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Addiction Counselors' Perceptions of Clinical Supervision Practices

Marla Harrison Newby
Old Dominion University, mnewb009@odu.edu

ADDICTION COUNSELORS' PERCEPTIONS OF CLINICAL SUPERVISION PRACTICES

by

Marla Harrison Newby

B.A., May 1986, Norfolk State University
M.S., August 1990, Old Dominion University

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Approved by:

_____
Kaprea F. Johnson (Chair)

_____
Norou Diawara (Methodologist)

_____
Narketta Sparkman-Key (Member)

ABSTRACT

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Marla Harrison Newby

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Chair: Dr. Kaprea Johnson

The addiction counseling clinical supervision literature has been limited in empirical studies focusing on best practices. Researchers have reported as much as 30 percent of addiction counselors are not receiving clinical supervision at all (Culbreth, 1999; Schmidt, 2012). Addiction counselors enter the field with a variety of credentials that can range from paraprofessional to graduate degrees. The inconsistent practices of clinical supervision in the addiction counseling field and limited research warrants concern for counselors' professional development. Survey data was examined from 84 addiction counselors' satisfaction with the frequency and quality of clinical supervision received based on professional credentials, years of experience, and analyzed the components of clinical supervision that predict higher ratings of satisfaction among addiction counselors. The findings showed that quality of clinical supervision and structure and support received in clinical supervision were significant predictors of addiction counselors' satisfaction with clinical supervision. The limitations identified were related to online self-report data and generalizability due to sample size. Future research suggestions are included.

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CHAPTER ONE: INTRODUCTION

Introduction

This chapter provides a summary of clinical supervision practices for addiction counselors. The significance and purpose of the study will be reviewed. The research questions and research design will also be presented. The assumptions, limitations, and definition of terms will conclude this chapter.

Background

Addiction counselors often have responsibilities that include clinical evaluation, treatment planning, referral, service coordination, client, family, group, community education and counseling (SAMHSA, 2011). However, a lack of consistent clinical supervision for addiction counselors has been studied since the early 1990s (Powell, 1991). Dr. David Powell, educator and trainer, was a pioneer in developing a theoretical framework for quality clinical supervision for substance abuse counselors. Powell also published the first and only manual introducing a clinical supervision model specifically for substance abuse counselors, the blended clinical supervision model (Powell & Brodsky, 2004). Juhnke and Culbreth (1994) appear to be one of first to recognize that clinical supervision for substance abuse counselors has been ignored. Culbreth (1999) produced additional research focusing on current and preferred supervision practices among counselors in chemical dependency counseling by examining differences in supervision preferences based on counselor recovery status and counselor graduate-level training. Culbreth and Borders (1998) focused on the impact of recovery status on the supervisory relationship in the supervision of SA counselors and the impact of SA counselors' recovery or nonrecovery status on their perceptions of the supervisory relationship.

Additionally, Reeves, Culbreth, and Greene (1997) examined the supervisory style of certified clinical supervisors of substance abuse counselor. The above studies all acknowledged the need for clinical supervision in addiction counseling to be improved.

Significance of the study

This study will contribute to the limited research on addiction counselors' perceptions of clinical supervision received in the workplace. Much of the research conducted in the field has been from the perspective of the clinical supervisor. More research is needed to examine clinical supervision from addiction counselors. Previous research has recommended further examination to discover the variables that impact effective clinical supervision practices in addiction counseling (Schmidt, 2012). Similar to the study by Best et al. (2014), which utilized frequency of supervision as an independent variable, this study will pair frequency with the quality of supervision to analyze the influence on satisfaction with clinical supervision. Addiction counselors' increased awareness about the effectiveness of clinical supervision can have a positive impact on their professional development which can result in better outcomes for clients. Although there is interest in expanding research in this area, it is recognized that there are barriers with implementing clinical supervision that is unique to addiction counseling professionals (Roche, Todd, & O'Connor, 2007; SAMHSA, 2009). Therefore, this study will use an instrument that identifies the specific components of clinical supervision and the counselors' credentials and work experience to determine their level of satisfaction with clinical supervision. "The personal and professional development of the counselor is enhanced through clinical supervision" (Powell, 1991). Schmidt (2012) also acknowledged the limited research investigating clinical supervision for substance abuse counselors.

Additionally, previous research has indicated that substance abuse counselors are satisfied with the supervision they received and primarily preferred supervisors who are trained as substance abuse counselors (Schmidt, 2012). However, there has been limited research addressing the continued efforts to improve addiction counseling clinical supervision for this group. The previous studies all provide data that supports the importance of clinical supervision for addiction counselors, but also recognize that supervision for addiction counselors needs improvement (Laschober, Eby, & Sauer, 2013;-Laschober, Eby,& Sauer, 2012). The aim of this study is to add support to the growing body of literature on clinical supervision factors that are related to satisfaction with supervision from addiction counselors.

Purpose of the study

The purpose of the study is to provide more evidence regarding addiction counselor satisfaction with the frequency and quality of clinical supervision received. The study will examine the clinical supervision for addiction counselors based on professional credentials and years of experience. This study will also analyze the components of clinical supervision that predict higher ratings of satisfaction among addiction counselors.

Research questions and Hypotheses

The following research questions and Hypotheses will be addressed:

Research question 1. How satisfied are addiction counselors with the frequency and quality of clinical supervision?

Hypothesis 1. Frequency and quality of clinical supervision will be a significant predictor of satisfaction with clinical supervision.

Research question 2. What components of clinical supervision predict a higher level of

satisfaction among addiction counselors?

Hypothesis 2. Addiction counselors will rate structure and support at a higher level than other components as predictors for satisfaction with clinical supervision.

Research question 3. How do years of experience and professional credentials among addiction counselors predict satisfaction with clinical supervision?

Hypothesis 3. Addiction counselors' years of experience and professional credentials will contribute to their level of satisfaction with clinical supervision.

Assumptions of the study

This study is based on three assumptions. The first assumption is the components of clinical supervision are the same across all counseling specialties. The second assumption is that all participants have received some form of clinical supervision in the past 30 days. Lastly, it is assumed that all participants completing the questionnaire will be addiction counselors. Since most of the participants will complete the questionnaire via responding to a mass email, it is not possible for the researcher to verify their credentials or current job status.

Definition of terms

The following definitions were developed by this researcher with the exception of the definitions for clinical supervision, administrative supervision, and components of clinical supervision.

Addiction/AOD/Substance Abuse Counselor: A counselor trained and employed to practice counseling skills that address substance use or misuse of mood-altering substances. And in this study, I will use the term "addiction counselor" to represent this definition.

Clinical Supervision: The process of a senior counselor (clinical supervisor) providing guidance, support, and education to a junior counselor (addiction counselor) to enhance professional development (Powell & Brodsky, 2004).

Perceptions: The collection of rating levels addiction counselors indicate on instruments measuring their experiences with receiving clinical supervision.

Components of clinical supervision: The aspects of clinical supervision that are provided by the clinical supervisor and addressed during clinical supervision sessions, i.e., mentoring, observation, feedback, gatekeeping, structure, knowledge, and practice (Substance Abuse and Mental Health Services Administration, 2009).

Quality of clinical supervision: The degree to which the clinical supervision received has a positive impact on the counselor's attitude toward job performance

Effectiveness of clinical supervision: The degree to which the clinical supervision received has a positive impact on the counselor's competency and/or self-efficacy.

Administrative supervision: The process of a senior staff providing management over the junior staff work duties (e.g. caseload, personnel issues, time reporting) in accordance with the respective agency policies and procedures (Powell & Brodsky, 2004).

Professional credentials: Education and training completed by the addiction counselor that allows him/her to perform the clinical duties in accordance with the code of ethics.

Years of experience: The number of years the counselor has been employed as an addiction counselor.

Recovery status: Whether an addiction counselor has a history of recovery from alcohol or drug addiction or not.

CHAPTER TWO: LITERATURE REVIEW

This chapter provides a review of clinical supervision for addiction counselors, the components of clinical supervision, counselors' perceptions of clinical supervision, the impact of clinical supervision, addiction counselor professional development, and predicting satisfaction with clinical supervision. Due to the limited history of this research, this review includes references to the earliest literature on the topic to demonstrate the limited growth in this area. The conclusion of this chapter will introduce the proposed study. The terms addiction counselor, clinical supervision, practices, and perceptions will be defined.

Counseling Profession

The counseling profession was established as an adjunct to the teaching profession in the early 20th century (Vacc & Loesch, 1987, Chapter 2). As this new profession evolved to discover its identity as a helping profession and established ethical guidelines during the 1960s (Neukrug, 2011, p. 10), clinical supervision was incorporated at a later stage of counselor education development. While the counseling field, in general, is newer, there are also different types of counselors with varying levels of credentials and degrees. There are rehabilitation counselors who are defined as counselors who provide counseling services for persons with disabilities, school counselors provide vocational and college preparatory counseling services in secondary education settings, mental health counselors provide counseling services that address a continuum of mental health issues, career counselors provide employment-related counseling services, college counselors provide counseling services that address needs related to the college and university environment (Vacc & Loesch, 1987, Chapter 2), and addiction counselors provide counseling services that address the abuse and dependence of legal and illegal mood-altering substances (Stevens & Smith, 2013, Chapter 2). Addiction counselors have been a unique group

within the counseling profession because they have a history of not benefiting from the most effective clinical supervision practices.

Clinical Supervision

Clinical supervision is defined as a relationship between a senior counselor and a junior counselor that involves the senior counselor providing modeling, support, and constructive feedback to the junior counselor over time that is evaluative, hierarchical, and has the purpose of enhancing professional development, monitoring the quality of professional services provided to the clients receiving the services, and gatekeeping for those entering the profession (Bernard & Goodyear, 2009). Powell and Brodsky (2004) define clinical supervision as "a disciplined, tutorial process wherein principles are transformed into practical skills, with four overlapping foci: administrative, evaluative, clinical, and supportive" (p. 11). Administrative supervision is when a senior counselor/supervisor provides formal feedback and guidance to the counselor regarding functioning effectively within the organization (Powell & Brodsky, 2004, Chapter 1) with caseload management, documentation, time reporting, and training. Evaluative supervision is the component of clinical supervision that includes assessing goals and objectives, providing feedback, and addressing performance standards with the counselor, the clinical components include the counselor's professional development in knowledge, skills, and self-awareness, and the supportive components include coaching, encouraging personal growth, and building morale (Powell & Brodsky, 2004, Chapter 2). The research shows evidence of the lack of consistent clinical supervision and confusion between administrative supervision and clinical supervision (Borders, 2005). Clinical supervision is considered to be imperative to counselors as the foundation for professional growth, competence, and self-efficacy (Schmidt, 2012). The research supports concern for the lack of clinical supervision for counselors and recommends

continued empirical research to identify the components that are most important to counselor professional development. Furthermore, as the research on the effectiveness of clinical supervision continues to grow, it is believed that it has a direct impact on the quality of care and treatment outcomes (Cashwell & Dooley, 2001).

Clinical supervision is an invaluable part of a counselor's professional development. The counseling field consists of clients presenting with a complexity of emotional and relationship issues will sometimes challenge a counselor's skillset. Clinical supervision provides structure and support to assist counselors with maintaining self-awareness, improving competence, and autonomy. Clinical supervision for substance abuse counselors has limited research, but it has been seen as an equally important part of their development. During the 1990s, researchers began to focus more on empirically examining the role of clinical supervision in the professional development of substance abuse counselors (Culbreth, 1999; Culbreth & Borders, 1999; Culbreth & Borders, 1998).

Clinical supervision in the counseling profession also consists of supervisors who are former counselors trained, typically on-site, to monitor skills of other counselors and provide leadership to counselors they are assigned to oversee (Culbreth, 1999; West, Mustaine, & Wyrick, 2002). The counseling profession has included clinical supervision across various counseling milieus. During the past 20-30 years, the counseling profession has evolved into counselors receiving clinical supervision as a process that formally begins while pursuing a graduate degree (Borders, 2005). Once counselors fully enter the workforce, they continue to receive clinical supervision from a senior staff person/supervisor who is usually their direct supervisor as well.

