of structure, phase and supervisory contract.

The structure of the supervisory relationship is best understood in terms of power and involvement. A power differential has the potential to affect the supervisory relationship. Although power is not the only factor that affects the level of interpersonal involvement of participants within a relationship (Holloway, 1995), the perception of power can have a significant impact.

Studies on interpersonal influence found in the counseling literature have focused largely on the impact of certain counselor characteristics including attractiveness, expertness, and trustworthiness as the agents of influence (Heppner & Heesacker, 1983; Slater, 1991). Researchers in the field of supervision have attempted to apply the same constructs to the examination of influence within the context of the supervisory relationship (Dondenhoff, 1981). Although there are similar elements, this poses a problem in that the supervisory process is distinctly different from the counseling process (Bernard & Goodyear, 1995; Borders & Leddick, 1987). In addition, other influences such as legitimate, coercive, and reward power are ignored (Schultz, et. al., 2002).

The objective of the phase component of the SAS model of supervision is to establish a working alliance and accomplish work through the supervisory process (Holloway, 1995). According to Bordin's (1983) model of supervision, mutual agreement regarding goals and direction and the emotional bond between the supervisor and supervisee constitute the alliance, whereas the tasks or actions taken in supervision constitute the work component. When taken together, these three constitute the supervisory working alliance which has been the focus of numerous studies (Efstation, Patton, Kardash, 1990; Ladany & Friedlander, 1995).

The final component of the supervisory relationship is the supervisory contract (Holloway, 1995). The contract is beneficial to the relationship because it clarifies expectations and needs, sets up content and relational parameters, establishes norms and rules and commitments, and negotiates specific tasks. Clearly the supervisory working alliance, as the central component of the supervisory relationship, holds great potential for influencing the process and outcomes of clinical supervision.

Addictions Treatment Model

Finally, Powell (1991) has suggested that there is a difference in the specific type of supervision required for addictions treatment. Powell has written extensively since the 1970's about addictions supervision. In 1993, Powell proposed a model of clinical supervision specifically for the addictions treatment field which blends aspects of several supervision theories. His model is developmental in nature and addresses nine descriptive dimensions of clinical supervision issues (e.g. influence, therapeutic strategy, counselor in treatment, etc). Powell (1993) also outlines issues specific to addictions counseling and supervision. It is because of these unique aspects of addictions counseling that attention is greatly needed in the area of supervision.

Although there are a great number of issues that are similar across types of counseling settings, at least three supervision issues are idiosyncratic to substance abuse counseling and deserve special attention (Powell, 1993). First, a significant number of treatment providers are paraprofessional. Unlike professional counselors, paraprofessional have not fulfilled educational requirements for a master's degree in counseling or allied human service field. Paraprofessional in some states are required to have little more than a high school diploma or equivalent and pass a state certification examination. They, therefore, lack formal graduate school instruction pertinent to the eight common core areas considered basic to the counseling profession (i.e., human growth and development, social and cultural foundations, helping relationships, group, lifestyle and career development, appraisal, research and evaluation, and professional orientation). Paraprofessional also may lack the fundamental counseling skills typically developed through participation in an organized sequence of practica and field-practica

experience (e.g. counseling internships) common to counselor education program graduates. They may also lack clear understanding helper boundaries learned and practiced by those participating in professional course work. The implication for supervision is clear: supervisors must be continually aware that paraprofessionals lack fundamental counselor training. Therefore, the supervision milieu must contain a strong educational component to ensure a minimal level of skill and knowledge-based competencies. Supervisors may find that working with paraprofessionals who lack adequate training may need to assume a greater proportion of the responsibility for treatment planning and can help paraprofessionals learn how to apply their existing skills with diverse clients.

A second complicating factor related to addictions supervision is that many professional counselors and paraprofessionals facilitating addictions treatment strongly believe that one must be in recovery to provide effective treatment (Powell, 1993). Treatment providers espousing this position may be highly resistant to supervision from non-recovering persons. Direct inquiry may be helpful in determining the counselor's position on this matter. Whatever the response indicated by the supervisee, it will be helpful to ask a follow-up question relating to how the two can work together effectively to provide the best possible treatment for the client. Since directness is prized in the substance abuse treatment community, it will encourage honesty on the part of the supervisee. Failure to address this important issue will likely result in pseudo-supervision, which wastes valuable time and inevitably impedes client progress. Even the most adamant helper who believes one must be in recovery to facilitate effective

treatment, will typically recognize the benefits of working together for the sake of the client.

Finally, though all treatment providers are influenced by personal issues, recovering helpers may be particularly vulnerable to imposing their personal experiences and unconscious beliefs on clients (e.g., what worked for me will work for you). A client's relapse may also provoke unconscious responses in the recovering helper (i.e., loss of empathy, reduction in patience, etc.) which may negatively affect the counseling relationship. Therefore, the supervisor's attention to these potential issues is critical. Teaching helpers that there is no one way to initiate or maintain recovery is essential. This can be done in several ways, one of which is the recovery expedition. This is where several people in recovery exchange the ways in which they achieved and maintained their recovery, thus showing that there is no one way of initiating and maintaining recovery. Small group exercises such as these promote effective ways of dealing with the anger, frustration, and fear related to the helper's own recovery.

MECHANISMS OF SUPERVISION

Following will be a review of some of the behaviors that accomplish the work of supervision. The techniques that allow the least direct observation by the supervisor begin this section and move toward the techniques that allow the most direct observation.

Within individual supervision, self-report was the most common in the field, while supervision using videotape replay was the strongest within training programs (Bernard & Goodyear, 1998). Live supervision and audiotape replay were also found to rate highly in particular studies and to rank third and fourth in overall usage.

Technical diversity among supervisors is desirable because it allows the supervisor to help a variety of supervisees attain a variety of supervision goals (Bernard & Goodyear, 1998). The following questions can be used by the supervisor to select the format and technique within individual supervision:

1. How will this mechanism of supervision be received?
2. Am I being true to my beliefs about how one learns to be a mental health practitioner?
3. Am I considering the three functions of supervision?
4. Am I considering the timing and/or relative structure of my supervision?
5. Are administrative constraints real or am I not advocating with a strong enough voice?
6. What does this particular supervisee need to learn next? Am I using the best technique for that purpose?
7. Am I skilled in the use of this particular technique?
8. Have I considered ethical safeguards?
9. Is it time to try something new?
10. Am I documenting the success of my method?
11. Am I willing to confront my own assumptions?

Once these questions have been considered, the choice of mechanism and technique becomes easier. Following is a description of the most commonly used mechanisms of supervision.

Self-report is one of the simplest mechanisms of supervision. It is, however, a difficult technique to perform well (Bernard & Goodyear, 1998). Ideally, the supervisee

will be challenged conceptually and personally and will learn a great deal. Self-report continues to be one of the most commonly used techniques of supervision, especially for post-graduate supervision (Goodyear & Nelson, 1997). At best, self-report is an intense tutorial relationship in which the supervisee fine-tunes both case conceptualization ability and personal knowledge as each relates to the therapist-client relationships. Self-report is generally viewed as far less appropriate for novice supervisees (Holloway, 1988). As she noted, this supervision strategy is only as good as the observational and conceptual abilities of the supervisee and the seasoned insightfulness of the supervisor. It seems, then, that there are too many opportunities for failure with self-report if it is the complete supervision plan. Since self-report is the oldest technique of supervision, there is a tendency to return to it when other techniques become burdensome (Bernard & Goodyear, 1998). Yet, when a situation is highly charged for the supervisee, it takes more than the open-ended context of self-report to help the supervisee to process the meaning of what occurred. There are times when that information does not enlighten but rather detracts from the issues. Knowing when this is the case and when to use self-report, takes both experience and attentiveness to the individual needs of the supervisee.

The progress note is a form of systematic written documentation of the cases being presented in supervision or of the therapeutic interventions (Bernard & Goodyear, 1998). Case notes can provide a means of controlling the type of information offered in supervision if a more direct technique is not used. Many of the advantages of using process notes are similar to those for self-report. Process notes allow a wealth of information to enter the supervisory session and, therefore, allow the supervisor an opportunity to track the supervisee's cognitive processes in ways that more active forms

of supervision don't allow (Goldberg, 1985). There is also value in the experiential component between supervisor and supervisee who are free from the distraction of media (e.g., audiotape, videotape, etc.). Also, there can be more worthwhile modeling of therapeutic conditions when process notes, as opposed to media, are the focus of supervision. However, the use of process notes is more appropriate for advanced supervisees, just as with self-report (Goldberg, 1985). Process notes have tremendous value especially when used in conjunction with other techniques of supervision (Bernard & Goodyear, 1998). Even a brief outline to track a counseling session can help both novice and experienced supervisees order their thinking in meaningful ways, allowing them to use their supervision time more fully.

Audiotape was the first to revolutionize our perceptions of what could be accomplished in supervision (Goodyear & Nelson, 1997). The audiotape allows supervisees to transport an accurate recording of counseling sessions to a supervisor who was not present at the time of the session. This can be done without the expense of facilities and equipment required for videotape. The audiotape is still one of the most widely used sources of information for supervisors who expect to have some sort of direct access to the work of their supervisees (Bernard & Goodyear, 1998). Most clients will not be resistant to having their sessions audiotaped as long as the assurance of confidentiality is given and the therapist does not present the audiotaping in a threatening way.

The process of supervision must be planned especially when there are several audiotapes (sessions) to be covered. It is the supervisor's responsibility to outline that plan (Bernard & Goodyear, 1998). These segments can be used in several ways and

delayed review of audiotapes is best used to facilitate the supervisee's perceptual-conceptual skills (Goldberg, 1985). There are several teaching goals identified by Goldberg (1985) that can be accomplished using audiotape but will not be delineated here since it is not the focus of the research study. Supervisors will always have a teaching function in mind if they pre-select a segment of audiotape for supervision purposes (Bernard & Goodyear, 1998). If, however, the supervisee selects a segment of the audiotape for supervision, it is assumed that the supervisee has had some experience already. Often a combination of audiotape and written critique or analysis is used in supervision sessions.

Some of the disadvantages of using audiotapes include the fact that a tape recorder always has an effect on therapy and its meaning to the client as well as to the therapist must be explored (Aveline, 1992). Taping could hurt the supervisory relationship if the exposure that the tape allowed led to humiliation for the therapist/supervisee. Finally, the taping could appear abusive to a client who is too weak to refuse.

Although videotape is often used as a backup, videotape has begun to be a standard advocated by many (e.g., Stoltenberg & Delworth, 1987). There are many advantages to using videotape including being able to read both the client's and therapist's body language and non-verbals as well as allowing the therapist to see themselves in the role of helper, thus allowing them to be an observer of their work (Bernard & Goodyear, 1998). Some of the disadvantages of using videotape may consist of the association supervisees make between television and videotape (Munson, 1983). Supervisees may feel that they need to perform to create an entertaining video and thereby suffer from performance anxiety. It is the supervisor's role to structure supervision so

that observers are stimulated cognitively while at the same time, attempting to safeguard the integrity of the supervisee on tape.

It has been argued that videotape supervision should focus on the interaction between supervisee and clients, as well as on the far more subtle internal processes experienced by the supervisee during both the therapy session and the supervision session. Breunlin et. al. (1988) therefore recommended six guidelines for working with both the cold accuracy of videotape and the dynamic reality experienced by the supervisee. These guidelines include

1. Focus videotape supervision by setting realistic goals for the supervised therapy session.
2. Relate internal process across contexts.
3. Select tape segments that focus on remedial performance.
4. Use supervisor comments to create a moderate evaluation of performance.
5. Refine goals moderately.
6. Maintain a moderate level of arousal.

Of course, these guidelines, though outlined for use with videotape in supervision, also apply to other techniques of supervision.

Finally, live supervision is a frequent form used in training programs but used less frequently in the field due to scheduling difficulties and structural restrictions (Bernard & Goodyear, 1998). Live supervision is defined as observing the supervisee during a therapy session and having active supervision during the session. There are several advantages which live supervision offers including a high safeguard for client welfare

because the supervisor is immediately available to intervene in case of emergency. Secondly, live supervision affords the supervisor a more complete picture of clients and supervisees than is achievable through audio- or videotape. This is because the camera position is fixed throughout the session giving only one view exclusively. Thirdly, the most utilized advantage of live supervision is that it offers the most flexibility regarding the timing of supervision. Supervision is conducted while the therapy session is still fresh in the supervisee's mind and before another therapy session can cloud potential supervisory points. The final advantage of live supervision must be monitored carefully since it involves other supervisees. When other supervisees are present in the observation room, there is often opportunity for instruction based on the session that is happening. When this instruction becomes very objective and candid and is not mentioned to the supervisee later, the level of trust among group members can suffer.

The only drawbacks to live supervision include those already mentioned: timing and structural considerations (Bernard & Goodyear, 1998).

SUPERVISION EFFECTIVENESS

The definition of supervision has often included perceptions of ineffective supervision and effective supervision. In 1994, Borders wrote that a "good" supervisor encompasses good counselor traits, good teacher traits, and good consultant traits in both the personal and professional arena. It was noted in this article that all supervisors benefit from training experiences focused on supervision knowledge and skills, training where potential supervisors reflect on their roles and responsibilities, and training where potential supervisors receive feedback from others about their work as supervisors. This supervision of supervisors has been advocated by many others as well (Machell, 1987;

Powell, 1991; Worthington, 1987; etc.). The challenge in supervision, of course, is to use many skills from different roles and of attending to different levels at the same time. However, there is little specification of what makes a supervisor effective and thus of how one builds the skills necessary to become effective (Worthington, 1987).

Ronnestad and Skovholt (1993) presented an extensive description of effective supervision. They concluded that there was reasonable validity to the perspective that what is good supervision depends on the developmental level of the supervisee. Supervisors of beginning supervisees should provide high levels of encouragement, support, feedback, and structure. The relationship with advanced supervisees is typically more complex since these supervisees tend to vacillate between feeling professionally insecure and professionally competent. The supervisor should take responsibility for creating, maintaining, and monitoring the relationship which serves to provide structure and a mediating role while supervisees are in turmoil. Thus, supervisors of experienced supervisees serve in a well-defined role of patient teacher with an emphasis on structure and instruction (Loganbill, et. al., 1982). As supervisees acquire experience, the need for instruction diminishes and it is the supervisory relationship which provides a supportive context as advanced supervisees assess and reassess their professional competencies and personal qualifications.

At the other end of the spectrum are the perspectives of what constitutes an ineffective supervisor. Identification of counter-productive supervisory behaviors, including a schema for their classification, is useful to enhance awareness among supervisors and educators. Six overarching principles were developed by Magnuson, Wilcoxon, and Norem (2000). These include a) Unbalanced, b) Developmentally

inappropriate, c) Intolerant of differences, d) Poor model of professional/personal attributes, e) Untrained, and f) Professionally apathetic. These principles are evidenced differently depending on which general sphere they are used in. The three general spheres include organizational/administrative, technical/cognitive, and relational/affective (Magnuson, Wilcoxon, and Norem, 2000). Many of the principles were obtained through discussions with other professionals in the field without examining specific behaviors and with no reasons given for the findings. It is, therefore, difficult to define these principles, how they are exhibited in any of the different spheres, and what makes them more important than other, perhaps equally valid principles. It is also difficult to understand the general sphere of organization/administrative and its effect on clinical supervision.

It is as difficult to describe the obligations of a clinical supervisor (different from administrative supervisor) as to describe what makes supervision effective or not. The definitions and meanings often become blurred. As with any leadership position, the vision of the clinical supervisor for their staff and organization are vital to the organization's effectiveness (Sternbach, 1993). Clinical supervisors should have a clear sense of purpose in their professional actions. According to Machell (1987), some of the purposes of clinical supervision include giving consultation on ethical, legal, political (within the organization) and administrative issues. The supervision of clinicians should, therefore, include the unhealthfulness of continual contact with "negative" client issues. Also, the supervisor should encourage achievement of supervisees by objectively recognizing a supervisee's gifts and as well as his/her possible limitations. Thirdly, the supervisor should create closure on clinical discussions and case reviews. In other words, make a decision about cases where the supervisee cannot or will not. Finally, the clinical

supervisor should monitor the emotional climate of the clinical staff to ensure quality of work and, ultimately, effectiveness of client treatment. Other areas of the supervisor's purpose include upholding the ethical standards. This is best achieved by quoting the relevant parts of the Code of Ethics when necessary (Ladany, et. al., 1999). Another area where the supervisor should use their expertise is in the area of staff development to allow the supervisees to meet his/her professional expectations (Machell, 1987). Finally, the clinical supervisor is in the unique position to foster collegiality among the staff to lessen the professional loneliness and isolation inherent in the addictions treatment field.

Machell's (1987) ideas for the clear sense of purpose that a clinical supervisor should have for all his/her professional actions, comes from his own experiences. He states quite clearly that these are universal obligations, yet no evidence is found that this article's conclusions are based on empirical evidence. Therefore, though there is no arguing with opinion or with what makes intuitive sense, the conclusions drawn must be taken within the context within which they were generated.

The goals of supervision are different from those of evaluation. Borders (1991) discussed these differences in regards to school counselors, but the ideas are just as valid for clinical counselors. She states that the purpose of supervision is to give feedback, promote greater self-awareness, enhance skills, and help create an integrated identity. The purpose of evaluation, however, is to make value judgments about the object of evaluation for the purpose of decision making. When supervision is only used in its evaluative function, several other goals such as education, are lost.

There are seven core competencies for supervisors that have been used as evaluation criteria (Getz, 1999). The core competencies are as follows: (a) models of

supervision; (b) counselor or supervisee development; (c) supervision methods and techniques; (d) supervisory relationship; (e) ethical, legal, and professional regulatory issues; (f) evaluation; (g) executive or administrative skills. Goals should be set with the supervisee and are evaluated throughout the supervision process. They goals may be broad and overriding or goals specific to one supervisee to address a specific need.

THE SUPERVISORY RELATIONSHIP

Several authors have suggested that the supervisory relationship is the most important aspect of supervision (e.g., Chen & Bernstein, 2000; Dye, 1994; Goodyear & Bernard, 1998; Sternbach, 1993; etc.). The interpersonal nature of supervision is a central component of supervision and the supervisory relationship will always depend on the two personalities involved (Sternbach, 1993). Other writers in the area of supervision have also stressed the relationship as the important variable in supervision (Loganbill, et. al, 1982; Mueller & Kell, 1973). For some, the ability to form and sustain relationships is more important than certain knowledge and skill factors (Dye, 1994). As far back as 1978, Moses and Hardin stated that: "The immediate goal of the supervisory process becomes the establishment of such a therapeutic relationship with the supervisee, a relationship which will set in motion and facilitate the supervisee's continuing personal and professional growth" (pp446). For others comfort and friendly expectation of a supervision session are more necessary than love or hope (Sternbach 1993). Research evidence in the area of supervision had been accumulating and suggests that the most effective element in contributing to supervisee growth is the nature of the relationship established by the supervisor (Loganbill, et. al. 1982). However, the relative importance of the relationship and the role it plays varies according to supervisory orientation (Dye,

1994). Finally, Hess (1987) asserted that if supervision were to consist of only the relationship, then many skills and conceptualizations would likely not develop. He asserted that whereas the supervisory relationship is part of supervision, it is not the supervision. Nevertheless, it is arguably the most essential part.

As with any intimate relationship, there are certain expectations in the supervisory relationship and each person enters it with their own set of assumptions and beliefs (Mueller & Kell, 1973). These are based on past experiences with other authority figures. The supervisee may be entirely unaware of these assumptions or of the appropriateness (or inappropriateness) of them. A primary focus of the supervisor is attention to these expectations. If the assumptions of the supervisor differ from those of the supervisee, there may be upheaval in the relationship. The process of determining these patterns becomes a complex and involved task of supervision. It is in this way that the supervisory relationship differs from ordinary relationships, because the focus is not only on the activity of the supervisee but also on the supervisee's feelings about that activity as well (Loganbill, et. al., 1982).

Relationship development in supervision emphasizes the importance of the development of trust and the clarification of expectations and goals between the supervisor and the supervisee at the initial stage of supervision (Ekstein & Wallerstein, 1972). Relationships with supervisees should be characterized by mutual respect, two-way interactions, and a collaborative spirit (Henderson, 1994). When these personal interactions are characterized by trust and respect, they then ideally become the hallmarks of the interpersonal climate of the organization and staff. However, the reality is that there is a power inequality in supervisory relationships (Bernard & Goodyear, 1992). The

person who needs the other more (supervisee or client) typically has less power than the person who is needed (supervisor or counselor); and the person who has permission to comment on the other's behavior also has the greater power (Strong, 1968). In addition, the supervisor has evaluative responsibilities with respect to the supervisee, an additional type of power (Bernard & Goodyear, 1992). Robiner (1982) pointed out that the power difference is a constant obstacle to gaining the mutual trust that is so important in supervision and which is essential to effective supervision. Trust affects the behavior of all parties involved in the supervisory relationship. A significant part of the overall supervisory relationship includes the level of comfort felt by both the supervisee and the supervisor. During the development of the TPRS-R (Trainee Personal Reaction Scale-Revised), Holloway and Wampold (1984) noted that the independent subscales have conceptually clear meanings within the context of the supervisory relationship. Rather than deal with the incidence of particular supervisory strategies, the TPRS-R provides a gauge for the climate of supervision which relates directly to the supervisory relationship.

The supervisory relationship, then, is can be viewed through two perspectives: first, the relationship serves as a vehicle through which essential knowledge can be given (Loganbill, et. al., 1982). This is necessary so that the supervisee can learn about counseling and therapy. The relationship can be the channel which allows acceptance of information and growth from other, outside sources. When considering this use of the relationship, it is important that an open, trusting bond be established in order to facilitate the passing of knowledge from the supervisor to the supervisee. Second, experiencing the relationship itself can be a significant learning experience. It can serve as a rich and valuable source of experience to facilitate the development of the supervisee. Conflict

represents an obstacle to growth. However, when considering that the relationship is an experience, it is the conflict itself that offers the basic learning material. No significant human relationship progresses without conflict or stress, stalemates or regression (Loganbill, et. al., 1982). It is these conflicts which can serve as a focus for promoting growth in the supervisee and depending on how it is resolved (or fails to be resolved) that dictates whether the relationship continues to grow and develop or stagnate (Bernard & Goodyear, 1992). This is similar to Bordin's (1983) assertion that it is the "weakening and repair" of the working alliance between two people that constitutes the basis of therapeutic change.

As with conflict, there are many factors which affect a relationship, and that between supervisor and supervisee is no different. These factors can include the client problem, setting variables and type and style of supervision (Bernard & Goodyear, 1992). Supervisees who report that their supervisor exhibited a greater adherence to supervisor ethical guidelines, indicated a stronger supervisory relationship in terms of a greater agreement on the goals and tasks of supervision and a stronger emotional bond (Ladany, et. al., 1999). Other factors which influence the supervisory relationship can be either static or dynamic in nature (Dye, 1994). Among the static factors are gender and sex role attitudes, supervisor's style, age, race, and ethnicity, and personality characteristics. Dynamic factors are those that may exist at only certain stages of the relationship or which are always present but in varying degrees or forms. These would include process variables such as stages of supervisee development and relationship dynamics such as resistance, power, parallel process, etc.

ll of these factors influence defining the supervisory relationship in several ways. However, the definition of a supervisory relationship that will be used for the context of this research is from Dye (1994) and states that the supervisory relationship is a reference to the manner in which supervisee and supervisor are connected as they work together to meet goals. Some of these goals are common across supervisory relationships and some goals are idiosyncratic. There has been some discussion of the working alliance and this is not technically different from the supervisory relationship in the context of this paper. Bordin (1979) suggested that the working alliance is a collaboration to change and is common across all techniques of therapy and thus supervision. The three elements composing this collaboration include the bond between the individuals involved, the extent to which they agree on goals, and the extent to which they agree on tasks. Chen and Bernstein (2000) broke supervision down into both a process and a relationship much like Loganbill, et. al., (1982) who noted two perspectives of the supervisory relationship. As a process, supervision, is concerned with the interaction of supervision participants, who reciprocally negotiate, shape and define the nature of their relationship. As a relationship, supervision functions as the context within which the supervisor-supervisee interactions unfold. The emphasis of supervision is on a purposeful, task-oriented learning process within the bidirectional nature of the supervision relationship (Efstation, Patton, and Kardash, 1990). That is, the relationship moves both upwards (e.g., supervisee to supervisor) and downwards (e.g., supervisor to supervisee) and is based on mutual influence. This mutual influence broadens the perspective of power even though the supervisor continues to have greater possibility to influence the supervisee (Bernard & Goodyear, 1992). Another factor effecting this two-way interaction is the supervisee's

belief or judgement about their own abilities (Larson & Daniels, 1998). Also known as self-efficacy, these supervisee beliefs have been shown to relate to counselor anxiety, counselor performance, and the supervision environment including the supervisory relationship. Thus, the importance of the relationship between the supervisee and the supervisor is inherent within the supervisory context (Loganbill, et. al., 1982).

Issues of both relationship and process have been combined within some proposed models of supervision that depict a sequence of counselor development stages or a framework of developmental issues (Chen & Bernstein, 2000). When developmental supervisory models are used, then one of the supervisory functions becomes enhancing the growth of the supervisee within stages (Loganbill, et. al., 1982). It is the supervisor's task to intensify and augment the experience of the supervisee in each stage. It is also the supervisor's task to ensure that the supervisee does not move too quickly through the stages without having the mastery of the stage before. It is the supervisor's responsibility to ensure that the supervisee experiences fully all parts of the process, even though some parts may be agonizing. Finally, another supervisory function is promoting transition from stage to stage. Natural events and natural transformations can promote transitions. If needed, however, the supervisor must facilitate the movement between the stages to continue encouraging the supervisee's growth throughout the stages. All of these tasks on the part of the supervisor are meant to enhance not only the supervisee's learning experience, but also the relationship fostered between the two. Just as the learning experience comes in stages, so does the relationship (e.g., Chen & Bernstein, 2000; Dye, 1994; Goodyear & Bernard, 1998; Loganbill, et. al., 1982; Sternbach, 1993, etc.). This developmental stage concept originates with the establishment of a clear, straightforward,

trustworthy relationship between the supervisee and the supervisor (Loganbill, et. al., 1982). Both Ekstein and Wallerstein (1972) and Kell and Mueller (1966) have listed three stages in the supervisory relationship. These phases include the beginning phase, the developing or mid-game phase, and the terminating or end-game phase. It is important that a supervisor recognize and appreciate that the progression of the relationship involves a process which occurs over time and cannot be expected to be at an end point immediately. Not all supervisory relationships develop fully, however, and may become abbreviated and therefore, never reach the terminating stage (Loganbill, et. al., 1982).

Supervisory Relationship Within Addictions Treatment

There is, however, little empirical evidence to support much of the research on supervisory relationships. In addition, the dynamics in the addictions treatment field include factors not otherwise present. These factors can include supervisory competence and attitude (Culbreth & Borders, 1998); the recovery status of either the supervisor or the supervisee (Culbreth & Borders, 1999); the age of the supervisee, since many of them come to the field as a result of a midlife career change associated with their recovery experience (Powell, 1993); and the level of education of either the supervisor or the supervisee (Reeves, Culbreth, & Greene, 1997). The supervisory relationship in addictions treatment counseling is critical to supervision outcome, yet dynamics in the addictions treatment field (i.e., self-help needs no formal supervision) have great potential for negatively affecting the relationship, (Culbreth & Borders, 1999). A number of researchers have indicated that the quality of the relationship variables in supervision is directly related to the positive outcome of supervision (Holloway, 1995; Worthington &

Roehlke, 1979). This conclusion has been supported by studies of supervisees across all levels of experience, all of whom have indicated a desire for supervision that is supportive and relationship oriented (Usher & Borders, 1993). In fact, Holloway, on the basis of her extensive research, views the supervisory relationship as the core factor in supervision (Holloway, 1995).

Though the supervisory relationship has been viewed as one of the critical aspects of supervision, several other factors in the addictions treatment field have been deemed important, yet lacked the empirical evidence to back up the claims. Culbreth and Borders (1998) conducted a qualitative study of recovering and non-recovering substance abuse supervisees. Their findings indicate that recovery status is important in supervision but is only one factor. Supervisor competence and attitude was found to be equally or even more important. Several findings from this study indicate that educational levels often paralleled recovery status. And, that different supervision approaches were used depending on recovery status, with both approaches viewed as equally successful. Finally, the quality of the supervisory relationship variables is directly related to the positive outcome of supervision. Though this study used a relatively small sample (n=5), it was qualitative in nature and preliminary to empirical studies. However, the reason that recovery status was such a small influencing factor was not stated or even speculated on.

Some themes that emerged and will be further discussed, include: supervisor competence, supervisor attitude, and recovery status (Culbreth & Borders, 1998). Supervisor competence reflected competence as a supervisor rather than competence as a supervisee. This difference was critical as imparting skills and knowledge to the supervisee so that the supervisee becomes a more effective counselor is not a counseling

skill, per se. Past experience was a significant factor in determining supervisor expertness. Supervisor attitude referred to how attitude was reflected in the daily work as a supervisor. This attitude was characterized as commitment to supervisory relationship, conveying a sense of trustworthiness, and providing a feeling of support for supervisees. Finally, recovery status was discussed and it was only when there were mismatches in recovery status (e.g., recovering supervisee with non-recovering supervisor) that problems were noted. However, actual differences in perception of recovery status were not fully articulated though these differences exist and effect the supervisory relationship.