The major accrediting body for counselors, including addiction counselors, is the Council of Accreditation of Counseling and Related Educational Programs (CACREP). CACREP accredits

counseling master's and Ph.D. programs. Therefore, addiction counselors who don't have a master's degree or who did not come from an accredited CACREP program may not have had the experiences required by CACREP for supervision. In a master's program, the 2016 CACREP standards require that practicum and internship students receive a minimum of one hour per week of supervision and at least one and a half hours of group supervision (CACREP, 2016). Practicum students are also under the supervision of a site supervisor, a student supervisor, and a faculty supervisor. Supervisors are required to have completed relevant training in counseling supervision. Research in clinical supervision has a history of quantitative and qualitative studies to examine the effectiveness, supervision training, and how clinical supervision effects professional development (Cashwell, 2001; Laschober, Eby, & Sauer, 2013; Spence et al., 2001) just to name a few. It appears that graduate students are getting clinical supervision when completing practicums and internships, but the practice of clinical supervision can be relatively inconsistent when counselors go into the workplace (Laschober, Eby, & Sauer, 2013).

The leading organization in the counseling profession is the American Counseling Association (ACA). The ACA was established in 1952, and its goal is a dedication to growth and enhancement of the counseling profession (ACA, 2018). The ACA Code of Ethics has specific guidelines for supervision, training, and teaching within the supervisor and supervisee relationship (ACA code of ethics, 2014). The code of ethics requires that supervisors are trained in supervision methods and techniques, they educate supervisees on about the professional boundaries of the supervision relationship, they inform supervisees of the policies and procedures that the supervisor must follow, the responsibilities of the supervisor and supervisee, and inform the supervisee of the process of providing ongoing feedback and gatekeeping.

The National Association for Alcoholism and Drug Abuse Counselors (NAADAC) offers three levels of certifications in addiction counseling (NAADAC, 2016) and has been the leading organization for addiction professional credentialing. NAADAC also has a code of ethics policy that requires the following: Supervision meetings are conducted at specific regular intervals, and documentation of each meeting is maintained (NAADAC, 2016). The code of ethics requires addiction professionals in a supervisor role have appropriate competencies and resources to perform the duties as well (NAADAC, 2016).

The professional standards for addiction counselors to receive clinical supervision confirm the importance of formal clinical supervision for counselors across all levels of counseling experience. The guidelines are periodically updated to ensure that counselors are prepared to effectively perform the counseling skills among a diverse population of clients. Maintaining credentials in addiction counseling requires ongoing supervision and completion of continuing education training.

Clinical supervision research for addiction counselors has focused on the recovery status of the supervisor and the counselor, and the supervisory relationship. Culbreth and Cooper (2008) conducted research on 232 substance abuse clinical supervisors to examine the components that can impact substance abuse supervisors' professional development. This study utilized the Counselor Supervisor Self-Efficacy Scale (CSSES; Barnes, 2005) to measure supervision knowledge, the Psychotherapy Supervisor Development Scale (PSDS; Baker et al., 2002) to measure factors of supervisor development, and the Role Questionnaire (RQ) to measure work environment. A little more than half (51.8%) of the respondents identified as not in recovery. A significant relationship between experience as a counselor and experience as a supervisor and supervisor self-efficacy was identified for recovering and non-recovering supervisors. These

findings also revealed that recovering supervisors tend to have less supervisory experience. The researchers recommended that just as much attention should be given to the developmental level of the substance abuse supervisor as is given to the substance abuse supervisee. Furthermore, among substance abuse clinical supervisors, it was found that recovering and non-recovering supervisors differ in factors that contribute to their supervisor development which needs to be acknowledged by the substance abuse field (Culbreth & Cooper, 2008). This issue undoubtedly has an impact on addiction counselor professional development.

Clinical Supervision within the Addiction Counseling profession

The addiction counseling profession has maintained challenges unique to the client population that is served. These challenges include how clinical supervision impacts a counselor's professional development (Cashwell & Dooley, 2001; Culbreth & Borders, 1998; Laschober et al., 2013; West & Hamm, 2012). A report by Juhnke and Culbreth (1994) brought attention to addictions supervision that explores the issue of how addictions supervision has been ignored. At that time, there had only been four articles that specifically focused on addictions supervision. Their report also revealed three primary issues unique to substance abuse counseling. The first issue is the history of substance abuse counselors as paraprofessionals who have not earned a graduate degree in counseling or a related field. A second issue was the belief among substance abuse treatment providers that one is more effective if he or she is in recovery. The third issue that was important to acknowledge was how much substance abuse treatment providers are influenced by their personal issues. Therefore, it was recommended that addictions supervision include consistent meeting times and establishing a supervision relationship that provides the structure and support counselors need to be most effective in producing positive client outcomes. Overall, Juhnke and Culbreth (1994) emphasized that although addictions counseling has its

challenges and rewards, it is essential to focus on skill development and supervisee concerns regarding non-recovering treatment providers.

Schmidt (2012) conducted a meta-analysis that found that a third of substance abuse counselors are not receiving clinical supervision. Schmidt (2012) reviewed articles dated from 1990-present which produced only nine articles that met his criteria. The article revealed that although clinical supervision is occurring, findings indicate significant differences in supervisor characteristics such as level of education, experience, and recovery status. The researcher also reviewed the literature from the perspective of the substance abuse counselor and found that those who received supervision are more likely to perceive the supervisory relationship as an asset to professional development and well-being when the relationship is positive. Schmidt (2012) reported that since the only research that has been conducted to analyze the effectiveness of the supervisory relationship has been based on the recovery status of the counselor and supervisor, more consideration also needs to be given to the education level of the counselor and supervisor and allowing them to have a mutual voice in establishing the relationship warrants further investigation. Furthermore, the counselor's perception of the supervisory relationship often yielded high ratings for satisfaction with the supervision they receive. Their ratings were based on their supervisors' competence, support of their professional growth, and education level. Substance abuse counselors also indicated higher ratings for supervisors who have experience providing substance abuse counseling. Schmidt (2012) also included research literature indicating that recovery status of the counselor and supervisor can have an impact on the quality of the relationship and that more educated supervisors tend to be nonrecovery. A review of the research revealed that supervisors rely primarily on counseling skills when engaging in supervision relationships (Schmidt, 2012). Schmidt (2012) concluded with future

research recommendations including focusing on professional development, quantity and quality of supervisors' experience as a supervisee, education and training of supervisors, and the practice of clinical supervision in substance abuse settings. Moreover, comparing live supervision and videotaping to self-report and/or no supervision at all, increasing understanding of the variables that contribute to effective supervisory relationships, and additional characteristics of supervisors and substance abuse counselors that contribute to the successful supervisory relationships were reviewed as well. The study considered the abundance of survey data to be a limitation of this area of research and recommended studying and reporting on specific interventions and outcomes. Schmidt (2012) also recommended conducting research on individuals from diverse backgrounds and focusing on specific populations.

More specifically, the research has now discovered that clinical supervision for addiction treatment supervisors and addiction counselors deserves some attention due to the complexities (Kavanagh et al., 2002) of working with people struggling with addiction and the various levels of professional training that prepares a person to become an addiction counselor. Although the research has had some growth during the past 15 years, there remains a great deal of data to be gathered to determine the most effective approach to provide clinical supervision for addiction counselors that will also contribute to successful client outcomes.

Although there continues to be limited research available that focuses explicitly on clinical supervision for addiction counselors, the Substance Abuse and Mental Health Services Administration (SAMHSA; 2009) has conducted reviews of the research that supports the significance of clinical supervision for addiction counselors. It is suspected that substance abuse counselors are receiving inconsistent or ineffective supervision. Inconsistent or ineffective supervision can occur when supervision is provided without formal training, which can result in

supervisors with less training not understanding counselor development and power differential. The SAMHSA (2009) Clinical Supervision and Professional Development of The Substance Abuse Counselor reported on the research that demonstrated how clinical supervision for substance abuse counselors is unique from other counseling specialties. The review of the literature included in this report also provided research results that found several important factors. It was reported that 38 percent of substance abuse counselors and 30 percent of supervisors are in recovery themselves. Other studies found that substance abuse counselors and supervisors are only moderately satisfied with the overall quality of the supervisory relationship which resulted in 35-40 percent of counselors and 22 percent of supervisors indicating the desire to leave their job which lends evidence to contributing factors to high turnover rates in the substance abuse field (SAMHSA, 2009). Limited opportunities for increased pay and promotion also contribute to low ratings of perceived organizational support, which contributes to workforce turnover as well (SAMHSA, 2009). The level of education for counselors and supervisors has also evolved to 60-80 percent having a bachelor's degree and 50 percent having a master's degree which produces new supervision challenges for counselors with graduate degrees and supervisors with less education. The nature of substance abuse and the contributing factors that occur in a person's life before and during treatment and the importance of the quality of the supervisory relationship for counselors are also issues that contribute to the uniqueness of substance abuse supervision. The literature review also included data regarding the status of clinical supervision for substance abuse counselors. Some agencies do not provide clinical supervision, and some ask senior staff, who are not trained to provide supervision for substance abuse counselors; there has been some data reported on how supervision has been practiced. Reviewing case notes and listening to case reviews by counselors were identified as the most

frequent modes of supervision at 70 percent, followed by observing group counseling sessions at 29 percent, and observing individual counseling sessions at 18 percent. This data demonstrates a significant difference in the methods of supervision practice in the substance abuse counseling field. Role overload, emotional exhaustion, and stress at work have also been reported by counselors and supervisors which suggests that these issues are not being addressed in the supervision process (SAMHSA, 2009).

Furthermore, Borders (2005) conducted a review of the research from American Counseling Association (ACA) published journals focusing on clinical supervision in the counseling profession during a five-year (1999-2004) span. This article provides a review of the foundation of clinical supervision and the organizations that were instrumental in creating the standards which include the Association for Counselor Education and Supervision (ACES), the National Board for Certified Counselors (NBCC), and the Council for Accreditation of Counseling and Related Programs (CACREP). The researcher's intention of focusing on clinical supervision studies appears to illustrate the growth in supervision research during this timeframe. Various articles were reviewed focusing on supervision approaches, supervision settings, supervision training, ethical and legal issues, and multicultural supervision. The categories of quantitative and qualitative research in counseling included school counseling, rehabilitation counseling, substance abuse counseling, supervisor training, supervisor competence, supervisory relationship, supervisory style, supervisor feedback and evaluation, supervision interventions, group supervision, multicultural supervision, and ethical behavior. Borders (2005) reported that, among the articles reviewed, supervisors were studied more often than supervisees. This study resulted in several conclusions, one of which was that there has been some concern for the lack of clinical supervision and understanding what clinical supervision is for counselors across all

specialties. The importance of the supervisory relationship and the supervisor's ability to establish a positive environment, especially multicultural supervision issues, were also findings from the research. Furthermore, the review of the literature revealed that supervisors could benefit from more training on relationship dynamics (Borders, 2005). The ability to discuss cultural issues within the supervisory relationship was recognized in several studies as worthy of consistent attention and training. Effectively providing positive and negative feedback, supervision of supervision, the limited research on providing supervision that is unique to the counseling setting, and the value of utilizing group supervision methods were also reviewed. The increase in research on supervision models, the option of using technology, research methods during this time, and recognizing that the "working alliance" were the most frequent variables used to measure the supervisory relationship. Overall, it was recommended that researchers continue to develop supervision research to enhance supervision practices (Borders, 2005).

Culbreth (1999) examined 134 substance abuse counselors regarding how the supervisory relationship is impacted by the recovery status of the counselor and supervisor based on supervisor style. The study utilized a questionnaire to measure counselors' responses to questions about clinical supervision and substance abuse. In addition to results on demographic data, his study showed that the most common method of supervision was individual followed by a combination of individual and group supervision. Most notable were the results indicating that 39 percent were in a work setting that did not require clinical supervision. Culbreth (1999) found that a third of substance abuse counselors do not receive any supervision. Furthermore, 50 percent of the supervisors were certified substance abuse counselors and only 39 percent had a master's degree. Recovering counselors indicated preferring to have supervision more

frequently than non-recovering counselors, more frequent supervision, and reported less confidence in non-recovering supervisors. Although clinical supervision was occurring, the substance abuse counselors in this study indicated a preference for supervision to be more deliberate instead of reactive. This study concluded with recommendations to further exam training for substance abuse supervisors, counselors' levels of satisfaction and preferences based on the supervision method, and the importance of providing quality care and the counselor's personal and professional development, especially for counselors currently not receiving supervision.

In at least one study, Chandler, Balkin, and Perepiczka (2011) found that the counselor's level of experience and self-efficacy can be directly impacted by clinical supervision. This study of 102 licensed counselors examined the education and training in substance abuse completed and their belief in their ability to effectively practice the counseling skills needed to address substance abuse issues with their clients. The researchers utilized the Substance Abuse Treatment Self-Efficacy Scale (SATSES) to measure the counselors' perceived self-efficacy. This study focused on the relationship between substance abuse graduate coursework and self-efficacy, practicum and internship hours and self-efficacy, the percentage of substance abuse clients served and self-efficacy, and continuing education hours in substance abuse and self-efficacy. Participants reported moderately high confidence for providing substance abuse services abilities, even though their training had been limited. It was strongly recommended that counselor educators be more deliberate in preparing future counselors to understand the importance of practicing within the scope of their expertise and infusing substance abuse counseling among counseling coursework. This demonstrates how counselors are sometimes

providing substance abuse treatment services without training and supervision specific to the substance abuse field.