After this preliminary study, Culbreth and Borders (1999) conducted an empirical study which looked at the effects of recovery status in the supervisory relationship. This survey included a random sample of 400 members of NAADAC (The Association of Addiction Professionals) with a 35% return rate. The demographic profile of respondents was similar to the general membership. No standardized instruments were used, however, a demographic questionnaire which included questions about the respondent's typical client and preferred supervisory practices were incorporated. This study backs up the conclusion that match of recovery status (e.g., recovering supervisor with recovering supervisee) is more important than an individual's recovery status. The perceptions of satisfaction with supervision and the supervisory relationship closely paralleled the match of recovery status not to recovery status alone. There were, however, several flaws which may make the results difficult to generalize. These include a low return rate, only surveying members of the professional organization, and validity and reliability of non-standardized instruments.

This study found that recovery status was viewed by both supervisors and supervisees alike as another variable similar to gender, race, cognitive style, etc. The finding that there was no difference in the rating of supervision satisfaction between recovering and non-recovering supervisees from this study were contradictory to those found by McGovern and Armstrong (1987) ten years earlier. Being in recovery is a less significant credential for supervisors than is believed in the recovering community (Culbreth & Borders, 1999). This was also true for non-recovering supervisees. Though this study was one of the first empirical studies done within the addiction treatment community, there were several limitations. Among them are that the packets were turned in the agency contact and logged in when they were returned, thus anonymity was not ensured. The questions assessing supervision satisfaction were not tested for reliability or validity and neither was the shortened version of the Barrett-Lennard Relationship Inventory.

Some of these concerns as well as others prompted a response from West, Mustaine, and Wyrick (2002). These critics of the original article stated that Culbreth and Borders (1999) failed to include other confounding variables such as those mentioned above, the educational level of respondents (formal vs. workshops, etc.), and the level of counselor effectiveness (longitudinal measure of client behavior change). The main criticism regarded effectiveness of supervision relating to long-term client change. This is, of course, difficult to measure in the addictions treatment community as effectiveness with clients is measured in several different ways, depending on treatment philosophy. Another criticism regarded the blurring of the lines between supervision effectiveness and

positive or negative perception of supervision. This will be addressed further in this chapter as well as in chapter three.

Of the critical aspects of the supervisory relationship identified in the literature which have particular relevance to the addictions treatment field, the following are included: supervisee's perceptions of the supervisory relationship (Holloway & Wampold, 1983); supervisory style, as defined by perceptions of the supervisor's behavior on the three dimensions of attractiveness, interpersonal sensitivity, and task orientation (Friedlander & Ward, 1984); the working alliance (Bordin, 1983) defined as agreement on the goals and tasks of the relationship and the presence of a necessary bond between the two individuals in the relationship; and the core conditions of the relationship, characterized by Rogers (1957) as level of regard, empathic understanding, unconditionality, and congruence. Each of these aspects of the supervisory relationship has a demonstrated relationship to supervision outcome (Culbreth & Borders, 1998), and each has specific implications for supervision of addictions treatment counselors.

First, the supervisee's perception of the supervisory relationship was described by Holloway and Wampold (1983) as related to particular judgments made by participants in the sessions. As such, a positive evaluation of self during the interview was positively correlated to a positive evaluation of the supervisor. Positive evaluation of the supervisor was also positively related to a positive evaluation of the level of comfort in the supervision session.

The working alliance is defined as agreement on the goals and tasks of the relationship and the presence of a necessary bond between the two individuals in the relationship by Bordin (1983). Bordin hypothesized that the building of a strong

therapeutic working alliance is a major feature of the change process, and the amount of change that results may be a function of the strength of that bond. The working alliance model of supervision does not incorporate theories of counseling as part of supervision. Rather, it looks at the alliance between the supervisor and the supervisee as the model. The goals of the supervisory alliance are stated from the supervisee's viewpoint and include mastering specific skills, enlarging one's understanding of clients, enlarging one's awareness of process issues, increasing awareness of self and impact on process, overcoming personal and intellectual obstacles to learning, deepening one's understanding of theory, providing stimulus to research and maintaining standards of service. The establishment of the contract between supervisor and supervisee should include discussion of goal orientation and of the process by which goals may be achieved (e.g., review of client session). Later evaluation may include a review of these goals and satisfaction or dissatisfaction with the established alliance.

Finally, a unique set of dynamics found in the addictions treatment field is recovering and nonrecovering supervisees and supervisors (Culbreth & Borders, 1999). These dynamics were once purported to be a great influence on the supervisory relationship. However, in this empirical study, the findings indicated no significant differences in ratings of satisfaction or relationship dimensions based on either the supervisees' or the supervisors' recovery status. A significant interaction effect for supervisee and supervisor recovery status (i.e., match or mismatch or recovery status) was found for all satisfaction and relationship measures (Culbreth & Borders, 1999).

Supervisory Styles

Master practitioners, who can guide and direct less experienced colleagues, are called supervisors in the helping professions and specifically, counseling (Bradley & Ladany, 2001). Other roles in other professions might be referred to as mentor, chief, captain, leader, or guide. Yet, whatever the official title, the main role of the supervisor is to perform the function of counselor supervision. The manner in which this is done is often referred to as supervisory style. Supervisory style as defined by Friedlander and Ward (1984), is the different approaches that supervisors use, in combination with their distinctive manner of responding to supervisees and includes the following factors: attractiveness, interpersonally sensitive, and task orientation. Steward, Breland, and Neil (2001) further defined supervisory style as the manner through which supervisors exhibit attractiveness, task orientation, and interpersonal sensitivity within the supervisory dyad. Another definition of supervisory style includes not only the distinctive manner of responding to supervisees but also the different approaches the supervisors use (Ladany, Walker, and Melincoff; 2001). Supervisory style also refers to the supervisors' distinctive manner of approaching and responding to supervisees and of implementing supervision (Friedlander & Ward, 1984). This definition emphasizes interpersonal or relationship aspects, which seem to be as important to supervision outcomes as the therapeutic relationship is to counseling outcomes (Ekstein & Wallerstein, 1972; Loganbill et al., 1982).

Supervisory style is related to many supervision-relevant processes and outcome variables (Ladany, Walker, and Melincoff; 2001). Teitelbaum (1998) noted that supervisory style has a profound impact on supervisees' self-evaluation as a clinician.

Specifically, a mix of supervisor attractive, interpersonally sensitive, and task-oriented styles have been found to be related to supervisor theoretical orientation (Ladany, Walker, and Melincoff; 2001). Also, the supervisory relationship was found to be a key component in the supervision process that is facilitated by the style used by the supervisor. However, this study had several flaws which bring their conclusions into question. The first criticism is that there was only a 15% return rate and no mention was made of how participants were recruited for this study. Finally, the data shown does not clearly support the authors' conclusions, some correlations are barely statistically significant. Though this may be due to the small and homogenous sample, the discussion does not address this.

Several authors use the term "role" to distinguish it from type of supervision and from technique of supervision (cf. Bernard & Goodyear, 1992; Friedlander & Ward, 1984; Ladany, Walker, and Melincoff; 2001). Supervisory roles have often been associated with supervisory style since that has been the easiest way of distinguishing style from theory, focus, and technique. These terms are not interchangeable, though many authors have not been clear about these distinctions (Bernard & Goodyear, 1992). There is no universal role for supervisors. However, roles are useful insofar as they simplify practitioners' understanding of different aspects of supervision by referring to other, more common relationships. However, each role is extrapolated from a social context other than supervision (Friedlander & Ward, 1984). That being said, the tendency of supervisors to draw on what already has been learned is complemented by the fact that it is possible to consider supervision a higher-order role that encompasses other professional roles (Bernard & Goodyear, 1998).

Yet, in the absence of an identifiable set of supervisory styles, it has been proposed that the supervisor adopts diverse roles (Friedlander & Ward, 1984). For example, sometimes being a lecturer, at times a counselor, teacher, or consultant. These roles are useful insofar as they simplify practitioners' understanding of different aspects of supervision by referring to other, more common relationships. However, each of these roles is extrapolated from a social context other than supervision. The distinctive dimensions of the supervisory relationship remain to be identified and were discussed previously. A significant relationship has also been found between each aspect of the supervision working alliance and supervisory style (Efstation, Patton, and Kardash, 1990). This supervisory working alliance is the supervisee-supervisor relationship in which supervisors act purposefully to influence supervisees through the use of technical knowledge and skill and in which supervisees act willingly to display their acquisition of that knowledge and skill (Gelso & Carter, 1985).

Within the supervisory process, the supervisor may play three roles: teacher, counselor, and consultant (Bradley & Ladany, 2001). In the teacher role, the supervisor takes the responsibility for determining the action necessary for the supervisee's acquisition of skills and gaining counseling competence. In the counselor role, the supervisor addresses interpersonal and intrapersonal issues of the supervisee as they relate to their ability to counsel effectively. As a consultant, the supervisor allows the supervisee to share in the responsibility for his or her learning.

The nature of role flexibility has long been suggested by several authors (Bernard & Goodyear, 1992; Danskin, 1957; Douce, 1989; Ekstein, 1964). The number of professional roles available to supervisors increases with the supervisor's level of

experience (Friedlander & Ward, 1984). The number of roles include, but are not limited to: counselor/therapist, teacher, mentor, consultant, evaluator, and administrator (Bernard & Goodyear, 1992). There are several basic assumptions regarding roles that should be clarified and are considered foundational.

The first assumption is that treating supervision as a metaphor for something else and consequently employing a role from that previous something is not only a fact of life but also desirable (Bernard & Goodyear, 1992). Though metaphor is excellent to use, it is not meant to be used literally. This means that certain attitudes and behaviors from therapy, for example, might be taken into the supervisory session but supervision is not therapy.

Another assumption about roles is that role flexibility is essential to good supervision outcomes (Bernard & Goodyear, 1992). This means both that the effective supervisor will have a wide range of roles from which to choose and also that the effective supervisor will be able to distinguish which role to use when. Not every role is appropriate with every supervisee in every situation.

The third assumption involves roles taken by a supervisor that will be responsive to the context in which supervision occurs (Bernard & Goodyear, 1992). In other words, the setting in which the supervision intervention occurs will influence the roles of both the supervisee and the supervisor. Friedlander and Ward (1984) found that both supervisors and supervisees reported that the supervisory style they called Interpersonally Sensitive was used more often in outpatient settings than in inpatient settings. It seems intuitive that when clients have less severe issues (i.e., outpatient settings), the supervisors can attend more to the relationships between themselves and their supervisee.

Finally, the fourth assumption is that there is a particular perceptual set that underlies all supervisory roles (Bernard & Goodyear, 1992). Liddle (1988) discussed the transition from therapist to supervisor as a role development process involving several evolutionary steps. An essential early step in the process is for the emerging supervisor to make a shift in focus. That is, the supervisor eventually must realize that the purpose of supervision is neither to treat the client nor to provide psychotherapy to the supervisee. Borders (1989) also discussed this same step in the supervisor's development. She maintained that the supervisor must make a shift in the transition from the role of counselor to supervisor. This perceptual shift must occur in order for the supervisor to effectively supervise.

The primary supervisory functions, according to Bradley and Ladany (2001) include monitoring and evaluating, instructing and advising, modeling, consulting and supporting and sharing. When looked at in terms of supervisory roles, the previously described functions are easily part of a supervisor's style. One such function not previously discussed in depth, includes that of evaluation. Harris (1994) described the heart of counselor evaluation as an on-going formative process which uses feedback and leads to supervisee skill improvement and positive client outcome. Summative evaluation, by the way, is how effective or ineffective, how adequate or inadequate, how appropriate or inappropriate the supervisee is in terms of the perceptions of the individuals who make use of the information provided by the evaluator (Isaac & Mitchell, 1981). Therefore, the evaluation process is a function of supervision. There are, however, several unique difficulties in this evaluation process including its complexity, unarticulated desired outcomes (these can be from either the supervisor or supervisee),

and finding the balance between ensuring a supportive environment and the evaluative component of the supervision process (Harris, 1994).

Effective evaluation practices include supervisee self-awareness, theoretical and conceptual knowledge, and skills and techniques (Borders, et al., 1991). Other effective evaluation practices (Bernard & Goodyear, 1992; Borders & Leddick, 1987; Stoltenberg & Delworth, 1987) include clearly communicating mutually agreed upon goals; identify and communicate strengths and weaknesses; constructive feedback is best (often hearing the message of supervision is delayed until a positive relationship is established); specific, behavioral, and observable feedback is more useful to the supervisee; use multiple measures of supervisee rating skills (e.g., standardized rating scales, work samples, conceptual case studies, etc.); maintain a series of work samples in a portfolio for summative evaluation; and use a developmental approach which emphasizes both progressive growth toward desired goals and the learning readiness of the supervisee. The beneficial outcomes of using a structured approach to supervisee evaluation includes lowered anxiety of the supervisee (and, often of the supervisor), clear evaluation criteria, and use of multiple methods of evaluation contributes to the supervisee's sense of self-worth and success (Harris, 1994).

Whether called role, style, or function, Friedlander and Ward (1984) found that a highly task-oriented style is endorsed by cognitive-behavioral supervisors while a highly interpersonal style is endorsed by humanistic and psychodynamic supervisors. Furthermore, their study found that supervisory styles appeared to be differentially related to the supervisee's level of experience. In other words, supervisors tended to be more task-oriented with beginning supervisees and more attractive and interpersonally sensitive

with more experienced supervisees. All three styles were strongly associated with the supervisee's reported willingness to work with different model supervisors and satisfaction with supervision.

There are also particular supervisory styles that are likely to heighten supervisee anxiety beyond what might be expected as typical (Bernard & Goodyear, 1998). Three styles seemed to increase supervisee anxiety according to Rosenblatt and Mayer (1975) and include amorphous supervision. Supervisors using this style offer too little clarity about what they expect. They also offer the supervisee too little structure or guidance regarding expectations. The supervisee's anxiety level with this style of supervision is moderated by the amount of experience the supervisee has. A beginning supervisee perceives themselves to need more structure than those who are more advanced (e.g., Loganbill, Hardy, & Delworth, 1982; Worthington, 1987). Another style that was seen to provoke anxiety in supervisees was unsupportive supervision (Rosenblatt and Mayer, 1975). Supervisors using this style generally are cold, aloof and perhaps even seen as hostile. This is consistent with what Hutt et al. (1983) found in their phenomenological study and described as negative supervision. In this style of supervision, the emotional tone is negative and the supervisee may come to expect the supervisor to offer criticism but no support. This may cause the supervisee to feel vulnerable and threatened, thus fostering anxiety through various forms of resistance. The final anxiety-provoking style described by Rosenblatt and Mayer (1975), is therapeutic supervision. In this style, the supervisor attributes shortcomings in the supervisee's work to some deficiencies in his/her personality. The supervisor, in turn, attempts to address this deficiency in detail within the context of supervision. What supervisees found objectionable was not that

their work was found to be inappropriate, but the causal attribution and the attempt to remedy it in supervision. Rosenblatt and Mayer (1975) found that this style of supervision caused greater anxiety than the previously mentioned styles. Of course, the optimal style of supervision combines support and challenge (Worthington & Roehlke, 1979) in a supportive, learning environment.

Other barriers to effective supervision include supervision styles noted by Liese and Beck (1997). They caution that three supervisory styles are particular barriers to effective supervision and include the Mister Rogers Supervisor (“it is bad when someone’s feelings get hurt”); the Attila the Supervisor (“I need to be right all the time”); and the “How do you feel?” Supervisor (believes supervisee’s feelings about clients are more important than their conceptualizations about them). Of course, this last style of supervision is often used with psychodynamic supervisors and is considered the norm. Differences in supervision style based on theoretical frameworks will not be addressed here as that is not the intent of this study.

Steward, Breland, and Neil (2001) found that supervisees’ perceptions of supervisors’ supervisory style, particularly the Attractiveness subscale, was associated with the degree of supervisees’ accuracy in self-evaluation of counseling competence and was not associated with supervisors’ evaluation of supervisees’ counseling competency. Novice supervisees who perceived supervisors as more attractive tended to make less accurate self-evaluations, whereas those who perceived supervisors as less attractive tended to make more accurate self-evaluations of counseling competency. These findings suggest the importance of the support-challenge aspect of supervision, which includes support and friendliness as well as confrontational and catalytic interventions with novice

counselor supervisees. Supervisees' self-evaluations will most closely approximate those of supervisor only to the degree that supervisees perceive that they (the supervisee) have been both challenged and supported. There was an absence of a significant relationship between supervisors' evaluation of supervisees' counseling competency and supervisory style. Supervisees' perceptions of their supervisors did not influence evaluations of supervisees' counseling competence as they might have in the absence of close supervision. Yager et al. (1989) reported similar findings in a study of experienced supervisors. Yager et al.'s findings suggest the importance of the supervision of supervision to decrease the probability of the "liking" or "halo" effect that has been noted in the literature on counselor evaluation (Bernard & Goodyear, 1998).

Friedlander and Ward (1984) found that factor studies and three significant tests of within-supervisor differences indicated that supervisory style is multidimensional. That is, a particular supervisor's style is best represented as a profile with varying degrees of attractiveness, interpersonal sensitivity, and task orientation. Supervisory style is logically related to theoretical orientation.

Other supervisory styles appeared in Cherniss and Egnatios (1977) and include the didactic-consultive supervisor who offers advice, suggestions, and interpretations concerning client dynamics and clinical technique. Another style was the insight-oriented supervisor who asks questions designed to stimulate the supervisee to think through and solve problems on his/her own. The third style was the feelings-oriented approach which encourages the supervisee to question emotional responses to the clinical process. Finally, the authoritative supervision style allows the supervisee little autonomy, the supervisee is told in specific terms what to do and how to do it. It was found that the

didactic-consultive supervisory style, followed by the insight-oriented style, and finally the feelings-oriented style were preferred by supervisees in this study (Cherniss and Egnatios, 1977). These preferred styles (in order of preference) positively correlated with supervision satisfaction. The authoritative style correlated negatively with clinical self-confidence. Though this study is based on limited information about data collection method and instruments, the response rate of 94% was exceptional. Therefore, the conclusions appear usable and are intuitively valid.

Another study used the concepts of support and direction to examine relationships between the supervisor's preferred style of supervision and the supervisee's preference (Hart & Nance, 2003). In this case, supervisory style was described as the distinctive ways of responding to supervisees and the different approaches used. Underlying all styles of supervision are support (showing empathy, building rapport) and direction (questioning, instructing, challenging the supervisee). Four distinct styles were noted and are summarized in the chart below.

A	high direction; low support	B	high direction; high support
C	low direction; high support	D	low direction; low support

The results indicated that if either of the supervisor-supervisee dyads preferred style A or B, then Style C or D was not preferred. Also, the preferences of supervisee and supervisor were not related but there had to be a match between readiness level of the supervisee and the counseling style. There were several criticisms of this study, the largest being that it took nine (9) years to collect this data. Also, the purported

relationship between style preference of supervisees and supervisors was not established and was also not related to developmental readiness in the discussion. However, the instruments and data gathering were intact and justified the inclusion of their conclusions.

Supervisory style, then seems to be one variable that merits attention in the study of counseling evaluation and supervisory outcome (Steward, Breland, and Neil, 2001)

Supervision Outcome

Counseling rests on a reasonably solid empirical foundation with only recent attention being paid to clinical supervision; therefore, the body of literature on the effect of clinical supervision is limited (Bernard & Goodyear, 1998; Ellis, Ladany, Krenzel, & Schult, 1996). Outcome expectancies have been measured in less than 15% of studies (Larson & Daniels, 1998). And, outcome expectancies or supervisor effectiveness has often been confused with a supervisee's satisfaction with supervision. Though several other authors discuss effective supervision, definitions are not provided (e.g., Bernard & Goodyear, 1998; Getz and Agnew, 1999; Ladany, et. al., 1999; Loganbill, et. al., 1982). One of the barriers to determining supervision effectiveness is the reliance on satisfaction measures to assess supervision outcomes (Goodyear & Bernard, 1998). Good supervision also depends on the developmental level of the supervisee (Ronnestad and Skovholt, 1993) and includes increasing counselor self-efficacy (Larson and Daniels, 1998). Few researchers have investigated the relationship between specific supervisor behaviors and supervisor effectiveness (Worthington & Roehlke, 1979). Finally, supervision outcome has been defined as encompassing good counselor traits, good teacher traits, and good consultant traits in both the personal and professional arena (Borders, 1994). It was noted in this article that all supervisors benefit from training experiences focused on supervision

knowledge and skills, training where potential supervisors reflect on their roles and responsibilities, and training where potential supervisors receive feedback from others about their work as supervisors. Since one way of defining supervision outcomes is by delineating the characteristics, role, and labels given to effective supervision, the following discussion will be presented. This is also necessary since no clear definition has emerged from the literature.

Characteristics of effective supervision outcome are described by Bradley and Ladany (2001). They include self-reflection and self-monitoring of the interpersonal process associated with the supervisor-supervisee interactions, along with the ability to move between identifying with and observing the experiences of both the supervisee and the clients. When supervisees have been surveyed to indicate the characteristics of effective supervisors, they include expertise, trustworthiness, interpersonal attractiveness, tolerance of supervisee mistakes in an atmosphere of safety, openness to feedback about their own style of relating, and a significant investment of time (White & Russell, 1995).

However, since there is a distinct absence of supervision outcome research (Goodyear & Bernard, 1998; Worthington, 1987), a look at the reasons behind the omission is necessary. There seem to be several reasons for this lack of examination. One of those reasons is that there has been relatively little theory-driven research in supervision. This is now beginning to change. Another reason for the lack of efficacy studies is that supervision researchers have not had supervision manuals or protocols to follow to ensure that a reasonably accurate version of a particular model is being followed. Finally, the absence of efficacy studies of supervision has been because it is difficult to design one that protects the clients. For example, it would be unethical to

assign one supervisee to an intervention and others to a control groups in which they see clients but receive no supervision.

Larson and Daniels (1998), in their literature review looked at how supervision outcome and counselor self-efficacy are related to the supervision environment. Counselor self-efficacy is defined as one's beliefs or judgments about one's own capabilities to effectively counsel a client in the near future. Among the variables noted to correlate with increased counselor self-efficacy were job satisfaction, increased task orientation of the supervisor, counselor's perception of support in the work environment, and positive performance feedback (shown as slightly more helpful than negative feedback). Personal counseling for counselors with low self-efficacy increased counseling performance as well. These discoveries are notable since this literature review covered 15 years and 32 articles. However, there were no articles mentioned where counselor self-efficacy was a secondary characteristic and therefore, articles whose main focus may have been another area but included self-efficacy as part of the study, were not mentioned or reviewed.

Getz and Agnew (1999) conducted a study which found that when supervision followed a specific structure (didactic training followed by experiential training), there was increased personal and professional growth. Though personal growth is tangentially related to supervision outcome it is included here. There were several methodological flaws, one of which included the structure of supervision and whether or not simply providing a structure for supervision would have given the same results. In other words, would providing any structure at all for supervision have the same results as providing this specific structure. Also, the study was conducted in such a way that one cannot

generalize to any other population, due mainly to the confounding variable of training. In other words, if counselors have already been trained to expect supervision, then training supervisors to provide supervision would not be as novel as it seems to have been in this agency. Also, details regarding the number of participants and how and when data was collected are not included in the study. However, the results that structured supervision increased personal and professional growth have been mentioned in other studies as well (cf. Goodyear & Bernard, 1998; Henderson, 1994; Ladany, et. al., 1999; Loganbill, et. al., 1982). Therefore, some validity can be assigned to these results.

According to another study, supervisors must be helped to understand that to provide truly effective supervision, thus effective supervision outcomes, they must think of their supervisees as learners and of themselves as educators who create appropriate learning environments (cf. Blocher, 1983; Borders, 1992; Stoltenberg, 1981).

Competent supervisors not only are competent counselors; they also are capable educators who apply their counseling skills, along with their teaching and consulting skills, in a new context and relationship, toward new goals (Borders, 1992). Rather than making plans for counseling the client, they devise learning strategies to help the supervisee be more effective with that client (assuming there is no harm to the client).

These supervisors are educators in the best sense of the word; they not only impart knowledge and skills, but also draw out the supervisee's inherent and natural skills so that he or she does not merely repeat what the master or others have done before them. As a result, their supervisees evolve an integrated personal and professional identity as a counselor.

Several methods of improving counselor competence, thus improving supervision outcome, were suggested by Hart (1994). These include use of live supervision, supervision conducted immediately following a counseling session or using an audio or videotape that has been previously reviewed by both the supervisor and supervisee. These methods would ensure immediate feedback for the supervisee. Though perhaps intuitively obvious, Hart (1994) does not give evidence regarding the reason immediate feedback is superior to delayed feedback. He also states that supervisors must take into account the supervisee's developmental level as well as the supervisee's skill with that type of client, anxiety around reviewing their own work, and their learning style. However, he states that as a supervisee becomes more competent, the supervisor should emphasize more advanced skills or more complex client issues. Hart (1994) also states that as supervisees become more advanced, the supervisor should become more of a consultant and colleague rather than teacher with less emphasis on live supervision. This has also been stated by Bernard and Goodyear (1998), Borders (1992), and Ladany, et. al. (1999). Though the article states some overall methods for effective supervision, there is no discussion of how or what led to these conclusions and the literature review is rather limited in scope as well.

In a discussion of solution focused strategies for supervision, Presbury et al. (1999) state that in order for one to be a better supervisor, one must focus on supervisee's competencies rather than on correcting deficiencies. This premise, though perhaps intuitive, is based on a literature review of other qualitative articles and is as robust as it can be, based on qualitative evidence. There are certain ideas that contribute to supervision outcome mentioned in this article, however, and they include balancing the

supervisor's dual tasks of training the supervisee and encouraging their development. Too much reliance on technological monitors (e.g., tape recorders, one-way mirrors, etc.) may inhibit the supervisee's development of their own inner vision which includes a sense of self-efficacy, confidence and trust of own resources in the moment with a client, and personal vision of self as an emerging counselor. Supervisors who encourage mutual respect, affirmation, empowerment, and listening encourage an ideal relationship. This collegial relationship is characterized by collaboration, encouragement, illumination, and discovery. When this type of relationship is present, it encourages a supervisee's inner vision and contributes to a positive supervision outcome, according to the conclusions drawn in this article.

C. H. Patterson (Freeman, 1992) had another idea about how to effect positive supervision outcome and it consisted of a match between the theoretical orientation of both supervisor and supervisee. This would include a congruence of both the process of therapy and the process of supervision as well as ensuring a common knowledge base. There should be a structure for expectations of both therapy and supervision, as well. Since supervision is a relationship, it shares the same principles of all good relationships which includes providing a non-threatening environment. The relationship is more important than developmental stages, according to Patterson. The personality of the supervisee is not important unless it interferes with the work being done with clients. Though Patterson's ideas are based on experience, there is little empirical evidence offered. Powell (1993) offers some conflicting ideas about supervision outcomes. Perhaps these differences are due to the unique nature of addictions treatment. Powell states that a supervisee's personality is very much part of the relationship and affects the

process of supervision. There is, however, also no empirical evidence offered for this view either.

Just as important to examining supervision outcomes which are positive is to look at outcomes which are counterproductive. Magnuson, Wilcoxon, and Norem (2000) looked at counterproductive supervisory behaviors and identified several. They classified them as a way to enhance awareness among supervisors and educators. Though their evidence dovetails with other qualitative findings, there were some design flaws which may have introduced confounding variables. The participants in this study were diverse, five interviews were conducted by telephone and six interviews were done in person. Another problem with the study was that, though the behaviors were examined, no reasons were given or even posited for the findings. Given these flaws, however, there is still valuable information given about supervision outcomes. This includes a complex structure of six overarching principles of counterproductive supervisory behavior. They are a) unbalanced (overemphasizing some elements of supervision experiences and excluding others); b) developmentally inappropriate (fail to recognize and respond to the changing needs of supervisees); c) intolerant of differences; d) poor model of professional and personal attributes (including boundary violations, intrusiveness, and exploitation); e) untrained (inadequate preparation, poor professional maturity); f) professionally apathetic (e.g., lazy). Interacting with these overarching principles are three general spheres within which these principles operate. These spheres are a) organizational/administrative (supervisor's failure to establish parameters within which supervision could be conducted); b) technical/cognitive (unskilled practitioners, unskilled supervisors, and unreliable professional resources); c) relational/affective (importance of providing a safe

environment by humanizing supervision). The overarching principles manifest themselves differently depending on which general sphere they are used in.

Supervisees' accurate self-evaluation of work with clients has been identified as an important outcome of successful clinical supervision (Steward, et al., 2001).

Counselor self-efficacy relates to, among other things, supervision environment (Larson & Daniels, 1998). Supervisee's perceptions of support in the work environment were found, in this study, to relate to counselor self-efficacy. Also, supervisees with little experience with supervision report lower self-efficacy. Even after these supervisees gained experience with supervision, there was still minimal relationship between self-efficacy and experience. A startling finding of this study was that supervisees who had low self-efficacy initially and engaged in personal counseling had a marked increase in counseling performance afterward. This was, however, only obliquely related to supervision.

Powell (1991) found that certain personality profiles of supervisors show that specific orientations make for supervisors deemed excellent by supervisee evaluations and employers. Ironically, this personality profile is the same as that of counselors deemed successful by supervisors. This study was based on a limited sample and undocumented reliability and validity of the instrument. However, the results are intriguing and warrant explanation. The following chart details the personality profile of Needs Driven Behavior. Values Driven Behavior was never described but noted as being outside the scope of this study.

Process—shapes environment, according to a particular view.	Product—the “how” and “why” of behavior
Dominance (action)—measure themselves by what is accomplished; shape their environment by overcoming opposition to accomplish results	Steadiness (maintain stability)—team players that emphasize cooperating with others
Influence (personality)—desire to be liked and likable; considered “people” people	Compliance (right way)—work with existing circumstances to promote quality in products and services

The personality profile of excellent supervisors includes high Influence, little or no Dominance, and some Steadiness and Compliance orientations. These supervisors were deemed excellent by supervisee evaluations and employers. This profile is also the same profile as for counselors.