The barriers to implementing and improving substance abuse clinical supervision were recognized as well. One issue is the research that has been reported from the viewpoint of the substance abuse counselor about the lack of clinical supervision (SAMHSA, 2009). Another issue has been examining whether the improved counseling skills for substance abuse counselors can be attributed to clinical supervision. It is suspected that the difficulty of studying these issues has prevented researchers from committing to expanding research on these variables.

Frequency of Clinical Supervision

There is some research that focuses on how clinical supervision impacts job satisfaction among counselors who provide drug and alcohol treatment services. Kavanagh et al. (2002) discussed the importance of supervision and limited research addressing this issue, due to the dilemma counselors and supervisors face in the alcohol and drug field regarding the regulations guiding the practice of the organization, administrative demands that overshadow professional development, and the percentage of counselors receiving no supervision. The researchers reported evidence that supervision does contribute to the development of advanced counseling skills and that satisfaction with supervision does have an impact on job satisfaction. The use of instructional methods and the changes in supervisees' skills and confidence level that occurs with experience were considered the primary focus for contributing to effective supervision. It was also determined that improved supervision could be achieved through providing access, adopting effective supervision procedures, addressing problems with routine implementation, and providing effective training and consultation. The complexity of drug and alcohol problems which includes relapses, self-harm, and additional problems in their lives produces a tremendous

challenge for addiction counselors (Kavanagh et al., 2002). Moreover, Kavanagh et al. (2002) found that addiction counselors' job satisfaction is affected when supervision is not regularly available to help them address these challenges.

A more recent study documenting the international concerns about the impact of clinical supervision by Best et al. (2014) examined whether satisfaction with clinical supervision was a predictor of job satisfaction. This study consisted of 43 AOD counselors and other staff members working in an AOD treatment center in Melbourne, Australia. The researchers used the Manchester Clinical Supervision Scale 26-item (MCSS-26; Winstanley & White, 2011) and the Organizational Readiness for Change (ORC) assessment to obtain their measurements. Best et al. (2014) found that 91% of the participants indicated that they valued clinical supervision. It was found that 40% of participants reported receiving clinical supervision once a month, but 14% of participants were not receiving any clinical supervision. This issue of inconsistency with receiving supervision at the scheduled time (30% were scheduled for once a month, but 40% of that group received clinical supervision as scheduled; 16% were scheduled fortnightly, but 7% received it as scheduled) discovered in this study. Overall, participants were more satisfied with their jobs when supervision was a valuable source of guidance and support, as well as when supervision was consistent, and there was continuity in the supervision relationship. High ratings for quality and frequency of clinical supervision were reported. Furthermore, while job-related stress level was rated low, job satisfaction was also low. Lastly, increased awareness in the substance abuse treatment field for implementing evidence-based practices (EBP) was needed (Best et al., 2014). Despite the findings, this study did not address interventions for participants who were not receiving clinical supervision.

Components of Clinical Supervision

Ellis (2010) conducted a review of the literature on clinical supervision that provided some guidance on using supervision theory as the foundation for clinical supervision practice given several myths that have been previously published regarding clinical supervision. One of the myths identified addressed the expectation that the supervision models have addressed all elements of clinical supervision. It was discovered that the supervision models that exist in the current research do not represent all of the dynamics that occur in clinical supervision practice, including the supervisory relationship. For example, using recordings of sessions to observe and monitor supervisees is highly recommended, as self-report on what is happening in counseling sessions is not always accurate, and a good supervisory alliance has demonstrated to be a driving force for positive supervision outcomes. Ellis (2010) was particularly concerned about the potential harm that can come to supervisees and clients when clinical supervision is harmful and/or inadequate. He reported evidence from previous studies that demonstrated upon the supervisee receiving the actual definition of harmful supervision, significantly more supervisees reported current or past supervision that was harmful or inadequate. Ellis (2010) stated that more resources are needed to be devoted to clinical supervision. The research on clinical supervision continues to be limited, and it was recommended that supervisors do not neglect diversity issues, do not avoid confronting their anxiety about their position of authority, do not provide inadequate or harmful supervision, and do not allow other supervisors to practice inadequate supervision. Moreover, Ellis (2010) encouraged supervisors to obtain and preserve a good supervisory relationship, practice communication skills and active listening, maintain empathy and support, work on empowering supervisees, respect and maintain interpersonal boundaries, use a supervision contract that includes informed consent, monitor the supervisee's skills during

sessions and provide feedback, make a commitment to gatekeeping, utilize supervision and consultation, and contribute to research. Furthermore, Chang (2013) recommended his contextual-functional meta-framework (CFM) for supervisors to explore and develop their supervision style. Supervisors would operate within the regulations of their respective agencies and be deliberate about practicing what Chang (2013) identified as the nine components of supervision (clinical educator, skill development coach, ethics/risk management consultant, catalyst, professional gatekeeper, organizational/administrative supervisor, personal supporter, professional mentor, and advocate/system change agent) to maintain structure in clinical supervision sessions and effectively meet the needs of supervisees.

A qualitative study by Starling and Baker (2000) explored the mode of peer group supervision with a group of four graduate students. The group supervision consisted of sharing cases and recordings of counseling sessions. The researchers conducted two intensive interviews with each participant focusing on peer group supervision. The results included themes indicating that peer feedback was important to group supervision, as well as, that the supervision structure of group and individual supervision worked well for participants during their internship. Although these studies did not focus on substance abuse supervision, they do provide clear evidence of the value of the supervisory relationship and the importance of continuing research in this area.

The training for clinical supervisors working with addiction counselors and for counselors providing SA services has also lacked clarity and consistency. A quantitative study by Laschober et al. (2013) examined the relationship between effective clinical supervision (supervisors who are "skilled and experienced senior clinicians who are well-informed about substance use disorders and evidence-based assessment, intervention, treatment, and recovery practices") and substance use disorder treatment counselor job performance among 392

counselor-supervisor dyads. The findings showed that 55% of the counselors were certified or licensed as a substance abuse professional, 52% had at least a master's degree, 39% identified as in recovery, 41% described their substance abuse training as "great extent", and 58% described their mental health counseling training as "a great extent". The supervisor in this study had an average of seven years as a clinical supervisor, 74% were certified or licensed as a substance abuse professional, 75% had at least a master's degree, 29% identified as in recovery, 35% described their substance abuse training as "great extent", 63% described their mental health counseling training as "a great extent", and 6% described their clinical supervision training as "a great extent". The importance of effective clinical supervision on substance use disorder counselors' professional development was acknowledged. The results indicated that the mentoring and acceptance, and confirmation provided by clinical supervisors was a predictor of counselor job performance. The researchers concluded that the counselor-supervisor relationship is important to the counselor's professional development, and it is important for clinical supervisors to receive appropriate training. This may represent an attitude from supervisors that formal training may not be necessary.

Years of experience as an Addiction Counselor

Regarding the supervisory relationship for counselors in general, Sumeral and Borders (1996) examined the perceived quality of the supervisory relationship for 40 entry-level and advanced counselors when there is an opportunity to address personal issues and interactions with their clients. The study utilized the Impact Message Inventory (IMI; Perkins, Kiesler, Anchin, Chirico, Kyle, & Freeman, 1979) to measure the counselors' perceptions of their supervisor's interactional style. The Supervisory Working Alliance Inventory (SWAI; Efstation, Patton, & Kardash, 1990) was used to measure the counselor-supervisor relationship, and the Session

Evaluation Questionnaire (SEQ; Stiles & Snow, 1984) was used to measure counselors' evaluation of a counseling or supervision session and their affective mood. Sumeral and Borders (1996) found that counselors' level of experience did not seem to significantly influence their rating of the supervisory relationship when comparing and focusing on personal issues or skills. Although counselors were viewing a supervision session, when personal issues were addressed, counselors did indicate a higher rating for their postsession mood. To explore the issue of negative experiences in supervision, which also has very limited research, Ramos-Sanchez et al. (2002) conducted an exploratory national supervision study on 126 graduate students to determine whether, from an attachment theory standpoint, the impact on how negative supervision experiences are perceived and the quality of the supervisory alliance based on their responses on a survey. Their results indicated that counselors with a higher developmental level indicated a better working alliance with their clinical supervisor than counselors at a lower developmental level. Furthermore, the participants who reported negative experiences (21.4%) with supervision also had lower scores than participants who reported no negative experiences. Negative experiences with supervision can have an impact on the counselor's clinical work, satisfaction with training, and career development (Ramos-Sanchez et al., 2002). These studies provided some evidence on the importance of good supervision across counselor developmental levels.

Addiction Counselor Professional Credentials

West and Hamm (2012) conducted a study on 57 clinical supervisors in the substance abuse field to explore the level of professional credentials, graduate education, and their perception of their expertise in clinical supervision. Since addiction counseling has been a specialty that has not been regulated by states to require a certain level of education or training to perform the job

duties, the researchers sought to compare supervisors who completed formal training with supervisors who were essentially para-professionals. The participants completed the Self-Assessment of Supervision-Related Knowledge and Skills survey (Borders & Leddick, 1987) focusing on teaching, counseling, consultation, and research. They found that participants (72%) who did not complete formal graduate coursework in clinical supervision rated themselves higher than did participants who did. This finding indicated that the clinical supervisors who did not complete formal graduate coursework perceived their supervision skills to be equivalent to clinical supervisors who completed graduate coursework. The researchers also found that 42% of the participants had licensure credentials in their states and 75% had earned a graduate degree. One-third of the clinical supervisors in this study did not have a professional license or certification. This study recognized that some programs decide to have only one clinical supervisor on staff and some programs assign clinical supervision duties to administrative supervisors. West and Hamm (2012) acknowledged some concern for the quality of clinical supervision for substance abuse counselors and recommends the need for ongoing research related to supervisor knowledge and supervisor knowledge of SA treatment providers.

Addiction Counselors' Perceptions of Clinical Supervision

The addiction counseling profession has experienced a transition over the past 30 years. One example of this transition has been that substance abuse professionals have become more educated (Laschober et al., 2012; Mulvey, Hubbard, & Hayashi, 2003; West & Hamm, 2012). Mulvey, Hubbard, & Hayashi (2003) conducted a retrospective study to examine the demographics, education levels, and employment histories of the substance abuse workforce through a nationally distributed survey. The study consisted of survey responses from 3,267 substance abuse treatment professionals. Among the results, 86% had been in field five years or

more, 62% had worked in the field 10 years or more, 72% had a drug and alcohol counseling certification, and more addiction counselors had at least a bachelor's degrees (80%) and master's degrees (49%) (Mulvey, Hubbard, & Hayashi, 2003). These findings represent quite an advancement from an area of counseling that began primarily with people who went into addiction counseling as former alcoholics and drug addicts themselves. Today's addiction counseling workforce prefers that counselors are certified, but sometimes requires at least a certification in addiction counseling. Mulvey, Hubbard, and Hayashi (2003) also found that there is an increasing need for younger counselors working in addiction counseling since it appears that most addictions counselors stay in the field, which also increases the average age of the counselors in the addiction counseling workforce.

Research has shown that clinicians providing substance abuse treatment are an important factor to treatment outcome and retention (Najavits, Crits-Christoph, & Dierberger, 2000). Najavits, Crits-Christoph, & Dierberger (2000) conducted a review of the literature to explore the clinicians' impact when providing substance use disorder treatment services. They considered one key finding from the literature to be evidence indicating that clinicians do influence treatment outcome and retention. This review of the literature also determined that clinician professional credentials did not predict effectiveness, matching clinicians and clients based on similar characteristics did not reveal consistent results, clinicians' fidelity and competence do appear to have some impact on treatment outcomes, the clinician's countertransference can contribute to poor treatment outcomes, the data on the therapeutic alliance between clinician and client has been inconsistent, very little research has examined the personality characteristics of the clinicians which have yielded inconsistent findings, and research on clinicians' attitudes and beliefs about substance use disorder treatment has occurred,

but data on how this impacts treatment outcomes, or retention remains limited (Najavits, Crits-Christoph, & Dierberger, 2000). Najavits, Crits-Christoph, & Dierberger (2000) concluded their review of the literature with identifying the need for supervisory support for addiction counselors, as well as, training, increased salaries, and career advancement opportunities as areas that can help improve counselors work and demonstrate more respect and validation towards counselors. These recommendations represented the limitations in empirical data at that time.