During supervision, supervisors behave in ways which they believe will contribute to helping supervisees develop into effective counselors and, thus, positive supervision outcome. Counselor’s perceptions of their relationships with their supervisors have been found to affect both their counseling performance (Lanning, 1971) and client outcome (Bibbo, 1975). When these personal interactions are characterized by trust and respect, they then ideally become the hallmarks of the interpersonal climate of the organization and staff. However, the reality is that there is a power inequality in supervisory relationships (Bernard & Goodyear, 1992). The person who needs the other more (supervisee or client) typically has less power than the person who is needed (supervisor or counselor); and the person who has permission to comment on the other’s behavior also has the greater power (Strong, 1968). In addition, the supervisor has evaluative responsibilities with respect to the supervisee, an additional type of power (Bernard & Goodyear, 1992). Robiner (1982) pointed out that the power difference is a constant

obstacle to gaining the mutual trust that is so important in supervision and which is essential to effective supervision.

CHAPTER THREE

METHODOLOGY

INTRODUCTION

This chapter will delineate the methodology used to explore the addiction treatment professional's perception of supervision outcomes, supervisory styles, counselor self-efficacy, and demographic variables. There were six research questions addressed in this study. Since this research is exploratory in nature and is not being used to validate a particular theory, no hypotheses were developed. The research questions were as follows:

Research Question 1: What do addictions treatment counselors perceive as the overall supervisory style of their clinical supervisors?

Research Question 2: Does the supervisory style of clinical supervisors of addictions treatment counselors predict the outcome of supervision?

Research Question 3: What type of delivery style of supervision do addictions treatment counselors receive?

Research Question 4: Is there a significant relationship between supervision outcome and specific demographic characteristics of addictions treatment professionals (e.g., age, years of experience, recovery status, gender, formal education)?

Research Question 5: What is the relationship between perceived addictions treatment counselor self-efficacy and perceptions of supervision outcome?

Research Question 6: Can supervision outcome be predicted from addiction treatment counselor perceived supervisory style and perceived self-efficacy?

PARTICIPANTS

Participants were chosen from among northern Virginia's Community Services Boards (CSB). The CSB's manage all mental health services including mental health centers, developmental delay services, and addiction treatment services and are publicly funded. Four large, urban CSB's have been chosen to participate. These CSB's were contacted so that a total of 300 packets were distributed for the use of this study. Participants came from a variety of settings within these CSB's. Demographic information about the participants begins on page 112 and is detailed in Table 1 (p. 114).

DESCRIPTION OF MEASURES

The Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984) was used to measure the supervisor's style, defined as the manner in which a supervisor approaches and responds to counselors and how she or he implements supervision within the supervisory relationship (Holloway & Wolleat, 1981). The SSI is a 33-item measure of the degree to which a supervisor or supervisee endorses behaviors that represent each of the three dimensions/factors of supervisory style: Attractiveness (friendly, flexible, supportive, open, positive, warm; 6 items), the Interpersonally Sensitive (perceptive, committed, intuitive, reflective, creative, resourceful, invested, therapeutic; 8 items), and Task-Oriented (goal-oriented, concrete, explicit, practical, structured, evaluative, prescriptive, didactic, thorough, focused; 10 items). The questionnaire consists of 33 items; each item is a single, descriptive adjective. Of those 33 items, 25 adjectives are used for the three subscales and 8 are filler items. On a 7-point Likert scale (1 = not very, 7 = very), respondents indicate to what extent the word is descriptive of their supervisor (if the respondent is a supervisee) or of their perceived supervision style (if the

respondent is a supervisor). Raw scores on the designated items for each scale are summed and the raw scores are then divided by the total number of items in each subscale, to obtain a mean scale index. The scale index ranges from 1 to 7, with the higher mean score indicating greater endorsement of the particular style. The version used for this study asks for the respondents to describe their supervisor.

In two studies conducted by Friedlander and Ward (1984), both the supervisor and trainee versions of the SSI scales were found to have moderately high internal consistency estimates (alpha), from .70 to .93. Test-retest reliability coefficients obtained at 2-week intervals ranged from .78 to .94 for the total inventory and for each scale. The convergent reliability estimates were obtained from three SSI subscale scores of doctoral practicum students (N=90) and three composite variables from Stenack and Dye's (1982) study, which identified specific items addressing professional task differences among teachers, counselors, and consultants. The correlations were found to range from moderately to highly positive. Inter-correlations among the scales range from .11 for Interpersonally Sensitive and Task Oriented to .61 for Attractive and Interpersonally Sensitive. Friedlander and Ward, (1984) reported several other studies of the psychometric properties of the SSI in which trainee scores were analyzed by level of training, supervisor scores were analyzed by theoretical orientation, and student scores were used to discriminate between supervisors of different theoretical orientations when working with the same trainee. The results of these studies support the psychometric adequacy of the SSI.

The Supervision Outcome Questionnaire (SOQ) is based on the work of Worthington and Roehlke (1979). It consists of three questions measuring satisfaction

with supervision, supervisor competence, and contribution of supervision to improved counseling. The SOQ was developed on a sample of two groups of subjects, supervisors and supervisees. It contains three items that are rated on a 7-point Likert scale ranging from *1=totally unsatisfied, it could not have been worse* to *7=totally satisfied, it could not have been better*.

In a study done by Worthington and Roehlke (1979), the instrument used consisted of 42 supervisor behaviors that were compiled from a number of informal interviews. These behaviors were rated by supervisors on a 5-point Likert scale (*5=absolutely crucial for good supervision* and *1=matters hardly at all for good supervision*) and reflected participants' perceptions of the importance of each behavior to good supervision. At the end of a semester, each of these 42 supervisor behaviors was rated by supervisees using a Likert-type scale (*5=perfectly descriptive of my supervisor's behavior* and *1=never, or very infrequently descriptive of my supervisor's behavior*). Ratings reflected how descriptive each behavior was of the supervisor's actual behavior during the semester that had just ended. Supervisees also rated the effectiveness of the supervision they had received. Each of the three areas was rated on a 7-point Likert scale (*1=totally unsatisfied, it could not have been worse* to *7=totally satisfied, it could not have been better*). The areas were a). satisfaction with supervision, b). how competent your supervisor was at giving good supervision, and c). how much interactions with your supervisor contributed to improvement in your counseling ability. The three items of the SOQ are drawn from part C of this previous study.

The Counseling Self-Efficacy Scale (COSES) is based on the work of Melchert, et. al. (1996). It consists of 20 items indicating the degree of agreement regarding the

respondents' confidence in their counseling abilities (see appendix H). The COSES was developed using participants with a wide range of experience and training, all of whom had ties to a department of counseling psychology at a large midwestern university. It contains 20 items that are rated on a 5-point Likert-type scale ranging from *1=very true* to *5=very false*. One half of the items are worded negatively to help protect against appealing response bias, thus requiring that responses to positively worded items (1, 2, 5, 7, 8, 13, 15, 16, 18, 20) be inversely recorded so that high scores correspond with high self-efficacy.

In a study conducted by Melchert, et. al. (1996), items for the COSES were developed from a literature review regarding knowledge and skill competencies needed by counselors. The COSES attempted to comprehensively assess skills normally used in the practice of counseling while excluding skills primarily associated with particular theoretical approaches. Agreement between all authors of the study was needed for item inclusion. Content validity was obtained using three expert judges to evaluate the COSES. In 19 of 20 instances, there was unanimous agreement with two of three judges agreeing on the other item. The study was conducted with 138 participants whose experience ranged from none, first year master's level counseling students, to 15+ years, licensed professional psychologists. The test-retest reliability was found to be .85 when the instrument was administered to a representative subsample one week after the original administration.

A demographic form was included as part of the participant packets. The items included highest degree obtained, recovery status of both the addictions treatment professional and of their supervisor, gender, ethnicity, case load, years of experience in

the addictions treatment field, frequency of supervision (both currently receiving and ideally would like to receive), and type of supervision received (see Appendix G). The variables of gender, ethnicity, educational degree, recovery status of the addictions treatment professional and their supervisor, number of clients in their case load, and years of experience in the addictions treatment field were explored in relation to the type of supervision that addictions treatment professionals receive. These variables were intended to provide descriptive data regarding current practices of clinical supervision.

PROCEDURE

Participants were recruited using northern Virginia's Community Services Boards (CSB). The CSB's manage all mental health services including mental health centers, developmental delay services, and addiction treatment services for designated counties and/or geographic regions and are state funded. Prospective participants were identified in the counties and areas of northern Virginia. As such, either the Director of Services or the director of Substance Abuse Services was contacted and prospective participants were identified. A single point of contact was identified for packet distribution in each county/area. This single point of contact distributed packets to all centers where prospective participants were located and collected them in sealed envelopes. These sealed envelopes were then provided to the researcher. A cover letter was included in each packet and asked supervisees to reflect on their supervision experience in the field of addictions treatment as well as providing informed consent. Participants were informed that their return of the packet constituted consent to participate in the study and that they could withdraw their consent at any time. Packets were distributed in such a manner as to reflect anonymity on the part of the supervisee.

PILOT STUDY

Participants

Eleven participants were solicited from a graduate course taught at a local university. Participants were recruited based on availability. The course instructor was contacted and a time to administer the measures as well as the Questionnaire Feedback Form was mutually agreed upon. In exchange for allowing the researcher to conduct this pilot study, the researcher gave an hour lecture on a relevant topic for this course after the instruments were administered. There were 11 students present ($n = 11$), and all agreed to partake in the pilot study.

All eleven surveys were returned (100%). The resulting pilot sample included 10 females (91%), 2 of whom were members of an ethnic minority group, and one male (9%) who was a member of an ethnic minority group. Overall, 63.6% ($n=7$) were White/European American, 18.2% ($n=2$) were Black/African American, and 18.2% ($n=2$) were Hispanic/Latino.

None of the participants were in recovery ($n=11$) and none of the participants' supervisors were in recovery ($n=11$).

A total of 6 participants, 54.5%, were in the 20-29 age range, with four (36.4%) in the 30-39 age range, and one (9.1%) in the 40-49 age range. Ten participants had some graduate work with one having a master's degree.

Procedure

Each participant in the pilot study was given a packet in the order shown in Appendix A with a cover letter as shown in Appendix B. Participants were instructed to complete the measures as if they were addictions treatment counselors and to note the

amount of time that each individual instrument would take them to complete.

Participants were also instructed to keep the instruments confidential by not writing their names on them. They were then instructed to complete the measures and then to complete the Questionnaire Feedback Form. The Questionnaire Feedback Form included items pertaining to the ease of completion, understandability, and time required to complete each instrument. (see Questionnaire Feedback Form in Appendix F). The Counselor Self-Efficacy Scale was not yet added to the packet at the time of the pilot study.

Results

Responses from the Questionnaire Feedback Form were clear and concrete. Comments on the clarity of the SSI included statements regarding definitions of the words "facilitative" and "didactic" that could be included in the directions. Another comment simply indicated that some word's meanings were unclear. Other comments indicated that the lines were difficult to follow.

The final comment indicated that the directions were not clear about who or what to rate.

The Demographic Questionnaire was generally clear with one participant indicating that the definitions of the "clinical supervisor" and "administrative supervisor" could be more direct.

Responses regarding the clarity of the Outcome Questionnaire showed that a definition of the phrase "initial perception" would have been helpful to one participant. One participant indicated that the word "objectivity" would be better used than the phrase "halo effect" while another participant thought the wording was currently very good. One participant indicated that there should be a greater distinction between the

scale numbers and another participant agreed that there should be fewer choices among the Likert-type scale (e.g., 1-3 versus 1-5).

The time to take the SSI averaged 3 minutes, the time to take the Demographic Questionnaire averaged 2 minutes, and the time to take the Outcome Questionnaire averaged 1 minute. Therefore, the total time to take all three instruments averaged 6 minutes.

Modifications to the Initial Instruments/Measures

The comments on the Questionnaire Feedback Form were carefully considered and as a result several modifications were made to the original instruments. For instance, the Demographic Questionnaire was modified to include more concise definitions of the phrases "clinical supervisor" and "administrative supervisor." Also, the option of "don't know" was added to question 3. Is your supervisor currently in recovery? Another question was added to indicate what type of licensure or certification the participant has. The SSI was modified to include lines between every fifth question and to define the words "facilitative" and "didactic" in the directions. The Outcome Questionnaire was not modified.

The revised instruments are presented in Appendix G.

DATA ANALYSES

Descriptive statistics . Means, standard deviations, frequencies, and percentages were computed for each survey item. Additional analyses were conducted to address the four research questions. Each research question was examined using the following data analyses:

Research Question 1: Research question 1 (perceptions of supervisors' styles)

was examined by analyzing and examining the means, standard deviations, response frequencies, and percentages of the Supervisory Styles Inventory exploring supervisees' perceived overall supervisory style of their clinical supervisor.

Research Question 2: Research question 2 (style prediction of outcome) was explored by calculating correlation coefficients as well as a regression analysis for the variables of concern: supervision style (Attractiveness, Interpersonally Sensitive, and Task Oriented) and supervision outcome. The alpha level was set at .05.

Research Question 3: Research question 3 (type of delivery style) was explored by analyzing the mean, standard deviation, response frequencies, and percentages of the type of supervision (e.g., individual, group, peer) addictions treatment counselors receive.

Research Question 4: Research question 4 (relationship between supervision outcome and demographic variables) was explored by calculating correlation coefficients as well as a regression analysis for the variables of concern: demographic questions and type of supervision received by addictions treatment counselors. The demographic variables which were examined are as follows: formal education, recovery status of supervisee, recovery status of supervisor, age, gender, race/ethnicity, caseload, years of experience. The alpha level was set at .05.

Research Question 5: Research question 5 (relationship between perceived counselor self-efficacy and supervision outcome) was explored by calculating a correlation coefficient as well as a regression analysis for the variables of concern: the counselor self-efficacy and supervision outcome. The alpha level was set at .05.

Research Question 6: Research question 6 (the relationship between perceived addictions treatment counselor self-efficacy and perceptions of supervision outcome) was

explored by using multiple regression analysis (step-wise regression) with supervision outcome as the dependent variable and with counselor self-efficacy and supervisory style (subscale of Attractiveness, subscale of Interpersonally Sensitive, and subscale of Task Oriented) as the independent variables. The alpha level was set at .05.

CHAPTER FOUR

RESULTS

INTRODUCTION

This chapter will report the results of the six research questions designed to explore the relationships between addiction treatment professional's perception of supervision outcomes, supervisory styles and demographic variables. More specifically, this study examined the following research questions:

1. What do addictions treatment counselors perceive as the overall supervisory style of their clinical supervisors?
2. Does the supervisory style of clinical supervisors of addictions treatment counselors predict the outcome of supervision?
3. What type of delivery style of supervision do addictions treatment counselors receive?
4. Is there a significant relationship between supervision outcome and specific demographic characteristics of addictions treatment professionals (e.g., age, years of experience, recovery status, gender, formal education)?
5. What is the relationship between perceived addictions treatment counselor self-efficacy and perceptions of supervision outcome?
6. Can supervision outcome be predicted from addiction treatment counselor perceived supervisory style and perceived self-efficacy?

DESCRIPTION OF PARTICIPANTS

One hundred and forty eight (n = 148) usable surveys were returned out of 299 that were distributed, for a return rate of 49.7%. A total of 150 surveys were returned,

however, two of them were unusable due to missing instruments in the return packet.

The breakdown of returns from each Community Services Board (CSB) was as follows:

Fairfax/Falls Church CSB returned 89 surveys (40.1%), Alexandria CSB returned 5 surveys (41.7%), Loudoun CSB returned 16 surveys (73%), and Prince William CSB returned 38 surveys (88.45%).

Of the 148 participants, 107 (72.3%) identified themselves as female and 41 (27.7%) identified themselves as male. Participants identified themselves ethnically as follows: 102 White/European American (68.92%), 28 Black/African American (18.92%), 10 Hispanic/Latino (6.76%), 5 Other (3.38%), 2 Asian-American/Asian-Pacific Islander (1.35%), and 1 Multi-racial (0.68%) (see Table 1). There is no data regarding the ethnic or gender diversity of addictions treatment professionals in general. Therefore, there is no way to determine whether this sample is reflective of the general population of addictions treatment professionals.

In terms of education, 97 participants had a Master's degree (65.54%), 17 had a Bachelor's degree (11.49%), 17 had "Some Graduate Work" (11.49%), 7 had Doctoral degrees (4.73%), 7 participants had "Some College" (4.73%), 2 had an Associates degree (1.35%), 1 had a Specialist degree (0.68%). When examining recovery status, 108 participants noted that they were not in recovery (72.97%) and 40 were in recovery (27.03%). Supervisors of participants had a similar rate of recovery with 109 supervisors not in recovery (73.65%) and 39 in recovery (26.35%).

Years of experience were noted to be high with 88 participants having over 8 years of experience in the field of addictions treatment (59.46%), 30 participants with 4-7

years of experience (20.27%), 20 participants with 2-3 years of experience (13.51%), and 10 participants having less than 1 year of experience (6.76%).

Looking at participants' caseloads, the majority of participants (n= 93, 62.84%) had less than 20 clients per week on average, 16 participants had an average of 20-25 clients (10.81%), 17 participants had an average of 25-30 clients per week (11.49%), 9 had an average of 30-35 clients per week (6.08%), 9 had an average over 40 clients per week (6.08%) and 4 had client loads averaging 35-40 per week (2.7%).

When asked about frequency of supervision, the majority of participants (n= 104) had Weekly supervision (70.27%), 22 had supervision every other week (14.86%), 16 had supervision on a monthly basis (10.81%), 5 had supervision semi-annually (3.38%), and one had supervision annually (0.68%).

When compared with the frequency of supervision that participants desired, the results are similar. There were 98 participants that wanted supervision on a weekly basis (66.22%), 33 wanted supervision every other week (22.30%), 12 wanted supervision monthly (8.11%), 4 wanted supervision on a semi-annual basis (2.7%), and one wanted supervision on annually (0.68%). The type of supervision that participants received included individual supervision for 86 participants (58.11%), group supervision for 15 participants (10.14%), peer supervision for 6 participants (4.05%), and a combination of several types of supervision for 41 participants (27.7%).

Table 1

Demographic Information of Sample

Characteristic	Sample	
	n	%
Gender		
Male	41	27.7
Female	107	72.3
Ethnicity		
White/European American	102	68.92
Black/African American	28	18.92
Hispanic/Latino	10	6.76
Asian/Asian American		
Pacific Islander	2	1.35
Multi-racial	1	0.68
Other	5	3.38
Level of Formal Education		
High School Diploma	0	
Some College	7	4.73
Associate Degree	2	1.35
Bachelor's Degree	17	11.49
Some Graduate Work	17	11.49
Master's Degree	97	65.54
Specialist Degree	1	0.68
Doctoral Degree	7	4.73
Participant in Recovery		
Yes	40	27.03
No	108	72.97
Supervisor in Recovery		
Yes	39	26.35
No	109	73.65

Demographic Information of Sample (con't)

Characteristic	Sample	
	n	%
Total Years of Experience		
0-1 Years	10	6.76
2-3 Years	20	13.51
4-7 Years	30	20.27
8 + Years	88	59.46
Current Weekly Caseload		
Under 20 Clients	93	62.84
20-25 Clients	16	10.81
25-30 Clients	17	11.49
30-35 Clients	9	6.08
35-40 Clients	4	2.70
Over 40 Clients	9	6.08
Frequency of Supervision		
Weekly (or more often)	104	70.27
Every Other Week	22	14.86
Monthly	16	10.81
Semi-Annually	5	3.38
Annually	1	0.68
Frequency of Supervision Desired		
Weekly (or more often)	98	66.22
Every Other Week	33	22.30
Monthly	12	8.11
Semi-Annually	4	2.70
Annually	1	0.68
Type of Supervision		
Individual	86	58.11
Group	15	10.14
Peer	6	4.05
Combination	41	27.70

RESULTS

The first research question “*What do addictions treatment counselors perceive as the overall supervisory style of their clinical supervisors?*” was explored by analyzing the means, standard deviations, and response frequencies of the participant’s responses to the Supervisory Styles Inventory (SSI). The means, standard deviations, and response frequency of the three subscales were also taken into account (see Table 2). The overall mean for the SSI was 5.39 (SD = 0.83). The range of possible scores is from one to seven (1-7) with a higher number indicating a more positive perception of style. This mean indicates a fairly positive overall perception of supervisory style.

When divided into subscales, the mean for the subscale of Attractiveness was 5.22 (SD = 1.18). There are six items in this subscale and examples of items include: “Friendly” and “Supportive.” This mean is also fairly high and indicates a positive perception of supervisors on attractiveness.

The Interpersonally Sensitive subscale had a mean of 5.72 (SD = 0.99). This subscale had eight items and examples of items included under this subscale are: “Perceptive” and “Reflective.” This mean is slightly higher than the mean for the Attractiveness subscale indicating an even more positive perception of supervisors’ interpersonally sensitive style.

The Task-Oriented subscale had a mean of 5.24 (SD = 1.09). The subscale Task-Oriented had a total of ten items which include: “Goal-oriented” and “Thorough.” This mean is close to that of the Attractiveness subscale and also indicates a positive

Table 2

Means and Standard Deviations of the Supervisory Styles Inventory (SSI; n = 148)

Item	Subscale 1: Attractiveness		Subscale 2: Interpersonally Sensitive		Subscale 3: Task-Oriented	
	M	S D	M	S D	M	S D
15. friendly	6.35	1.01				
16. flexible	5.99	1.23				
22. supportive	6.23	1.18				
23. open	5.96	1.24				
29. positive	6.06	1.15				
33. warm	6.96	1.27				
2. perceptive			5.57	1.33		
5. committed			6.16	1.10		
10. intuitive			5.50	1.47		
11. reflective			5.53	1.31		
21. creative			5.39	1.32		
25. resourceful			5.84	1.14		
26. invested			6.20	1.16		
28. therapeutic			5.57	1.42		
1. goal-directed					5.30	1.46
3. concrete					5.04	1.47
4. explicit					5.09	1.37
7. practical					5.78	1.16
13. structured					5.03	1.61
14. evaluative					5.27	1.36
17. prescriptive					5.06	1.49
18. didactic					4.86	1.57
19. thorough					5.47	1.42
20. focused					5.45	1.34

Note: Items 6, 8, 9, 12, 24, 27, 30-32 are filler items.

perception of supervisors on task orientation.

There were 8 filler items which were not included in data analysis and not included in any subscale.

The second research question, “*Does the supervisory style of clinical supervisors of addictions treatment counselors predict the outcome of supervision?*” was examined by conducting a linear regression analysis. The scatterplot for the two variables, as shown in Figure 1, indicates that the two variables are linearly related such that as overall Supervisory Styles Inventory (SSI) score increases the total score for Supervision Outcome Questionnaire (SOQ) also increases. The regression equation for predicting the supervision outcome score is:

$$\text{Predicted Supervision Outcome} = 2.98 (\text{SSI Total}) + 0.39$$

At the 95% confidence interval for the slope, total SSI score is significantly related to the predicted supervision outcome. A higher total supervisory styles score indicates a more positive supervision outcome. The correlation between the SOQ total score and the SSI total score was 0.55, $p < 0.0001$. The effect size for this equation is 0.30 indicating that almost a third of the supervision outcome results can be predicted from it.

The next research question, “*What type of delivery style of supervision do addictions treatment counselors receive?*” was explored by analyzing and examining the response frequency and percentage of each of the different types of supervision that addictions treatment counselors receive. The most frequent type of supervision received was “Individual Supervision” for 86 of the 148 respondents (58.11%). A “Combination” of supervisory delivery styles which included individual, group, and peer supervision

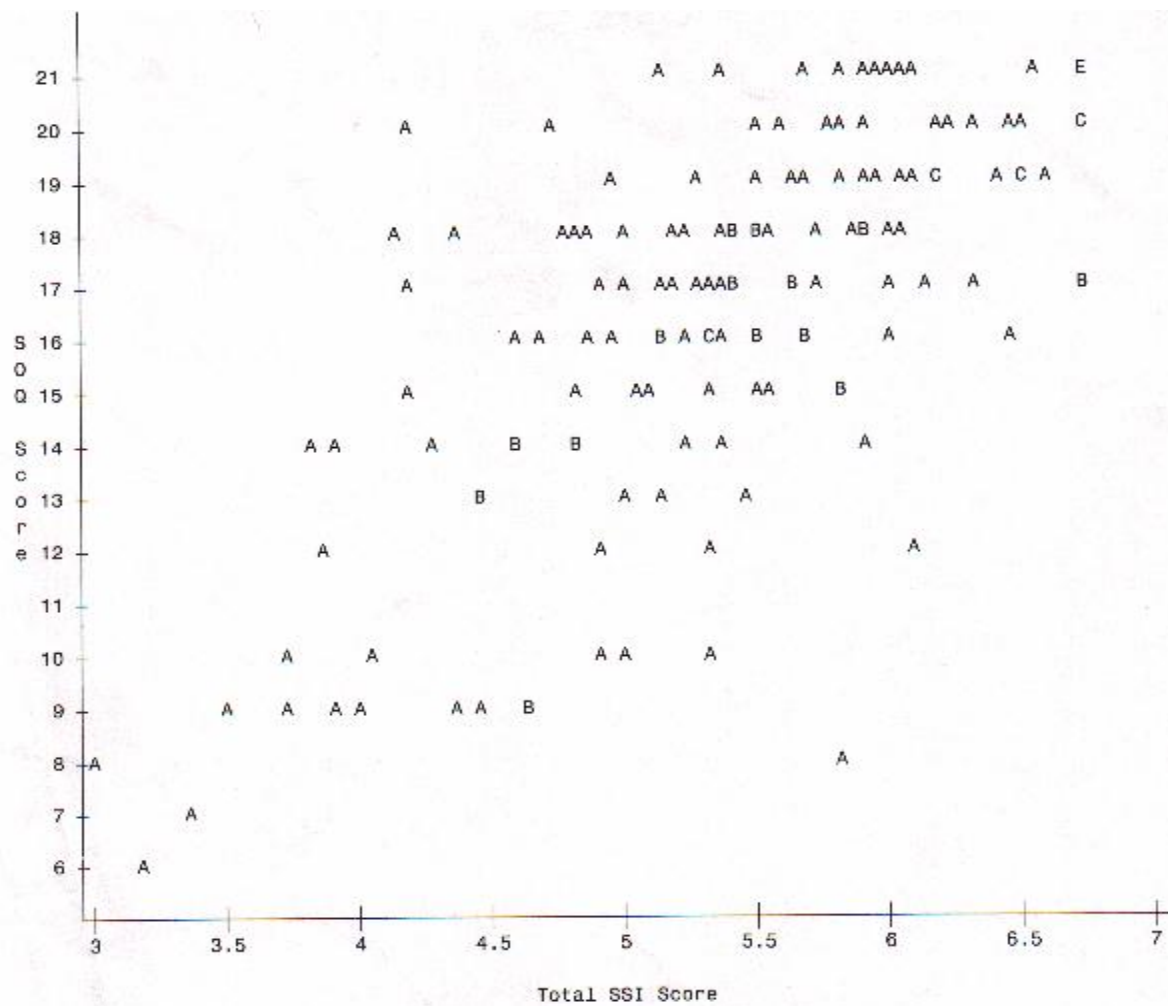


Figure 1: Scatterplot of SSI and SOQ

accounted for the next highest percentage with 27.7% ($n = 41$). “Group Supervision” accounted for 10.14% ($n = 15$) and six participants (4.05%) reported receiving “Peer Supervision.”

In order to examine the question, “Is there a relationship between specific demographic variables (e.g., age, years of experience, counselor and supervisor recovery status, gender, and formal education level) and the supervision outcome of addictions counselors?”, a series of analysis of variance was conducted. The dependent variable was the total score of the supervision outcome measure. The independent variables were the age of the counselor, years of experience, the counselor recovery status, supervisor recovery status, gender, and formal education level. Gender was the only demographic variable that was significantly related to supervision outcome. Male counselors ($M = 17.73$, $SD = 3.78$) reported higher supervision outcome scores than female counselors ($M = 15.95$, $SD = 2.61$) (see Table 3).

As a post hoc analysis, a hierarchical multiple regression analysis was conducted to predict the overall supervision outcome from the recovery status of addictions counselors and supervisors. The results of this analysis indicated that the recovery status of the counselor and supervisor did not account for a significant amount of the supervision outcome variability, $R^2 = .01$, $F(2, 147) = 1.10$, $p > .01$.

A second analysis was conducted to evaluate whether the other demographic variables predicted supervision outcome over and above the recovery status of the counselor and supervisor. The other demographic variables did not account for a significant proportion of the supervision outcome after controlling for the effects of recovery status (see Table 4).

The research question “What is the relationship between perceived addictions treatment counselor self-efficacy and perceptions of supervision outcome?” was explored by conducting a correlational analysis between the total score of the Counselor Self-Efficacy Scale (CSES) and the total score of the Supervision Outcome Questionnaire (SOQ). The resulting coefficient was 0.04 and was not significant at the 0.01 level. This indicates that counselor self-efficacy is not statistically significant relative to supervision outcome.

And finally, the research question, “Can supervision outcome be predicted from addiction treatment counselor perceived supervisory style and perceived self-efficacy?” was examined by conducting regression analyses to evaluate the prediction of supervision outcome from the SSI and the CSES. The regression equation for predicting the total supervision outcome is:

$$SOQ = (-0.02) CSES + (3.00) SSI + 2.19$$

Although the R-squared for this regression was statistically significant ($p < .001$) and large, the CSES variable did not contribute significantly to the regression equation; the SOQ was predicted entirely by the SSI variable. Therefore, as counselors increase their satisfaction with supervisory styles, their satisfaction with supervision also increases. The effect size for this equation is 0.48 indicating that almost half of the supervision outcome results can be predicted from it.