Benefits of Clinical Supervision for Addiction Counselors

Spence et al. (2001) conducted a comprehensive review of the research on clinical supervision for Australian mental health professionals due to the limited empirical data in this area. This provided similar findings to other research on clinical supervision for addiction counselors which included recognizing that good clinical supervision is important to maintaining and enhancing the quality of clinical practice, and the discrepancy between mental health workers' desire for clinical supervision and the demands administrative obligations have on workloads that have resulted in receiving no supervision. Although the data is limited, supervisees reported various likes and dislikes about clinical supervision and acknowledged the need for additional research to examine the impact of clinical supervision from the supervisee's viewpoint (Spence et al., 2001). The qualities that were preferred included but was not limited to a nurturing climate and relationship with supervisor; respect and empathy; creating a "space for thinking"; being available, punctual, and accessible; and being flexible and allowing increased autonomy. The qualities disliked included allowing administrative issues to dominate supervision, unclear or vague feedback, schedule not allowing time for supervision, and inadequate professional knowledge. Spence et al. (2001) also provided recommendations on

research to study the impact of professional education and training on counselors' job performance.

A study by Cashwell and Dooley (2001) conducted the only research to date that examined counselors who were receiving and not receiving clinical supervision to analyze the impact on self-efficacy. Although this was a small study (33 participants), they found a significant difference between the two groups. This study utilized the Counseling Self-Estimate Inventory (COSE; Larson et al., 1992) to measure counselors' responses to self-efficacy ratings. Counselors who received clinical supervision reported higher levels of self-efficacy (Cashwell and Dooley, 2001). This study provides more evidence that clinical supervision can contribute to counselors' professional growth and quality care for clients.

Predicting Satisfaction with Clinical Supervision

The quality of clinical supervision and the impact of clinical supervision on addiction counselor's professional development has also been examined. Reeves, Culbreth, and Greene (1997) were concerned about the lack of empirical evidence on clinical supervisors in the substance abuse counseling field at that time and examined the supervisory styles of substance abuse clinical supervisors. This study examined the responses to the Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984) and the Supervisory Styles Index (Long et al., 1996) made by 72 clinical supervisors. Their results indicated that substance abuse counselor supervisors focused on establishing a collegial and relationship-oriented supervision setting for their supervisees, and younger supervisors and supervisors with more educational training were more flexible in the style of supervision. A more recent study by Laschober, Eby, and Sauer (2012) collected data from 484 clinical supervisor-counselor dyads to examine supervision practices from the viewpoint of the supervisor and the counselor. This study used a rating scale

completed by substance abuse counselors about their clinical supervisor. The findings showed that the clinical supervisors had an average of seven years of experience and completed approximately 90 hours of clinical supervision training. The researchers found that supervisors' clinical supervision training continues to be wide-ranged, counselors generally view their supervisors as effective, supervisors appear to value spending time in supervision with counselors, and supervisors have been using a variety of methods when interacting and providing feedback to counselors.

Culbreth and Borders (1999) conducted their study on the impact of clinical supervision based on the recovery status of the counselor and supervisor. They examined 366 counselors' perceptions of the supervisory relationship based on supervisory style, social influence, working alliance, and the core conditions of the relationship. The study utilized the Supervisory Styles Inventory (Friedlander & Ward, 1984) to measure supervisory styles, the Supervisory Rating Form (Schiavone & Jessell, 1988) to measure social influence related to supervisory relationships, the Working Alliance Inventory (Horvath & Greenberg, 1989) to measure working alliance, and the Barrett-Lennard Relationship Inventory (Schacht et al., 1988) to measure conditions that influence behavior change, all completed by substance abuse counselors. The findings of the study indicated that there were no significant differences between ratings of satisfaction with the supervisory relationship among recovering (34%) and non-recovering (65%) counselors. Furthermore, significant differences between the supervisory relationship variables were not found between recovering and non-recovering counselors and supervisors. Nonetheless, when counselors and supervisors matched in recovery status, there were significant differences in ratings of satisfaction. They concluded that recovery status does play a role in the supervisory relationship. The findings in this study also support the need for formal training for

substance abuse supervisors and utilizing group and individual supervision methods may contribute diminished differences in mismatched recovery status situations.

Similarly, in an earlier qualitative study Culbreth & Borders (1998) interviewed five substance abuse counselors to examine social influence, working alliance, and core conditions of the supervisory relationship. The identified themes indicated that counselors were more likely to speak highly of their overall supervision experience when they considered their supervisors to be competent, despite recovery status, and counselors who were dissatisfied with their supervisory experience perceived that their supervisors were not committed to the supervisory relationship. Overall, although the substance abuse counselors considered recovery status to be a significant issue, it was not the most important (Culbreth & Borders, 1998).

The history of studies investigating the impact of clinical supervision practices on substance abuse counselors continues to demonstrate that there is more to be discovered in this area of research. Some of the previous research has recommended the importance of further studying the variables that contribute to the formation of successful supervisory relationships (Schmidt, 2012), and whether quality clinical supervision translates into improved clinical skills and client outcomes (Chandler, Balkin, and Perepiczka, 2011; Culbreth, 1999; SAMHSA, 2009). Examining changes in supervisors' and counselors' perceptions of clinical supervision over time (Laschober, Eby, and Sauer, 2012) and whether effective clinical supervision can improve substance use disorder counselors' professional development (Laschober, Eby, and Sauer, 2013) were also recommended for future research.

Summary

Overall, previous research has provided empirical evidence on the quality and satisfaction with clinical supervision for addiction counselors. The addiction counseling profession began

with basically no structured training in working with people struggling with addiction to alcohol and drugs, but there have been great strides in this field to formalize the addiction counselor and addiction supervisor educational training process. It is as crucial for addiction counselors to benefit from the formal clinical supervision process which should be reliable and consistent. The research has not addressed how frequency and quality impact satisfaction with clinical supervision, addiction counselors' years of experience and professional credentials and how it impacts satisfaction with clinical supervision or the impact of the components of clinical supervision on perceived satisfaction with clinical supervision. The aspects of clinical supervision for addiction counselors that can provide more data reflecting how it impacts the addiction counselor's professional development is what this study aims to discover.

CHAPTER THREE: METHODOLOGY

Research Design

This study was a quantitative non-experimental study examining addiction counselors' responses to the Supervisory Satisfaction Questionnaire (SSQ) (Ladany, Hill, Corbett, & Nutt, 1996) and the Counselor Evaluation of Supervisor (Borders & Leddick, 1987; Powell & Brodsky, 2004) clinical supervision surveys. The correlation between the frequency and satisfaction with clinical supervision for addiction counselors were examined. The correlation between quality of clinical supervision and satisfaction with clinical supervision for addiction counselors was also be examined. The study examined the relationship between addiction counselors' years of experience, professional credentials and satisfaction with clinical supervision as well. There is an absence of data examining the relationship among these variables in the literature. This chapter discusses the design, instrumentation, hypotheses, data analysis plan, and delimitations.

Research questions and Hypotheses

The following research questions and hypotheses were analyzed:

Research question 1: How satisfied are addiction counselors with the frequency and quality of clinical supervision?

Hypothesis 1. Frequency and quality of clinical supervision will be a significant predictor of satisfaction with clinical supervision.

A Pearson correlation was used to test this hypothesis to confirm a relationship between frequency, quality, and satisfaction with clinical supervision. A sequential multiple regression was conducted to analyze the data to demonstrate the strength of the independent variables

predicting the dependent variable. The frequency and quality of clinical supervision was measured by using the addiction counselors' responses to questions on the SSQ.

Research question 2: What components of clinical supervision predict a higher level of satisfaction among addiction counselors?

Hypothesis 2. Addiction counselors will rate structure and support at a higher level than other components as predictors for satisfaction with clinical supervision.

Descriptive statistics were used to test this hypothesis to confirm the rating level for structure and support in comparison to the other components of clinical supervision. A Pearson correlation was also conducted to confirm a relationship between the structure of, support provided, and overall satisfaction with clinical supervision. A multiple regression was conducted to analyze the strength of the relationship between the independent variable and the dependent variable. The structure and support received from clinical supervision was measured by using the addiction counselors' responses to questions on the Counselor Evaluation of Supervisor (Borders & Leddick, 1987; Powell & Brodsky, 2004).

Research question 3: How do years of experience and professional credentials among addiction counselors predict satisfaction with clinical supervision?

Hypothesis 3. Addiction counselors' years of experience and professional credentials will contribute to their level of satisfaction with clinical supervision.

Descriptive statistics and percentages were used to test this hypothesis to confirm the characteristics of addiction counselors as a group. A Pearson correlation was used to determine the relationship between years of experience, professional credentials, and satisfaction with clinical supervision. A sequential multiple regression was conducted to analyze the data to

demonstrate the strength of the independent variables predicting the dependent variable. The level of satisfaction with clinical supervision was measured by using the addiction counselors' responses to questions on the SSQ.

Participants

This study utilized a convenience sample of 112 addiction counselors who are working in outpatient, inpatient or residential substance abuse treatment settings. Addiction counselors who are employed in any substance abuse treatment setting were solicited to participate in the study through an email invitation from this researcher, an email listserv, or the professional organization where they currently hold a membership. These counselors also varied in years of experience, gender, age, ethnic group, education and training, recovery status, and location.

Surveys were completed via an online Qualtrics (Qualtrics, 2018), a software program that can record the participant responses and compile the data to allow for data analysis. Each survey took approximately 15 minutes to complete.

The proposal for this study was submitted for acceptance to the Old Dominion University Institutional Review Board to confirm that this research does not present any potential harm to subjects. This included protecting the confidentiality of all the participants in the study. The study did not proceed until IRB approval was received.

Convenience sampling was used to obtain participants. Substance abuse counselors from mental health agencies, inpatient facilities, jails, prisons, and private practice via electronic mail. Participants received an invitation to participate in the study at their email address. The email message consisted of me introducing myself and explaining the purpose of the study and that the primary requirement to participate is being employed as an addiction counselor in a cover letter.

The cover letter also explained informed consent and a link to complete the survey electronically. The email addresses of participants were obtained through the researcher's professional relationships, contact information posted on the respective agency websites, and contacting the participant by phone to request the email address if needed. Any contact information for potential participants received directly from a participant, and the researcher contacted the potential participant by phone, email, or in person if necessary. The researcher also invited addiction counselors to participate in the surveys through their response to the national counseling listserv operated by Kent State University, CESNET email. The researcher's contact information was included in the cover letter should there be any questions or problems with completing the survey. The possibilities of low response rates and incorrect email addresses that can affect response rate were considered. There was also the possibility of missing data due to unanswered questions while completing the survey. Each participant's confidentiality was protected by completing the survey through a website that was not directly connected to the researcher or the researcher's email, and the participant did not provide any identifying information during the process of completing the survey. Each survey began with a confidentiality statement that was electronically signed by the participant by selecting "yes" to continue completing the survey or "no" to decline to participate. Any participants selecting "no" were transferred to an "end of survey" message and exited out of the instrument.

Instrumentation

The survey instruments consisted of the 40 item Counselor Evaluation of Supervisor (CES) (Borders & Leddick, 1987; Powell & Brodsky, 2004) and the 8 item Supervisory Satisfaction Questionnaire (SSQ) (Ladany, Hill, Corbett, & Nutt, 1996). Permission was obtained from Dr. L. DiAnne Borders to use the CES and from Dr. Nicholas Ladany to use the SSQ for this

research. Reliability and validity estimates were calculated and have been documented in previous studies for the SSQ. Reliability and validity estimates have not been documented in previous studies for the CES. Participants were asked to provide demographic information related to their work as addiction counselors, clinical supervision, gender, age, credentials, work setting, clientele, time in current position, supervision of other staff, supervisor's gender, supervisor's credentials, and allocation of supervisor. The questionnaires contained areas that address the counselors' clientele, current supervision experiences, preferred supervision experiences, and participant demographic information.

The Counselor Evaluation of Supervisor (CES) consisted of answering scale items on a Likert scale. The Counselor Evaluation of Supervisor is a 40-item questionnaire asked questions about the importance/value of clinical supervision, finding time, trust/rapport, supervisor advice/support, improved care/skills as a result of supervision, and reflection. For example, the item "Helps me feel at ease with the supervision process" and "Structures supervision appropriately" (Borders & Leddick, 1987). Questions on the scale were answered using a 7-point Likert scale where 1 represents extremely dissatisfied, and 7 represents extremely satisfied. Powell and Brodsky (2004) adapted this instrument as a tool for counselors to evaluate their supervisors' design and delivery of clinical supervision. The Cronbach's alpha is 0.99 which is good, was conducted by the researcher. After a thorough search of the literature, there were no previous studies found that had used this instrument. The researcher selected this instrument because it contains items specifically related to components of clinical supervision that represent structure and support from the supervisor.