Another linear regression was conducted to evaluate the prediction of supervision outcome from the individual supervisory styles (the subscales of Attractiveness, Interpersonally Sensitive, and Task-Oriented) and counselor self-efficacy. The regression equation for predicting the overall supervision outcome is:

$$SOQ = (-0.03)CSES + (0.02)SSI\textit{ Attractiveness} + (0.03)SSI\textit{ Task-Oriented} + (0.30)SSI\textit{ Sensitivity} + 2.95$$

Although the R-squared for this regression was statistically significant ($p < .001$) the Attractiveness and Task-Oriented variables did not contribute significantly to the regression equation; the SOQ was predicted entirely by the Interpersonal Sensitivity variable. Therefore, counselors who score higher on the Interpersonally Sensitive subscale will have increased supervision outcome, tangentially more effective supervision.

Table 3

Analyses of Variance for Supervision Outcome by Demographic Variables

Source	df	F	ρ
Counselor recovery	1, 146	1.70	.19
Supervisor recovery	1,146	.36	.55
Years of Experience	3,144	.22	.87
Educational Level	6,141	1.93	.08
Age	5,142	.73	.59
Gender	1,146	7.64	.01*

Table 4

Summary of Regression Analysis for Demographic Variables Predicting SupervisionOutcome

Variable	B	SE B	β
Step 1			
Counselor Recovery Status	-.90	.66	-.11
Supervisor Recovery Status	-.48	.67	-.06
Step 2			
Age of Counselor	-.31	.68	-.03
Years of Experience	-.00	.34	.00
Educational Level	-.20	.25	-.06
Gender	-.41	.28	-.13

Table 5

Means and Standard Deviations of the Supervision Outcome Questionnaire (SOQ; n = 148)

<u>Item</u>	<u>M</u>	<u>SD</u>
1. Satisfaction with supervision	5.64	1.27
2. How competent was your supervisor at giving good supervision?	5.85	1.13
3. How much did interactions with your supervisor contribute to improvement in your counseling ability?	4.95	1.58
<u>Overall</u>	<u>5.48</u>	<u>1.19</u>

Note: the higher the number, the more positive the perception of supervisory outcome

Note: the range is from one to seven (1 - 7)

Table 6

Means and Standard Deviations of the Counselor Self-Efficacy Scale (CSES; n = 148)

	Mean	SD
1* My knowledge of personality development is adequate for counseling effectively.	4.32	0.69
2* My knowledge of ethical issues related to counseling is adequate for me to perform professionally.	4.68	0.66
3. My knowledge of behavior change principles is not adequate.	4.27	0.99
4. I am not able to perform psychological assessment to professional standards.	3.92	1.18
5* I am able to recognize the major psychiatric conditions.	4.16	1.04
6. My knowledge regarding crisis intervention is not adequate.	4.39	0.93
7* I am able to efficiently develop therapeutic relationships with clients.	4.77	0.66
8* I can effectively facilitate client self-exploration.	4.53	0.72
9. I am not able to accurately identify client affect.	4.49	0.86
10. I cannot discriminate between meaningful and irrelevant client data.	4.39	0.95
11. I am not able to accurately identify my own emotional reactions to clients.	4.50	0.83
12. I am not able to conceptualize client cases to form clinical hypotheses.	4.52	0.67
13* I can effectively facilitate appropriate goal development with clients.	4.49	0.83

Means and Standard Deviations of the Counselor Self-Efficacy Scale (CSES; n = 148)
(con't)

	Mean	SD
14. I am not able to apply behavior change skills effectively.	4.45	0.73
15* I am able to keep my personal issues from negatively affecting my counseling.	4.44	0.78
16* I am familiar with the advantages and disadvantages of group counseling as a form of intervention.	4.64	0.66
17. My knowledge of the principles of group dynamics is not adequate.	4.43	0.89
18* I am able to recognize the facilitative and debilitating behaviors of group members.	4.48	0.75
19. I am not familiar with the ethical and professional issues specific to group work.	4.53	0.79
20* I can function effectively as a group leader/facilitator.	4.68	0.66
Overall	4.45	0.37

Note: the range is from one to five (1 - 5) with 1 = very true, 3 = neither true nor false, and 5 = very false

* = reverse coded for scoring as item was worded in the negative higher the score, the higher the perceived self-efficacy

CHAPTER FIVE

DISCUSSION

This study sought to examine the supervisory styles, supervision outcome, and types of supervision found among addictions treatment counseling supervisors. Overall, the results were encouraging. Addiction counselors reported that their supervisors' styles as generally positive and that their supervisors have a positive effect on their counseling. In the addictions treatment field, this is encouraging because of the history of supervision in the addictions counseling profession.

The present study's results also indicated that there is not a dominant supervisory style utilized by addiction treatment counselors' supervisors. In this sample, all three styles of supervision (e.g., Attractiveness, Interpersonally Sensitive, and Task Oriented) were reported by the participants, with the Interpersonally Sensitive style being experienced at a slightly higher rate. Reeves, et. al. (1997), in a study of supervisors, found that the Interpersonally Sensitive style was significantly correlated with positive supervisory relationship. Although this study did not examine the supervisory relationship of addictions treatment counselors and their supervisors, this is an area for future research. Studies in other counseling specialties (e.g., Ladany, Walker, Melnicoff, 2001; Teitelbaum, 1998; Usher & Borders, 1993) show that supervisory style influences the supervisory relationship as well as many process and outcome variables (e.g., supervisory working alliance). Perhaps this result indicates that addiction counselors prefer a supervisor who is perceptive, intuitive, and therapeutic. Future research should build upon the results found here and examine supervisors' style in relationship to supervision satisfaction, supervisory relationship and other factors related to supervision.

One of the most compelling results of this study is the fact that the supervisory style of an addictions supervisor can predict the outcome of supervision. In other words, if a supervisee rates his/her supervisor's style as positive (higher scores on the SSI), then the supervisee will also rate the outcome of supervision high. This is important for supervisors because it suggests that there is a direct link between a supervisee's perception of his/her supervisor's style and his/her perception of supervision outcome and perhaps the process of supervision. Surprisingly, the results illustrated that only gender was significantly related to the participants' perceptions of supervision outcome. Considering that there are no other studies that have examined the extent of demographic variables on the outcome of addictions supervision, this result provides an impetus for further investigation into the effect of gender on supervision, particularly in the addictions treatment profession.

The non-effect of counselor and supervisor recovery status on supervision outcome was also very surprising, considering the emphasis placed in the literature on the influence of recovery status in the addictions treatment profession. Although the results of this study suggest that recovery status does not have a significant effect on the outcome of addictions supervision, future research should further explore the influence of recovery status on long-term counselor effectiveness, counselor burnout, and job satisfaction.

The result that indicates that counselor self-efficacy is not significantly related to supervision outcome and level of experience is difficult to explain. Perhaps more experienced addiction treatment counselors are more confident in their counseling abilities (counselor self-efficacy) and therefore, their level of counselor self-efficacy is not significantly related to supervision outcome. It is possible that supervision outcome

for counselors with high levels of counselor self-efficacy is more closely related to other variables (e.g., supervisory relationship, working alliance). Clearly, this is an area that should be examined further in future research.

IMPLICATIONS FOR THE TRAINING OF SUPERVISORS

Based on the results of this study, there are several training implications for addictions treatment counselor supervisors. First, since the results indicated that counselor self-efficacy is negatively related to supervision outcome and supervisory style is positively related to supervision outcome, then supervisors should likely be cognizant of the importance of their style. It seems that counselor educators should pay close attention to their trainees' supervisory style, counselor self-efficacy, and supervision outcome. For instance, training activities might include personal assessments of supervisory styles and discussions about one's style in relationship to counselor efficacy.

Because the results of this research indicate that addiction treatment counselors found all three supervisory styles to be present, trainers of supervisors should be cognizant of the relationship between supervisory style and counseling specialty areas. For example, it is possible that supervisors of addictions treatment counselors may need to demonstrate a different style of supervision than a supervisor of elementary school counselors or family counselors. This could be true because of the literature that speaks to the unique characteristics of addictions treatment professionals (e.g., recovery status, level of education). Although this study didn't explore the differences between supervision employed among various counseling specialties, this is an important aspect for trainers of supervisors to consider. More specifically, supervisors may opt to work on developing supervisory styles that reflect the positive styles on the *Supervisory Styles*

Inventory.

IMPLICATIONS FOR FUTURE RESEARCH

As mentioned throughout this chapter, there are numerous areas of research that should be examined further in order to better understand the influence of supervisory style, supervision outcome, and counselor self-efficacy in the addictions treatment field. First, an area that needs further investigation is counselor self-efficacy and supervision outcome for addictions treatment professionals. Again, the unique characteristics of the addictions treatment field must be taken into account. Of greatest importance is that addictions treatment professionals have often had many years of experience in the field while not necessarily having the formal education. The reverse is becoming more the norm as this particular field changes, with a greater number of entry-level professionals having graduate degrees and being supervised by professionals with years of experience but no formal graduate degree. This dynamic of counselors who are in recovery but have little or no formal education supervising counselors who have no experience with recovery but who have advanced degrees (e.g., M.Ed., MA) may have an influence on counselor self-efficacy. This dynamic may be examined from several points of view. First, counselor self-efficacy of entry-level counselors may be examined in relation to supervision style and level of graduate education of both the counselor and supervisor. Second, the counselor self-efficacy of experienced counselors (more than eight years in the field of addictions treatment) may be examined in relation to the level of graduate education of both the counselor and supervisor. Finally, the supervisory relationship may be examined with particular emphasis on counselor self-efficacy and how this is related to

recovery status of both the supervisor and the counselor as well as how counselor self-efficacy is related to the counselor's years of experience.

Further exploration of the relationship between counselor self-efficacy with supervision outcome is also needed. Again, both the counselor's level of graduate education and years of experience as well as the supervisor's level of graduate education and years of experience may be taken into account in order to determine how counselor self-efficacy is related to supervision outcome. There may be some indication that recovery status as well as years of experience and level of graduate education could influence the relationship between these variables. Also, future research should use other indicators of counselor self-efficacy and supervision outcome to determine their relationship. It is possible that the instruments used in this study did not "tap" accurate levels of counselor self-efficacy and supervision outcome. Since there are very few instruments that measure these variables, future research should focus on the development and validation of instruments that measure these variables for future research.

As mentioned in the preceding paragraph, there is no psychometrically sound instrument of supervision outcome. All measures of supervision outcome ask supervisees whether or not they like their supervisor and enjoy their supervision sessions. As Goodyear and Bernard (1998) stated, "A third barrier to determining supervision's effectiveness is the wide-spread reliance on satisfaction measures to assess supervision outcomes (p 9)." Therefore, a quantitative measure of supervision outcome is needed in order for before supervision outcome can be measured with any degree of validity and reliability.

It also seems relevant to explore where the point is in the supervisory relationship when the optimal combination of supervisory styles would be most effective in enhancing supervisee growth. For example, a supervisee who cannot conceptualize a client with integrative complexity, when it comes to recognizing gender issues and its effect on addictions treatment, may benefit from a supervisor whose initial predominant style is friendly and warm. As this alliance is built, the supervisor may then offer a combination of interpersonally sensitive and task-oriented styles that attends more directly to the supervisee's less-than-adequate integrative complexity. In addition, future research should examine the relationship between counselor development and the supervision outcome of addictions treatment counselors. It is possible that addictions treatment counselors develop differently from some of the models of counselor development found in the literature (e.g., Loganbill, Delworth, and Hardy, 1982; Worthington, 1987). Considering the recovery status of many addictions treatment professionals, it seems fitting that future research explore the possibility of differences in counselor development of addictions treatment counselors and its relation to supervision style and outcome.

LIMITATIONS OF THE STUDY

Although the results of this study are encouraging, there are limitations that one must consider. First, the results were based on the supervisee's perceptions rather than on actual observations. It is quite possible that supervisors would view their style and supervisee's counselor self-efficacy differently. A related issue is that since supervision has an evaluative component that results in a power differential between supervisors and supervisees, participant responses involving evaluation of their supervisor may have been affected even though the responses were anonymous and voluntary.

As stated earlier, there is no instrument that exclusively measures supervision outcome. There are several instruments that have appropriate supervision outcome measures imbedded in them (as was used in this study) but, there are no instruments where validation and reliability have been measured.

As with all studies that are self-report in nature, there is an inherent bias. Further research using greater numbers of participants from both public and private agencies may eliminate this bias. Also, future studies may include matching supervisor with supervisee results for further examination and possible elimination of this reporting bias. Since the sample was not randomized, generalizability of the results may be limited to the state agencies involved in the study.

Finally, the data collection procedures were dictated by each agency. In some cases, the supervisor's supervisor handed the instrument packets to participants. This may have influenced results. Again, a greater number of participants may eliminate any inherent bias that this method of data collection may have inadvertently caused.

APPENDIX A: Order of Measures in Pilot Study Packet

Cover letter

Demographic Questionnaire

Supervisory Styles Inventory

Supervision Outcome Questionnaire

Questionnaire Feedback Form

APPENDIX B: Cover Letter in Pilot Study Packet

September 15, 2004

Dear Colleague;

Greetings! You have been selected to participate in a study being implemented to investigate the relationship between supervisory style and supervision outcome of addictions treatment professionals. Since there has been very little research in this area, your participation is very important to our understanding of supervision outcomes experienced by addictions treatment professionals.

When responding to the items on the questionnaires, please refer to your current work in the addictions treatment field. In order to preserve your confidentiality, you are not required to give any identifying information (e.g., name). It is important to remember that by completing and returning the questionnaires, you are giving your informed consent to participate. Included in this packet is a supervision outcome questionnaire, the Supervisory Styles Inventory (SSI), and a demographic questionnaire. Completing this packet should take no longer than 20 minutes. When you have completed the questionnaires, please return them to in the postage paid envelope by September 22, 2004.

I am conducting this research study under the guidance of Dr. Cheryl Holcomb-McCoy, Counselor Education Program, 3208 Benjamin Bldg., University of Maryland, College Park, MD 20742-1125. If you have any questions regarding this study, please feel free to contact me at gpberger@wam.umd.edu or Dr. Holcomb-McCoy at ch193@uemail.umd.edu.

Thank you for your assistance in this project!

Sincerely,

Gisela P. Berger
Doctoral Candidate
Counselor Education Program

Appendix C: Demographic Questionnaire used in Pilot Study

Demographic Questionnaire

For the purposes of this study, the following definition of clinical supervision will be used. This is so that clinical supervision can be clearly distinguished from administrative supervision.

Clinical supervision--an intensive, interpersonally focused relationship in which one person is appointed to assist the development of therapeutic competence in the other person and an evaluative relationship exists which has the simultaneous purposes of enhancing the professional function of the supervisee, monitoring the quality of professional services offered to clients, and serving as a gatekeeper for those in the profession.