The SSQ consists of answering scale items on a Likert scale for each participant. The SSQ is an 8-item questionnaire that asks questions about the quality and satisfaction with clinical

supervision. For example, the item "How would you rate the quality of the supervision you have received?" and "To what extent has this supervision fit your needs?" (Ladany, Hill, & Nutt, 1996). Questions on the scale are answered using a 4-point Likert scale where 1 represents poor, and 4 represents excellent. The Cronbach's alpha is 0.96 which is good (Tromski-Klingshirn & Davis, 2007). Other studies that have used this scale (Fernando & Hulse-Killacky, 2005) have found similar levels of reliability.

The demographic information consisted of completing 15 items of categorical and continuous data about the counselor, the counselor's supervisor, and the clinical supervision sessions. For example, the item "gender" and "Frequency of supervision sessions." Categorical questions like "gender" were answered by selecting male or female, and continuous questions like "Years of experience as an addiction counselor" were answered by entering a numerical value to represent years. The demographic data provided the data on the counselors' years of experience and professional credentials to determine a relationship with their rating on satisfaction with clinical supervision.

Analysis

Multiple Regression Analyses (Chandler, Balkin, & Perepiczha, 2011; Culbreth & Cooper, 2008; Fernando & Hulse-Killacky, 2005) was conducted to determine the relationship between the dependent variable (satisfaction with clinical supervision) and the independent variables (quality of clinical supervision, frequency of clinical supervision, years of experience, and professional credentials) (see Table 1). The data were analyzed using a hierarchical method to determine how much frequency of clinical supervision, quality of clinical supervision, years of experience and professional credentials predict satisfaction with clinical supervision.

A correlational statistical power analysis was conducted using the G*Power software for *F* tests to determine the appropriate sample size based on an effect size of 0.15, α=.05, and power of 0.80. The results of the analysis indicated a minimum sample size of 85 participants at a *F*=2.48 and df =80. It is also worth noting that small sample sizes have been a common issue among previous research, hence larger sample sizes were recommended for future research (Best et al., 2014; Powell, 1991, Reeves, Culbreth, & Greene, 1997; West & Hamm, 2012).

The data were analyzed using descriptive statistics to include frequencies, means, and standard deviations. A Pearson correlation was also conducted to demonstrate the relationship between the frequency of clinical supervision and satisfaction with clinical supervision. If the selected statistics method proved to be troublesome to the data collected, the researcher prepared also to conduct a coefficient of determination. The researcher had access to the individually completed surveys to review all data entered by participants and clean up any missing data or problematic issues. For any survey items that create a major problem (e.g., no responses to the same item) or any surveys that had more than five items not answered was excluded from the study. The researcher created a data set for her records that were also be kept in an SPSS file.

Data Analysis Plan

Table 1 *Proposed Statistical Analyses*

Research question	Key Variable	Type of Data	Data Analysis
How satisfied are addiction counselors with the frequency and quality of clinical supervision?	SSQ	Scale	Hierarchical Multiple Regression
What components of clinical supervision predict a higher level of satisfaction among addiction counselors?	Counselor Evaluation of Supervisor	Scale	Multiple Regression

How do years of experience and professional credentials among addiction counselors predict satisfaction with clinical supervision?	Years of experience Professional credentials SSQ Counselor Evaluation of Supervisor	Nominal Categorical Scale Scale	Hierarchical Multiple Regression

Note. Counselor Evaluation of Supervisor (Borders & Leddick, 1987; Powell & Brodsky, 2004); SSQ-Supervisory Satisfaction Questionnaire (Ladany, Hill, Corbett, & Nutt, 1996; 8 items)

Delimitations

This study only used participants who are addiction counselors in order to enhance the limited research on this specific area of clinical supervision.

The limitations of the study were anticipated to be at a minimum. One limitation of the study is related to the instrumentation. Since the surveys were completed independently by the participant, it is possible for a participant to misunderstand the rating scale or inadvertently select an incorrect response to a question. The only instructions the participant received was provided at the beginning of the survey and the researcher was not available if questions occurred while a participant was completing the survey. A second limitation consisted of participants may not be represented from all treatment settings. Since participation in the study occurred through participants responding to the request to complete the surveys online, there was no way to control for ensuring that counselors from all settings are represented, which may limit data collected due to some treatment settings being omitted. A third limitation was the researcher's inability to verify the counselors' credentials or current job status through responses to the online surveys.

CHAPTER FOUR: RESULTS

This chapter will discuss the findings from the quantitative analysis of the research questions and hypotheses. The findings will also explain the demographic data and potential trends among participants. There were 112 respondents to the online survey and 28 of the surveys contained incomplete survey data at the end of data collection for the study, leaving a total of 84 completed. This is likely attributed to participants starting the survey but did not return to the survey to complete the remaining survey questions.

Descriptive Data

There were 84 surveys completed by addiction counselors. The participants consisted of 71% (*n* = 60) females and 29% (*n* = 24) males. All age ranges were represented which consisted of 18-80 years old. Addiction counselors in the age range of 36-45 represented the largest group at 28.6% (see Table 2). The participants reported that 43% are currently employed as addiction

Table 2

Participant Demographics

	Addiction Counselor =N (%)	
Demographic	Female	Male
Gender	60 (71.4)	24 (28.6)
Age		
18-25	2 (2.4)	0
26-35	19 (22.6)	7 (8.3)
36-45	17 (20.2)	7 (8.3)
46-55	10 (11.9)	7 (8.3)
56-65	10 (11.9)	3 (3.6)
66-80	2 (2.4)	0
Occupation		
Addiction Counselor	25 (29.8)	11 (13.1)
MH Counselor	13 (15.5)	5 (6.0)
Other	22 (26.2)	8 (9.5)
Addiction&MH Counselor	8 (9.6)	3 (3.6)
BH Counselor	1 (1.2)	0

BH Case Manager	1 (1.2)	0
Clinical Manager	1 (1.2)	0
Co-occurring Counselor	1 (1.2)	2 (2.4)
Counselor Educator	1 (1.2)	0
Doctoral student	1 (1.2)	2 (2.4)
Drug Court Coordinator	1 (1.2)	0
LPC	1 (1.2)	1 (1.2)
LPC & Art Therapist	1 (1.2)	0
Medical Social Worker	1 (1.2)	0
Opiate Prevention Coord.	1 (1.2)	0
Registered Nurse	1 (1.2)	0
Student & Therapist	2 (2.4)	0
Counselor identity		
Addiction Counselor	22 (26.2)	12 (14.3)
MH Counselor	22 (26.2)	5 (6.0)
Rehabilitation Counselor	1 (1.2)	1 (1.2)
Other	15 (17.9)	6 (7.1)
All of the above	1 (1.2)	1 (1.2)
BH Counselor	1 (1.2)	0
BH Specialist	0	1 (1.2)
LPC & Art Therapist	1 (1.2)	0
Addiction&MH Counselor	1 (1.2)	3 (3.6)
Clinical Counselor	1 (1.2)	0
College Counselor	1 (1.2)	0
Counselor	1 (1.2)	0
Drug Court Counselor	1 (1.2)	0
LPC	2 (2.4)	1 (1.2)
Future counselor educator	1 (1.2)	0
Reg. Clinical Counselor	1 (1.2)	0
Highest Degree		
Bachelor's	5 (6.0)	2 (2.4)
Master's	45 (53.6)	20 (23.8)
Doctorate	7 (8.3)	2 (2.4)
Other	3 (3.6)	0
2 years of college	1 (1.2)	0
2nd year doctoral student	1 (1.2)	0
ABD	1 (1.2)	0
Years of experience		
1 yr or <	9 (10.7)	2 (2.4)
2-5	15 (17.9)	8 (9.5)
5-10	15 (17.9)	8 (9.5)
10-20	13 (15.5)	4 (4.8)
20-30	5 (6.0)	2 (2.4)
30-40	3 (3.6)	0
Certified or Licensed		
Yes	37 (44.0)	17 (20.2)

No	16 (19.0)	4 (4.8)
Other	7 (8.3)	3 (3.6)
BCACC&CCPA	1 (1.2)	0
CAADC	0	3 (3.6)
In the past	1 (1.2)	0
LMFT	1 (1.2)	0
LPC&LGPC	1 (1.2)	0
NCC	1 (1.2)	0
P-LMHC	1 (1.2)	0
Pending exam	1 (1.2)	0
Current setting		
Outpatient	40 (72.7)	15 (27.3)
Inpatient	3 (50.0)	3 (50.0)
Residential	9 (81.8)	2 (18.2)
Jail-based	1 (100.0)	1 (100.0)
TC	4 (66.7)	2 (33.3)
Other	13 (72.2)	5 (27.8)
College Counseling Ctr	2 (2.4)	1 (1.2)
Court	2 (2.4)	0
Doctoral Student	0	1 (1.2)
Hospital	1 (1.2)	0
Insurance company	1 (1.2)	0
Integrated care facility	0	2 (2.4)
Primary Care office	1 (1.2)	0
Prison	1 (1.2)	0
Private practice	3 (3.6)	0
Re-entry	1 (1.2)	0
Type of treatment		
Individual Therapy	53 (72.6)	20 (27.4)
Group Therapy	42 (67.7)	20 (32.3)
Psycho-education	40 (67.8)	19 (32.2)
Family Therapy	18 (69.2)	8 (30.8)
Crisis Intervention	28 (71.8)	11 (28.2
Other	8 (80.0)	2 (20.0)
Complementary therapy	1 (1.2)	0
Drop in counseling	1 (1.2)	0
Emotional support	1 (1.2)	0
Graduate Student	0	1 (1.2)
MAT	1 (1.2)	1 (1.2)
Relapse prevention group	1 (1.2)	0
Women in drug court	1 (1.2)	0
Time working in current position		
1 month-1year	16 (19.0)	7 (8.3)
1-3 years	16 (19.0)	9 (10.7)
3-6 years	11 (13.1)	2 (2.4)

6-10 years	9 (10.7)	3 (3.6)
10 years +	8 (9.5)	3 (3.6)
Supervisor gender		
Male	20 (23.8)	6 (7.1)
Female	39 (46.4)	16 (19.0)
Do not wish to disclose	1 (1.2)	2 (2.4)
Supervisor highest degree		
HS Diploma	1 (1.2)	0
Associate's	1 (1.2)	0
Bachelor's	4 (4.8)	3 (3.6)
Master's	41 (48.8)	18 (21.4)
Doctorate	11 (13.1)	3 (3.6)
Other	2 (2.4)	0
LPC	1 (1.2)	0
Unknown	1 (1.2)	0
Supervisor counselor identity		
Addiction Counselor	15 (17.9)	7 (8.3)
MH Counselor	25 (29.8)	12 (14.3)
Rehabilitation Counselor	2 (2.4)	0
Other	18 (21.4)	5 (6.0)
All of the above	0	1 (1.2)
BH Counselor	1 (1.2)	0
BH Specialist	0	1 (1.2)
Clinical Supervisor	1 (1.2)	0
Counselor educator	1 (1.2)	0
Insurance company CM	1 (1.2)	0
LCSW	2 (2.4)	1 (1.2)
Leadership	1 (1.2)	0
LPC	2 (2.4)	1 (1.2)
MFT	1 (1.2)	0
Addiction&MH Counselor	1 (1.2)	0
Psychologist	2 (2.4)	0
RN	1 (1.2)	0
Social Worker	1 (1.2)	0
Type of supervision received		
Clinical	22 (26.2)	8 (9.5)
Administrative	8 (9.5)	4 (4.8)
Clinical & Administrative	27 (32.1)	11 (13.1)
No clinical or administrative	1 (1.2)	1 (1.2)
Other	2 (2.4)	0
Consultation	1 (1.2)	0
Blank	1 (1.2)	0
Frequency of Supervision		
Weekly	32 (38.1)	10 (11.9)
Monthly	12 (14.3)	6 (7.1)
Every 2-3 months	2 (2.4)	2 (2.4)

Unscheduled	6 (7.1)	4 (4.8)
Other	8 (9.5)	2 (2.4)
2-3 times per week	1 (1.2)	0
b/t weekly&monthly	1 (1.2)	0
Bi-weekly	4 (4.8)	1 (1.2)
NA	1 (1.2)	0
No-weekly	1 (1.2)	0

Note. *N* = 84; MH=Mental Health, BH=Behavioral Health, LPC=Licensed Professional Counselor, ABD=All But Dissertation, BCACC=British Columbia Association of Clinical Counsellors, CCPA=Canadian Counselling and Psychotherapy Association, CAADC=Certified Advanced Alcohol and Drug Counselor, LMFT=Licensed Marriage & Family Therapist, Coord=Coordinator, LGPC=Licensed Graduate Professional Counselor, NCC=National Certified Counselor, P-LMHC=Pending Licensed Mental Health Counseling, MAT=Medication Assisted Treatment, CM=Case Manager, LCSW=Licensed Clinical Social Worker, MFT=Marriage & Family Therapist, RN=Registered Nurse

counselors, 21% are employed as mental counselors and 36% reported their current employment as other, which includes clients who present with substance use disorder issues. The "other" category consisted of the following occupations: both addiction and mental counselor (9), behavioral health counselor (1), behavioral health case manager (1), clinical manager (1), co-occurring substance abuse counselor (3), counselor educator (1), private practice (1), doctoral candidate/doctoral student (2), drug court coordinator(1), licensed professional counselor (LPC)/Art therapist (1), LPC (1), medical social worker(1), opiate prevention coordinator (1), registered nurse (RN) (1), and student/therapist (2). Participants' level of education consisted of 8% (*n* = 7) having a bachelor's degree, 77% (*n* = 65) have completed a master's degree, 11% (*n* = 9) have a doctorate, and 4% (*n* = 3) reported other which consisted of two years of college (1), second year doctoral student (1), and an "all but the dissertation" student (1) (see Table 2). The number of years of experience varied from less than one year to 40. Counselors reported 2-5 years of experience and 5-10 years of experience each at 27.4% which were the largest groups

represented. In addition to years of experience, 64% (*n* = 54) counselors reported having a substance abuse certification or license and those who did not have a substance abuse certification reported having an LPC (1), licensed marriage and family therapist (LMFT)(1), National Counselor Certification (NCC) (1), British Columbia Association of Clinical Counsellors (BCACC) and Canadian Counselling and Psychotherapy Association (CCPA) (1), LPC and LGPC (1), Pending-Licensed Mental Health Counselor (P-LMHC) (1), or pending examination (1). Moreover, the participants' amount of time working in their current position consisted of 30% who have worked in their position for the past 1-3 years closely followed by one month-one year at 27% and ten years or more at 13%.

The characteristics of addiction supervisors as reported by the addiction counselors consist of 65% (*n* = 55) female, 31% (*n* = 26) male, and 4% (*n* = 3) did not disclose the supervisor's gender. The supervisors' level of education was reported as 70% have a master's degree, 17% have a doctoral degree, 8% have a bachelor's degree, 1% with an associate's degree, 1% with a high school diploma, 1% with an LPC, and 1% reported that the supervisor's level of education was unknown. The supervisor's counselor identity was reported as 26% addiction counselor, 44% mental health counselor, 2% rehabilitation counselor, and 27% selected other which includes "all of the above" (1), behavioral health counselor (1), behavioral health specialist (1), clinical supervisor (1), counselor educator (1), insurance company case manager (1), LCSW (3), leadership (1), LPC (3), marriage and family therapist (1), mental health and addiction counselor (1), psychologist (2), RN (1), and social worker (1).

Most of the participants, 65% (*n* = 55), reported currently employed in an outpatient treatment setting. Furthermore, 21% reported working in other settings such as college counseling center (2), courts (2), hospital (1), insurance company (1), integrated care facility (1), primary care

office (1), prison (1), private practice (4) and re-entry (1). Table 2 shows the types of treatment the addiction counselors provided. Interestingly, 87% reported providing individual therapy, 74% reported providing group therapy, 70% provide psycho-education, 31% provide family therapy, 46% provide crisis intervention, 11% provide other treatment services to include complementary therapy (1), drop-in counseling (1), emotional support (1) , medication-assisted treatment (MAT) (1), and relapse prevention services (1), women in drug court (1) , and graduate student (1).

Participants reported whether they received clinical supervision in the current employment. They reported receiving clinical supervision only (36%), administrative supervision only (14%), clinical and administrative supervision (45%), no clinical or administrative supervision (2%), and other supervision (2%) which was reported as consultation.

The frequency of supervision sessions reported by participants consisted of weekly (50%), monthly (21%), every 2-3 months (5%), unscheduled (12%), and other (12%) which was described as bi-weekly (5), between weekly and monthly (1), 2-3 times per week (1), not applicable (NA) (1), and no weekly (1).

Descriptive statistics were conducted for the Supervision Satisfaction Questionnaire (SSQ) and the Counselor Evaluation of Supervisor (CES) questionnaire (see Table 3). The SSQ items

Table 3
Descriptive Statistics of Independent variables and Dependent variable

Characteristic	N	Mean	Std. Deviation	Skewness	Kurtosis
CES TOTAL SCORES	84	205.7619	7.27664	-.669	-.173
SSQ TOTAL SCORES	84	23.5476	7.27664	-.464	-1.031
FREQOFCS	84	2.0238	1.44908	.746	-1.116
YEARSOFEXP	84	2.9405	1.29272	.387	-.402

CREDEN1	84	4.0952	.57286	1.191	3.575
CREDEN2	84	1.4762	.70243	1.155	-.015

Note. CES=Counselor Evaluation of Supervisor; SSQ=Supervision Satisfaction Questionnaire; FREQOFCS=frequency of clinical supervision; YEARSOF EXP=years of experience; CREDEN1=highest degree completed; CREDEN2=certified or licensed as an addiction counselor.

were answered on a scale of 1 (low rating) to 4 (high rating) and the mean scores on individual items ranged from 2.83 to 3.02. The CES items were answered on a scale of 1 (extremely dissatisfied) to 7 (extremely satisfied) and the mean scores on the individual items ranged from 4.05 to 5.98. In order to effectively manage the data from both questionnaires for the analysis, the SSQ and CES ratings were recoded into total scores. The descriptive statistics for the SSQTOTAL included a minimum score of 8.00 and a maximum of 32.00, a mean of 23.55, standard deviation of 7.28, and variance of 52.95. The skewness was -.464 and the kurtosis was -1.031 which displayed an estimated symmetric distribution. The CESTOTAL descriptive statistics were a minimum of 69.00 and a maximum of 280.00, a mean of 205.76, standard deviation of 54.66, and variance of 2987.32. The skewness was -.669 and the kurtosis was -.173 which displayed a moderately skewed distribution.

Overall Findings

Research question 1: How satisfied are addiction counselors with the frequency and quality of clinical supervision?

Hypothesis 1. Frequency and quality of clinical supervision will be a significant predictor of satisfaction with clinical supervision.

A Pearson correlation was conducted to confirm a relationship between frequency (M = 2.14, SD = 1.45), quality (M = 2.92, SD = 1.02), and satisfaction with clinical supervision (M = 20.63, SD = 6.31). The frequency variable was not found to have a significant correlation with quality and satisfaction ratings, $r(82) = .045$, $p = .68$, *ns*. A Pearson correlation was also conducted on the relationship between quality and satisfaction with clinical supervision which did reveal a significant correlation, $r(82) = .938$, $p < .001$. A hierarchical regression analysis (see Table 4) was conducted

Table 4
Hierarchical Multiple Regression Analyses Predicting Satisfaction on SSQ-1 (N=84)

Step and Predictor variable	R^2	ΔR^2	*B*	SE *B*	β
Step 1					
QUALITY TOTAL	.880	.880*	5.802*	.236	.938
Step 2					
QUALITY TOTAL					
FREQOFCS	.881	.001	.117	.197	.023
Total R^2	1.761				

Note. SSQ=Supervision Satisfaction Questionnaire; QUALITY TOTAL=Quality of Supervision FREQOFCS=frequency of clinical supervision

*$p < .001$

on these variables resulted in ratings on the quality of clinical supervision explaining 88% of the variance in satisfaction with clinical supervision ratings. Therefore, the ANOVA results indicated quality of clinical supervision was a significant predictor of satisfaction with clinical supervision, $F(1, 82) = 602.17$, $p < .001$, $R^2 = .88$ and when frequency was added as predictor the ANOVA results were also significant, $F(2, 81) = 298.90$, $p < .001$, $R^2 = .88$. However, model 1 of the coefficients table did find that quality of supervision did contribute variance that was significant, $b = 5.802$, $\beta = .938$, $p < .001$, and the frequency variable did not contribute any

additional variance to the level of satisfaction, $b = .117$, $\beta = .023$, $p = .553$. The mean score addiction counselors reported on the SSQ for quality of supervision was 2.92.

Overall, the results partially supported hypothesis 1. The frequency of clinical supervision reported by addiction counselors does not impact their level of satisfaction with clinical supervision, but addiction counselors' ratings on the quality of clinical supervision received had a direct impact on satisfaction with clinical supervision.

Research question 2: What components of clinical supervision predict a higher level of satisfaction among addiction counselors?

Hypothesis 2. Addiction counselors will rate structure and support at a higher level than other components as predictors for satisfaction with clinical supervision.

A regression analysis (see Table 5) revealed the average CES scores (M=205.76, SD = 54.66)

Table 5
Regression Analyses Predicting Satisfaction on SSQ (N=84)

Model and Predictor variable	R^2	ΔR^2	*B*	SE *B*	β
Step 1					
CES TOTAL	.835	.835*	.122*	.006	.914
Total R^2	.835				

Note. CES=Counselor Evaluation of Supervisor

*$p < .001$

and SSQ scores (M = 23.55, SD = 7.28) were moderate to high on the corresponding Likert scales. A Pearson correlation was conducted to confirm the relationship between the components of clinical supervision and satisfaction with clinical supervision. This did reveal a significant correlation between CES scores and SSQ scores, $r(82) = .914$, $p < .001$. The regression analysis also showed that CES scores accounted for 83.5% of the variance in SSQ

scores which was statistically significant, $F(1, 82) = 415.92$, $p < .001$, $R^2 = .84$. The regression model further validated that the addiction counselor's ratings on the CES were a significant predictor of ratings on the SSQ, $b = .122$, $\beta = .914$, $p < .001$. The mean scores reported on the CES were 205.76 and the mean scores for the SSQ were 23.55. The CES item, *"My clinical supervisor makes me feel accepted and respected as a person"* received the highest mean score of 5.98 and the item, *"My clinical supervisor helps develop increased skill in critiquing and gaining insight from counseling tapes"*, received the lowest mean score of 4.05.

Overall, the results indicated that hypothesis 2 was fully supported. Addiction counselors who reported consistently receiving the components of clinical supervision on the CES also reported a higher level of satisfaction with clinical supervision.

Research question 3: How do years of experience and professional credentials among addiction counselors predict satisfaction with clinical supervision?

Hypothesis 3. Addiction counselors' years of experience and professional credentials will contribute to their level of satisfaction with clinical supervision.

Addiction counselors' years of experience ($M = 2.94$, $SD = 1.29$) and professional credentials, highest degree completed ($M = 4.09$, $SD = .573$), and certification or license as an addiction counselor ($M = 1.48$, $SD = .702$) were examined to determine how much they impacted their SSQ scores. A Pearson correlation (see Table 6) was conducted and revealed that there was not a

Table 6

Correlations for research question 3 (N=84)

Variable	1	2	3	4
SSQ TOTAL	---	.107	-.102	-.059
YEARSOFEXP		---	.154**	-.260

CREDEN1	---	.185***
CREDEN2		---

Note. SSQ=Supervision Satisfaction Questionnaire; FREQOFCS=frequency of clinical supervision; YEARSOF EXP=years of experience; CREDEN1=highest degree completed; CREDEN2=certified or licensed as an addiction counselor.
**p < .01, ***p < .05

significant relationship between years of experience, $r(82) = .107$, $p = .166$, *ns*, professional credentials, $r(82) = -.102$, $p = .177$, *ns* (highest degree completed), , $r(82) = -.059$, $p = .298$, *ns* (certified of licensed as an addiction counselor) and SSQ scores. A significant correlation was found between years of experience and certified or licensed as an addiction counselor, $r(82) = -.260$, $p = .008$. A significant correlation was found between highest degree completed and certified or licensed as an addiction counselor, $r(82) = .185$, $p = .046$, as well. The results of the multiple regression analysis (see Table 7) showed the effect of years of experience and

Table 7

Hierarchical Multiple Regression Analyses Predicting Satisfaction on SSQ-3 (N=84)

Step and Predictor variable	R^2	ΔR^2	*B*	SE *B*	β
Step 1	.012	.012			
YEARSOFEXP			.604	.618	.107
Step 2	.026	.014			
YEARSOFEXP					
CREDEN1			-1.546	1.410	-.122
Step 3	.026	.000			
YEARSOFEXP					
CREDEN1					
CREDEN2			-.039	1.218	-.004
Total R^2	.064				

Note. YEARSOF EXP=years of experience; CREDEN1=highest degree completed; CREDEN2=certified or licensed as an addiction counselor.

professional credentials had an effect of 2.6% on SSQ scores and were not statistically significant among the three variables (b = .604, β = .107, p =.332 (years of experience), b = -1.546, β = -.122, p = .276 (highest degree completed), b = -.039, β = -.004, p =.974 (certified or licensed as an addiction counselor)).