Administrative supervision--an organizational position which is responsible for time sheets, personnel management, administration of leave and sick days, program management, and other business management details.

Are you currently receiving clinical supervision?

IF YES, please continue

IF NO, please pass on to a colleague who is

1. What is your level of formal education? (Please check only one)
 - a. High school (or equivalent)
 - b. Some college (attended but not completed)
 - c. Associates Degree (AA, AS, etc.)
 - d. Bachelors Degree (BA, BS, etc.)
 - e. Some graduate work (attended graduate courses but not completed)
 - f. Masters Degree (MA, MS, MEd, etc.)
 - g. Specialist Degree (Ed.S, etc.)
 - h. Doctoral Degree (PhD, EdD, PsyD, etc.)
2. Are you yourself currently in recovery?
 - a. Yes
 - b. No
3. Is your supervisor currently in recovery?
 - a. Yes
 - b. No

4. What is your age?
- a. 20-29
 - b. 30-39
 - c. 40-49
 - d. 50-59
 - e. 60-69
 - f. 70-79
5. What is your gender?
- a. Female
 - b. Male
6. What is your race/ethnicity? (Please check only one)
- a. White/European-American
 - b. Black/African-American
 - c. Hispanic/Latino
 - d. Asian-American/Asian-Pacific Islander
 - e. Multi-racial
 - f. Other
7. Is your administrative supervisor a different person from your clinical supervisor?
- a. Yes
 - b. No
8. What is your current, average, WEEKLY caseload?
- a. under 20 clients
 - b. 20-25 clients
 - c. 25-30 clients
 - d. 30-35 clients
 - e. 35-40 clients
 - f. over 30 clients
9. How many years of experience do you have in the addictions treatment field?
- a. ____ 0-1 Years
 - b. ____ 2-3 Years
 - c. ____ 4-7 Years
 - d. ____ 8+ Years
10. How often do you receive clinical supervision? (Please check only one)
- a. Weekly (or more often)
 - b. Every-other-week
 - c. Monthly
 - d. Semi-annually
 - e. Annually
11. How often, ideally, would you LIKE to receive clinical supervision? (Please check only one)
- a. Weekly (or more often)
 - b. Every-other-week
 - c. Monthly
 - d. Semi-annually
 - e. Annually

12. What type of supervision do you PREDOMINANTLY receive?
- a. Individual (includes dyads)
 - b. Group (defined as more than people)
 - c. Peer
 - d. Combination of any of the above types
 - e. Other (please elaborate): _____

APPENDIX D: Supervisor Styles Inventory used in Pilot Study Packet**Supervisor Styles Inventory**

Please indicate your perception of the style of your current or most recent supervisor of therapy/counseling on each of the following descriptors. Circle the number on the scale, from 1 to 7, which best reflects your view of him/her.

	1	2	3	4	5	6	7
	not very						very
1. goal-directed	1	2	3	4	5	6	7
2. perceptive	1	2	3	4	5	6	7
3. concrete	1	2	3	4	5	6	7
4. explicit	1	2	3	4	5	6	7
5. committed	1	2	3	4	5	6	7
6. affirming	1	2	3	4	5	6	7
7. practical	1	2	3	4	5	6	7
8. sensitive	1	2	3	4	5	6	7
9. collaborative	1	2	3	4	5	6	7
10. intuitive	1	2	3	4	5	6	7
11. reflective	1	2	3	4	5	6	7
12. responsive	1	2	3	4	5	6	7
13. structured	1	2	3	4	5	6	7
14. evaluative	1	2	3	4	5	6	7
15. friendly	1	2	3	4	5	6	7
16. flexible	1	2	3	4	5	6	7
17. prescriptive	1	2	3	4	5	6	7
18. didactic	1	2	3	4	5	6	7
19. thorough	1	2	3	4	5	6	7
20. focused	1	2	3	4	5	6	7
21. creative	1	2	3	4	5	6	7
22. supportive	1	2	3	4	5	6	7
23. open	1	2	3	4	5	6	7
24. realistic	1	2	3	4	5	6	7
25. resourceful	1	2	3	4	5	6	7
26. invested	1	2	3	4	5	6	7
27. facilitative	1	2	3	4	5	6	7
28. therapeutic	1	2	3	4	5	6	7
29. positive	1	2	3	4	5	6	7
30. trusting	1	2	3	4	5	6	7
31. informative	1	2	3	4	5	6	7
32. humorous	1	2	3	4	5	6	7
33. warm	1	2	3	4	5	6	7

APPENDIX E: Supervision Outcome Questionnaire used in Pilot Study Packet

Supervision Outcome Questionnaire

This questionnaire is designed to evaluate the supervision you are receiving. It asks you to rate the effectiveness of the supervision you are receiving. Please consider each item carefully on its own merits. Try to avoid the “halo effect” in which a good supervisor, or one you get along with, receives high marks on everything.

Please circle the following items as to how descriptive it is of your view of your supervisor’s effectiveness.

1. Satisfaction with supervision

1	2	3	4	5	6	7
totally unsatisfied it could not have been worse	mostly unsatisfied it could have been better	more satisfied than not.	so-so; neither satisfied or unsatisfied.	more satisfied than not.	mostly satisfied could have been a little better.	totally satisfied

2. How competent was your supervisor at giving good supervision?

1	2	3	4	5	6	7
totally incompetent	mostly incompetent	more incompetent than not	so-so	more competent than not	mostly competent	totally competent

3. How much did interactions with your supervisor contribute to improvement in your counseling ability?

1	2	3	4	5	6	7
had almost no effect	had a small effect	had some- what of an effect	had an effect	had a substantial effect	had a large effect	had a very large effect

APPENDIX F: Questionnaire Feedback Form used in Pilot Study Packet**Questionnaire Feedback**

Thank you so much for agreeing to participate in this pilot study. To assist me in making the enclosed questionnaires as easy to use as possible, I would like to ask you the following:

1. How clear were the items? Did you understand what was being asked?
 - a. On the SSI
 - b. On the demographic questionnaire
 - c. On the supervisory outcomes questionnaire
 - d. What would have made the unclear items clearer?
2. How long did it take you to fill out:
 - a. The SSI
 - b. The demographic questionnaire
 - c. The supervisory outcomes questionnaire
3. How clear were the directions for:
 - a. On the SSI
 - b. On the demographic questionnaire
 - c. On the supervisory outcomes questionnaire
 - d. What would have made the unclear directions clearer?
4. What did you think of the wording on the:
 - a. On the SSI
 - b. On the demographic questionnaire
 - c. On the supervisory outcomes questionnaire
5. Overall thoughts about these instruments?

Appendix G: Revised Surveys

Demographic Questionnaire

For the purposes of this study, the following definition of clinical supervision will be used. This is so that clinical supervision can be clearly distinguished from administrative supervision.

Clinical supervision—one who assists the development of therapeutic competence in another person with an evaluative component to enhance their professionalism, monitor the quality of services offered to clients, and serve as a gatekeeper for the profession.

Administrative supervision—one who is responsible for time sheets, personnel management, administration of leave and sick days, program management, and other business management details.

Are you currently receiving clinical supervision?

IF YES, please continue

IF NO, please pass on to a colleague who is

1. What is your level of formal education? (Please check only one)
 - a. High school (or equivalent)
 - b. Some college (attended but not completed)
 - c. Associates Degree (AA, AS, etc.)
 - d. Bachelors Degree (BA, BS, etc.)
 - e. Some graduate work (attended graduate courses but not completed)
 - f. Masters Degree (MA, MS, MEd, etc.)
 - g. Specialist Degree (Ed.S, etc.)
 - h. Doctoral Degree (PhD, EdD, PsyD, etc.)
2. What type of licensure/certification do you have?

a. State licensure	c. Licensure from national organization (e.g., NAADAC)
b. State certification	d. Certification from national organization
3. Are you yourself currently in recovery?

a. Yes	b. No
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4. Is your supervisor currently in recovery?

a. Yes	b. No	c. Don't Know
--------	-------	---------------

5. What is your age?
- a. 20-29
 - b. 30-39
 - c. 40-49
 - d. 50-59
 - e. 60-69
 - f. 70-79
6. What is your gender?
- a. Female
 - b. Male
7. What is your race/ethnicity? (Please check only one)
- a. White/European-American
 - b. Black/African-American
 - c. Hispanic/Latino
 - d. Asian-American/Asian-Pacific Islander
 - e. Multi-racial
 - f. Other
8. Is your administrative supervisor a different person from your clinical supervisor?
- a. Yes
 - b. No
9. What is your current, average, WEEKLY caseload?
- a. under 20 clients
 - b. 20-25 clients
 - c. 25-30 clients
 - d. 30-35 clients
 - e. 35-40 clients
 - f. over 40 clients
10. How many years of experience do you have in the addictions treatment field?
- a. 0-1 Years
 - b. 2-3 Years
 - c. 4-7 Years
 - d. 8+ Years
11. How often do you receive clinical supervision? (Please check only one)
- a. Weekly (or more often)
 - b. Every-other-week
 - c. Monthly
 - d. Semi-annually
 - e. Annually
12. How often, ideally, would you LIKE to receive clinical supervision? (Please check only one)
- a. Weekly (or more often)
 - b. Every-other-week
 - c. Monthly
 - d. Semi-annually
 - e. Annually

13. What type of supervision do you PREDOMINANTLY receive?

- a. Individual (includes dyads)
- b. Group (defined as more than 3 people)
- c. Peer
- d. Combination of any of the above types
- e. Other (please elaborate): _____

Supervisory Styles Inventory

Please indicate your perception of the style of your current clinical supervisor on each of the following descriptors. Circle the number on the scale, from 1 to 7, which best reflects your view of him/her. To assist your rating process, the following definition of “didactic” is provided: giving instruction and the following definition of “facilitative” is provided: to lessen the difficulty, make easier.

	1	2	3	4	5	6	7
	not very						very
1. goal-directed	1	2	3	4	5	6	7
2. perceptive	1	2	3	4	5	6	7
3. concrete	1	2	3	4	5	6	7
4. explicit	1	2	3	4	5	6	7
5. committed	1	2	3	4	5	6	7
6. affirming	1	2	3	4	5	6	7
7. practical	1	2	3	4	5	6	7
8. sensitive	1	2	3	4	5	6	7
9. collaborative	1	2	3	4	5	6	7
10. intuitive	1	2	3	4	5	6	7
11. reflective	1	2	3	4	5	6	7
12. responsive	1	2	3	4	5	6	7
13. structured	1	2	3	4	5	6	7
14. evaluative	1	2	3	4	5	6	7
15. friendly	1	2	3	4	5	6	7
16. flexible	1	2	3	4	5	6	7
17. prescriptive	1	2	3	4	5	6	7
18. didactic	1	2	3	4	5	6	7
19. thorough	1	2	3	4	5	6	7
20. focused	1	2	3	4	5	6	7
21. creative	1	2	3	4	5	6	7
22. supportive	1	2	3	4	5	6	7
23. open	1	2	3	4	5	6	7
24. realistic	1	2	3	4	5	6	7
25. resourceful	1	2	3	4	5	6	7
26. invested	1	2	3	4	5	6	7
27. facilitative	1	2	3	4	5	6	7
28. therapeutic	1	2	3	4	5	6	7
29. positive	1	2	3	4	5	6	7
30. trusting	1	2	3	4	5	6	7
31. informative	1	2	3	4	5	6	7
32. humorous	1	2	3	4	5	6	7
33. warm	1	2	3	4	5	6	7

Supervision Outcome Questionnaire

This questionnaire is designed to evaluate the supervision you are receiving. It asks you to rate the effectiveness of the supervision you are receiving. Please consider each item carefully on its own merits. Try to avoid the “halo effect” in which a good supervisor, or one you get along with, receives high marks on everything.

Please circle the following items as to how descriptive it is of your view of your supervisor’s effectiveness.

1. Satisfaction with supervision

1	2	3	4	5	6	7
totally unsatisfied it could not have been worse	mostly unsatisfied it could have been better	more satisfied than not.	so-so; neither satisfied or unsatisfied.	more satisfied than not.	mostly satisfied could have been a little better.	totally satisfied

2. How competent was your supervisor at giving good supervision?

1	2	3	4	5	6	7
totally incompetent	mostly incompetent	more incompetent than not	so-so	more competent than not	mostly competent	totally competent

3. How much did interactions with your supervisor contribute to improvement in your counseling ability?

1	2	3	4	5	6	7
had almost no effect	had a small effect	had some- what of an effect	had an effect	had a substantial effect	had a large effect	had a very large effect

Appendix H: Additional Survey: Counselor Self-Efficacy Scale

The Counselor Self-Efficacy Scale

This instrument assesses your confidence about your counseling abilities. This is a general scale that does not include skills associated with any particular theoretical approach. Please indicate your agreement with a particular statement by circling the appropriate number using the scale below.

1	2	3	4	5
very true		neither true, nor false		very false

1. My knowledge of personality development is adequate for counseling effectively.

1	2	3	4	5
---	---	---	---	---

2. My knowledge of ethical issues related to counseling is adequate for me to perform professionally.

1	2	3	4	5
---	---	---	---	---

3. My knowledge of behavior change principles is not adequate.

1	2	3	4	5
---	---	---	---	---

4. I am not able to perform psychological assessment to professional standards.

1	2	3	4	5
---	---	---	---	---

5. I am able to recognize the major psychiatric conditions.

1	2	3	4	5
---	---	---	---	---

6. My knowledge regarding crisis intervention is not adequate.

1	2	3	4	5
---	---	---	---	---

7. I am able to efficiently develop therapeutic relationships with clients.

1	2	3	4	5
---	---	---	---	---

8. I can effectively facilitate client self-exploration.

1	2	3	4	5
---	---	---	---	---

9. I am not able to accurately identify client affect.

1	2	3	4	5
---	---	---	---	---

10. I cannot discriminate between meaningful and irrelevant client data.

1	2	3	4	5
---	---	---	---	---

11. I am not able to accurately identify my own emotional reactions to clients.

1	2	3	4	5
---	---	---	---	---

very true			neither true, nor false			very false
	12. I am not able to conceptualize client cases to form clinical hypotheses.					
	1	2	3	4	5	
	13. I can effectively facilitate appropriate goal development with clients.					
	1	2	3	4	5	
	14. I am not able to apply behavior change skills effectively.					
	1	2	3	4	5	
	15. I am able to keep my personal issues from negatively affecting my counseling					
	1	2	3	4	5	
	16. I am familiar with the advantages and disadvantages of group counseling as a form of intervention.					
	1	2	3	4	5	
	17. My knowledge of the principles of group dynamics is not adequate.					
	1	2	3	4	5	
	18. I am able to recognize the facilitative and debilitative behaviors of group members.					
	1	2	3	4	5	
	19. I am not familiar with the ethical and professional issues specific to group work.					
	1	2	3	4	5	
	20. I can function effectively as a group leader/facilitator.					
	1	2	3	4	5	

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