Overall, the results of hypothesis 3 were not supported. The participants' satisfaction ratings on the SSQ does not appear to be impacted by their credentials or years of experience working as an addiction counselor. The predictors were correlated with one another in such a way that the credentials or years of experience variables did not offer any significant amount of unique variance in explaining the dependent variable.

CHAPTER FIVE: DISCUSSION

This chapter explores and summarizes findings of addictions counselors' satisfaction with clinical supervision. Previous research is used to discuss similarities and differences. Implications of this study on counseling research and clinical supervision practices in the addiction counseling field and counselor educators is introduced as well. The chapter will conclude with recommendations for future research and conclusions.

Summary of Findings

Addiction counselors' perceptions of clinical supervision practices were examined in this study using addiction counselors' responses to demographic questions, the Counselor Evaluation of Supervisor and the Supervision Satisfaction Questionnaire. The frequency and quality of clinical supervision sessions were studied with satisfaction ratings from the SSQ. This study examined addiction counselors' ratings on the CES on their perceptions of structure and support received in clinical supervision and the impact on satisfaction ratings on the SSQ as well. This study also looked at the impact of addiction counselors' years of experience and professional credentials (highest degree completed and certification or licensed as an addiction counselor) and satisfaction responses from the SSQ.

The impact of frequency and quality on the level of satisfaction with clinical supervision was examined in research question one. Similar to previous findings (Best et al., 2014), the frequency of clinical supervision reported did not have a significant impact on SSQ scores. Best et al. (2014) found that the frequency variable did not show a significant contribution to the variance for job satisfaction. Although the majority of addiction counselors indicated receiving clinical supervision on a weekly basis, it appears that this level of frequency does not automatically suggest that addiction counselors have a preference for how often clinical

supervision occurs. This may be due to sample size or the frequency options provided on the survey. For example, bi-weekly supervision was not a response option but was added in the "other" category for this survey item. It is possible that counselors selected a frequency that was closest to the clinical supervision currently received and elected only from the response choices available. Furthermore, addiction counselors did not have the option to select zero for the frequency of clinical supervision, although 14% (n = 12) reported receiving administrative supervision only and 4% (n = 2) reported receiving no clinical or administrative supervision.

The perceived quality of clinical supervision was examined through the SSQ and was recoded to separate from the other SSQ scores. The quality ratings and level of satisfaction ratings were significant. This is similar to previous research using the SSQ finding that counselor supervisees were very satisfied with the quality of the clinical supervision they received (Tromski-Klingshirn & Davis, 2007). Although the full hypothesis was not supported, it is notable that two-thirds of the addiction counselors indicating moderate to high-quality ratings also selected moderate to high satisfaction ratings.

Research question two examined the impact of addiction counselors' ratings of perceived structure and support in clinical supervision from the CES on satisfaction ratings from the SSQ. There was a significant relationship between CES and SSQ responses which is similar to previous findings by Schmidt (2012) in which substance abuse counselors reported from previous research more satisfaction with supervision when their supervisor incorporated building a supportive relationship and showing that they understand the substance abuse counselors' experience. The CES asked addiction counselors to provide ratings on the structure of clinical supervision received by their current supervisor (e.g. "My clinical supervisor structures supervision appropriately", "My clinical supervisor adequately emphasizes the development of

my strengths and capabilities", and "My clinical supervisor deals appropriately with the content in counseling sessions"), and the support received in clinical supervision (e.g. "My clinical supervisor helps me feel at ease with the supervision process", "My clinical supervisor provides me with specific help in areas I need to work on", and "My clinical supervisor enables me to express opinions, questions, and concerns about my counseling"). The CES is a recommended instrument for use with addiction clinical supervision (Powell & Brodskey, 2004). The significant main effect helps to demonstrate that addiction counselors who indicated higher ratings on the CES also had higher satisfaction ratings on the SSQ. Likewise, addiction counselors who indicated low ratings on the CES also had lower ratings on the SSQ. The CES was used to ensure that addiction counselors were aware of the which components of clinical supervision they were rating their clinical supervisor before they provided overall satisfaction ratings. This finding provides evidence on the specific components of clinical supervision that contribute to addiction counselors' professional development. Past research finding that counselors job performance is positively impacted by task proficiency, sponsorship, acceptance-and-confirmation, and mentoring, and have recommended more research to examine the benefits of effective clinical supervision and professional development for addiction counselors (Laschober, Eby, & Sauer, 2013).

The effect of years of experience and professional credentials on the level of satisfaction with clinical supervision was examined in research question three. There was no significant effect found for years of experience as an addiction counselor and level of satisfaction with clinical supervision. The largest group of responses for this variable was one-third of the addiction counselors reporting five to ten years' experience working as an addiction counselor. There may not have been enough responses across all categories of years of experience to uniquely impact

SSQ ratings. There was also no significant effect for professional credentials when grouped with years of experience to predict the level of satisfaction with clinical supervision. Although there was a significant correlation found between years of experience, highest degree completed, and certified or licensed as an addiction counselor, however it was not supported in the regression analysis. Interestingly, this sample of addiction counselors did reveal a trend of more counselors in the field with reporting at least a master's degree (n = 65, 73%) and holding a certification or license as an addiction counselor (n = 54, 65%). This finding highlights one of the concerns from previous research which identified the lack of education and credentialing standards for substance abuse counselors as compared to mental health counseling (Kerwin et al., 2006). Laschobor, Eby, and Sauer (2013) also examined effective clinical supervision and job performance for substance abuse counselors which included 52 percent of the counselors having at least a master's degree and 55 percent being certified or licensed as a substance abuse professional. Although the credentials of addiction counselors were well represented in this study, in regard to time in their current position, the smallest group was "10 years or more" (13%) which may be representative the history of turnover in the addiction counseling field (Eby & Laschober, 2014; Schmidt, 2012).

One unexpected finding showed individual, group, and psycho-education, which have been staples of addiction counseling services, it is interesting that more, if not all, of the counselors, did not indicate providing these services.

Limitations

A few limitations were identified during this research. The first limitation is related to the survey instrument and self-report by participants. The full online survey consisted of 63 questions to be completed by each participant. It was discovered that there were 26 incomplete

cases at the end of data collection. The incomplete data consisted of participants electronically signing the confidentiality consent form but did not respond to any of the questions. Some participants responsed to the demographic questions but did not complete the CES or SSQ sections of the instrument. As an online survey, it is unclear whether the incomplete data was due to the participant intending to return to the survey to complete it, whether there were questions that they did not want to complete, or whether participants discovered they were not eligible to complete the survey after beginning the instrument. To protect confidentiality, it was not possible to contact any of the participants whose survey was incomplete, so those had to be discarded. Among the participants who did complete the survey, it is not possible to confirm that they are working as addiction counselors or have the credentials reported. Some responses to the survey did demonstrate the participants were adding their specific education level or professional credential if it was not listed as a survey response.

A second limitation that was discovered was related to participants indicating they were not receiving any clinical supervision, but were receiving administrative supervision only (14%), no clinical or administrative supervision (4%), or something else which has also been found in previous research (Best et al., 2014; Schmidt, 2012). The CES and SSQ are designed counselors who are receiving clinical supervision specifically. It may have been more accurate to transfer the participant to the end of the survey when one of those supervision options were selected or send the participant to a section on the survey with questions related to lack of clinical supervision or job satisfaction. Since these participants did respond to all questions, it is unknown whether responses were based on past clinical supervision, perceptions of administrative supervision currently received, or lack of understanding about the components of

clinical supervision. It is also possible that participants in this category did not understand the instructions provided for the survey.

The sample size (N=84) analyzed for this study fell just below the target minimum participants of 85 to achieve the recommended effect size to be generalized across all populations of addiction counseling. However, addiction counselors completing this online survey were from various regions across the US and Canada. Recruitment of addiction counselors consisted of direct emails inviting participants to complete the instrument, posting an email announcement on the counseling listserv, and emailing counseling and substance abuse professional organizations to request that the link to the survey be distributed to their members. Some professional organizations required a fee for distributing the email and survey link which limited the researcher's ability to use those resources. The researcher was able to contact addiction professionals in various regions around the US and Canada. The majority of the participants invited to participate were in the state of Virginia.

The use of the CES instrument was also a limitation of the study. Borders and Leddick (1987) initially published this instrument in the *Handbook of Counseling Supervision*. The researcher carefully reviewed each of the questions which consisted of the specific characteristics of clinical supervision practices to appropriately test the research hypothesis. However, following a search of previous studies, the past use of this instrument could only be verified in the *Clinical Supervision in Alcohol and Drug Abuse Counseling* (Powell and Brodskey, 2004) manual. This helped lend some evidence to the value of using the CES with the addiction professional population. The validity and reliability were calculated by the researcher which demonstrated a high alpha level and significant correlations between the instrument components. It was important that the research participants were able to directly reference the

components of clinical supervision to understand best how to rate their level of satisfaction. Furthermore, other clinical supervision instruments that have been used in past research were not available to the researcher.

The last limitation that was noted was that this study did not collect data on race or ethnic groups among the participants. This was the researcher's decision, and it is essential to recognize that this limits the ability to measure the diversity of the participants and obtain new diversity data related to the addiction counseling field. As a result, it is unknown how much identified race or ethnic groups among the participants influenced their responses on the survey.

Implications for Addiction Counselors

Growing awareness of the impact clinical supervision has on addiction counselors' performance, and treatment outcomes cannot be understated. This study does show that addiction counselors value clinical supervision which benefits professional development and provides an opportunity for effectively adopting evidence-based practices (Best et al., 2014). The most recent opiate epidemic has brought the devastation of addictive disorders to the forefront. Addiction counselors can use these and similar findings to advocate for themselves to continue to obtain the support needed to provide effective counseling skills for people struggling with this chronic and complex health issue. It is vital for addiction counselors to remember that clinical supervision is a benefit to professional development, not something to be practiced haphazardly or only if the time from a busy caseload permits. It is also important for addiction counselors to know whether their respective supervisors have been formally trained in clinical supervision.

This study provided evidence that the profession continues to be dominated by female addiction professionals with a graduate level education and certification or licensure credentials. Addiction counselors can also learn from this research that education level and professional

credentials have not been significant factors in their perception of satisfaction with clinical supervision. It is recommended that addiction counselors communicate with their supervisors to determine the most effective supervision support based on their individual professional goals.

Implications for Clinical Supervision for Addiction Counselors

Clinical supervision for addiction counselors is occurring but continues to struggle for approximately one-third of the profession. This study found that addiction counselors reported on average, moderate to high levels of satisfaction with clinical supervision, but showed that 18% (n = 16) are not receiving any clinical supervision. It is important for addiction counselors and addiction clinical supervisors to recognize the negative impact poor clinical supervision practices can have on the addiction counselor's professional development as well as treatment outcomes. The challenge of working with persons who need to make significant changes to how they live their lives, often with minimal resources, makes the addiction counselor a vital part of the individual's recovery. The level of complexity in this counseling profession also challenges addiction counselors and clinical supervisors to maintain strong counseling skills and receive support and mentoring to ensure that they are providing the most effective services for their clients (Laschober, Eby, Sauer, 2013). For the gap in receiving administrative supervision only or no supervision to close it may be necessary for the profession to adopt universal standards for all addiction practitioners. These standards could give more addiction counselors the opportunity to use their voice when they recognize the need for effective clinical supervision.

It is important for the addiction counseling profession to make an overall commitment to all addiction counselors receiving clinical supervision and training addiction clinical supervisors to understand all aspects of performing supervision skills unique to this field (SAMHSA, 2009). This study provides recent data on the smaller percentage of addiction counselors (n = 11, 13%)

remaining in their current position beyond ten years. The risk of ongoing turnover in this workforce is an issue clinical supervisors should not ignore. It would be beneficial for addiction clinical supervisors to develop a system of receiving feedback from the addiction counselors they work with to maintain awareness of the importance of their role and to help identify training needs (Willis, 2010). Feedback for the supervisor provides an opportunity to foster accountability for professional development that can be modeled for the counselor. Ramos-Sanchez et al. (2002) recommended the importance of supervisors receiving feedback to help prevent adverse supervision experiences. Since addiction treatment is the only treatment service that terminates a client for lack of progress on the exact issue that brought them to treatment, it can be misleading to counselors who may not understand that they play a significant role in the success of the client's treatment experience (Najavits, Crits-Christoph, & Dierberger, 2000). Effective clinical supervision practices can help addiction counselors maintain awareness of the dynamics of the counselor's role in addiction treatment success and failures.

Previous studies (Culbreth & Cooper, 2008; Laschober, Eby, & Sauer, 2013) have examined addiction counselor and supervisor relationship and how it impacts addiction counselors' job performance. Although the research was able to use a large sample size, there is concern about whether addiction counselors are accurately reporting if their needs are being met when they are aware that they are being examined in the same study with their supervisor. It is important to continue the gather research data on addiction clinical supervision to provide clinical supervisors with the most recent knowledge about the impact of the clinical supervision they provide.

Implications for Counselor Educators

This study provides more evidence of the clinical supervision practices in the addiction counseling field as reported from the voice of addiction counselors. It is important for counselor

educators to be aware of the limited research in this area of counseling. Although consistent clinical supervision known to be the appropriate practice for counselors in training and is required by CACREP (2016) standards, as gatekeepers, it is important to maintain awareness of the research focusing on supervision practices beyond the structured training level. The issue of addiction counselors not receiving clinical supervision impacts the present and the future of addiction counseling. It could also be argued that limited or lack of clinical supervision for addiction counselors impacts the entire counseling profession. Counselor educators can continue to educate future counselors about the quality of the clinical supervision they receive and model the importance of providing effective clinical supervision.

This study also shows that with the expansion of addiction counseling among other behavioral health treatment providers (n = 30, 36%), which results in differences in commitment and skillset regarding clinical supervision. Counselor educators can help future counselors understand how to advocate for effective communication and support through clinical supervision throughout their careers. Although the limitations of the study have been identified, this research provides the opportunity for counselor educators to participate in future research aimed at addressing the clinical supervision needs for addiction counselors and provide more empirical evidence on how to improve clinical supervision practices that fit the unique needs of this population.

Future Research

Research examining clinical supervision from the voice of the addiction counselor continues to be limited. It is important for them to know that clinical supervision is as necessary after practicum and internship experiences as it is during, as well as the critical role it has in their professional development. One recommendation is to expand the current study by increasing the sample size. Along with increasing sample size, the use of an additional quantitative instrument

to examine the impact of clinical supervision across treatment settings could determine any differences in clinical supervision practices based on the treatment setting. An increased sample could also provide the opportunity to discover relationships among the demographic data such as the unexpected impact of years of experience on professional credentials.

Another recommendation is to conduct more qualitative or mixed methods research which can help capture themes related to addiction counselors' experiences with clinical supervision. It may also be beneficial to conduct longitudinal studies to addressing gatekeeping similar to the study by Fulton et al. (2016). Although this study reported a small percentage of participants reporting no clinical supervision, it would add value to the research to collect qualitative data on addiction counselors and the treatment settings that have resulted in the lack of clinical supervision. This may also bring awareness to addiction treatment settings that do not require clinical supervision (Schmidt, 2012) which also brings into question what addiction counselors want from clinical supervision and the adoption of evidence-based practices (Best et al., 2014) when clinical supervision is not a priority.

Future research is also recommended to share the most recent benefits with the addiction counseling community during professional conferences and trainings. This can demonstrate to addiction counselors and supervisors the value of communication and support (Schmidt, 2012) on professional development while also treating clinical supervision as a priority. The addiction counseling field can learn more about the significance of maintaining clinical supervision and not primarily latest drug and alcohol statistics. West and Hamm (2012) recommend the establishment of minimum supervision standards. Although standards have been developed for graduate students completing practicums and internships, there is no evidence that the same standards are universally practiced beyond graduate school.

Conclusion

The frequency and quality of clinical supervision, the components of clinical supervision, years of experience as an addiction counselor, and professional credentials were examined to determine how they impact satisfaction with clinical supervision. The purpose of the study was to provide more evidence to the limited research on clinical supervision for addiction counselors while identifying areas that can predict satisfaction with clinical supervision. The quality and components of clinical supervision were found to be significant predictors of satisfaction with clinical supervision. The regression analysis found CES scores predicted SSQ scores. However, there is no evidence from previous research that the instruments for this study have been used together to measure clinical supervision satisfaction. This warrants further investigation to determine how these instruments help identify the components of clinical supervision that are most important to their professional development.

This study found that addiction counselors value the quality and the structure and support received in clinical supervision. The frequency of clinical supervision, years of experience, and professional credentials did not have a significant impact on the level of satisfaction. This may suggest that addiction counselors value clinical supervision regardless of the frequency and their credentials. In other words, if addiction counselors are generally satisfied with clinical supervision received, they are satisfied with the frequency as well. This study also revealed that most of the participants have at least a master's degree and hold a certification or license. They reported that the majority of their supervisors have at least a master's degree and are certified or licensed as well. Additionally, there was a percentage of clinical supervisors who have a doctoral degree. This apparent trend can be beneficial to the addiction profession. Although the level of educational credentials does not guarantee appropriate supervision training, addiction

counselors appear to be more trusting of the clinical supervision received due to equivalent education levels. The findings from this study do contribute to the limited research in this area and warrant future research with increased sample size and collecting additional qualitative data.

As reported in previous research (Best et al., 2014; Culbreth, 1999; Schmidt, 2012), this study found that clinical supervision for addiction counselors is occurring. Most of the addiction counselors indicated being satisfied with the clinical supervision received. However, there continues to be a part of the addiction counseling community who are not receiving clinical supervision. More addiction counselors are working with a minimum master's degree which confirms that clinical supervision standards were practiced when the counselors were in training. Nonetheless, in programs that do not require clinical supervision, do not have addiction professionals who are appropriately trained to provide clinical supervision, or do not make clinical supervision a priority, there should be a strong concern for treatment outcomes and staff burnout. The relevance of improving professional development standards for addiction counselors and their clinical supervisors is warranted.

CHAPTER SIX: MANUSCRIPT

Addiction Counselors' perceptions of Clinical Supervision Practices

Marla Harrison Newby

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ABSTRACT

The addiction counseling clinical supervision literature has been limited in empirical studies focusing on best practices. Researchers have reported as much as 30 percent of addiction counselors are not receiving clinical supervision at all (Culbreth, 1999; Schmidt, 2012). Addiction counselors enter the field with a variety of credentials that can range from paraprofessional to graduate degrees. The inconsistent practices of clinical supervision in the addiction counseling field and limited research warrants concern for client outcomes. Survey data was examined from 84 addiction counselors' satisfaction with the frequency and quality of clinical supervision received based on professional credentials, years of experience, and analyzed the components of clinical supervision that predict higher ratings of satisfaction among addiction counselors. The findings showed that quality of clinical supervision and structure and support received in clinical supervision were significant predictors of addiction counselors' satisfaction with clinical supervision. The limitations identified were related to online self-report data and generalizability due to sample size. Future research suggestions are included.

Keywords-clinical supervision, addiction counselor, perceptions, satisfaction

Addiction Counselors' perceptions of Clinical Supervision Practices

Research has discovered that clinical supervision for addiction treatment supervisors and addiction counselors deserves some attention due to the complexities (Kavanagh et al., 2002) of working with people struggling with addiction and the various levels of professional training that prepares a person to become an addiction counselor. Culbreth (1999) also found that a third of substance abuse counselors do not receive any supervision. This review of the research focusing specifically on the limited research on clinical supervision for substance abuse counselors supported the need for more studies on the status of clinical supervision in the addiction counseling field. Gathering more data on substance abuse counselors receiving supervision was strongly recommended. Schmidt (2012) conducted a meta-analysis that found that a third of substance abuse counselors are not receiving clinical supervision. Schmidt (2012) reported that since the only research that has been conducted to analyze the effectiveness of the supervisory relationship has been based on the recovery status of the counselor and supervisor, more consideration also needs to be given to the education level of the counselor and supervisor, and allowing them to have a mutual voice in establishing the relationship warrants further investigation. Schmidt (2012) recommended future research to include focusing on professional development, quantity and quality of supervisors' experience as a supervisee, education and training of supervisors, the practice of clinical supervision in substance abuse settings, comparing live supervision and videotaping to self-report and/or no supervision at all, increasing understanding of the variables that contribute to effective supervisory relationships, and additional characteristics of supervisors and substance abuse counselors that contribute to the successful supervisory relationships.

The SAMHSA (2009) Clinical Supervision and Professional Development of The Substance Abuse Counselor reported on the research that demonstrated how clinical supervision for substance abuse counselors is unique from other counseling specialties. The studies reviewed in this report found that substance abuse counselors and supervisors were only moderately satisfied with the overall quality of the supervisory relationship which resulted in 35-40 percent of counselors and 22 percent of supervisors indicating the desire to leave their job which also lends evidence to contributing factors to high turnover rates in the substance abuse field (SAMHSA, 2009). The level of education for counselors and supervisors had evolved to 60-80 percent having a bachelor's degree and 50 percent having a master's degree which produces new supervision challenges for counselors with graduate degrees and supervisors with less education. The most frequent mode of supervision identified was reviewing case notes and listening to case reviews by counselors, followed by observing group counseling sessions, and observing individual counseling sessions. This data demonstrates a significant difference in the methods of supervision practice in the substance abuse counseling field. Moreover, role overload, emotional exhaustion, and stress at work have also been reported by counselors and supervisors which suggests that these issues are not being addressed in supervision (SAMHSA, 2009).

Best et al. (2014) examined whether satisfaction with clinical supervision for AOD counselors and other workers was a predictor of job satisfaction. It was found that 40% of participants indicated receiving clinical supervision once a month, but 14% of participants were not receiving any clinical supervision. Overall, alcohol and drug counselors were more satisfied with their jobs when supervision was a valuable source of guidance and support, as well as when supervision was consistent and there was continuity in the supervision relationship. Lastly,

increased awareness in the substance abuse treatment field for implementing evidence-based practices (EBP) was needed (Best et al., 2014).

West and Hamm (2012) acknowledged some concern for the quality of clinical supervision for substance abuse counselors and recommends the need for ongoing research related to supervisor knowledge and supervisor knowledge of SA treatment providers. Borders (2005) reported that supervisors have been studied more often than supervisees. This study resulted in several conclusions, one of which was that there has been some concern for the lack of clinical supervision and understanding what clinical supervision is for counselors across all specialties.

The barriers to implementing and improving substance abuse clinical supervision were recognized as well. One issue is the research that has been reported from the point of view of the substance abuse counselor about the lack of clinical supervision (SAMHSA, 2009). Another issue has been examining whether the improved counseling skills for substance abuse counselors can be attributed to clinical supervision. Examining the relationship between substance abuse clinical supervision interventions and improved client outcomes has been lacking in the research as well (Kavangh et al., 2002; SAMHSA, 2009).

Ellis (2010) was particularly concerned about the potential harm that can come to supervisees and clients when clinical supervision is harmful and/or inadequate. He reported evidence from previous studies that demonstrated upon the supervisee receiving the actual definition of harmful supervision, significantly more supervisees reported current or past supervision that was harmful or inadequate. Ellis (2010) concluded that more resources are needed devoted to clinical supervision.

Laschober, Eby, and Sauer (2012) examined supervision practices from the viewpoint of the supervisor and the counselor. The researchers found that supervisors' clinical supervision

training continues to be wide-ranged, counselors generally view their supervisors as effective, supervisors appear to value spending time in supervision with counselors, and supervisors have been using a variety of methods when interacting and providing feedback to counselors.

Overall, further research is needed to obtain empirical evidence on the quality and satisfaction with clinical supervision for addiction counselors. The addiction counseling profession began with basically no structured training in working with people struggling with addiction to alcohol and drugs, but there have been great strides in this field to formalize the addiction counselor and addiction supervisor educational training process. It is just as important for addiction counselors to benefit from the formal clinical supervision process which should be reliable and consistent. The nature of substance abuse and the contributing factors that occur in a person's life before and during treatment, and the importance of the quality of the supervisory relationship for counselors are also issues that contribute to the uniqueness of substance abuse supervision. Research addressing addiction counselors' years of experience and professional credentials in relation to clinical supervision needs or their perceptions of client outcomes in settings where clinical supervision is absent. The aspects of clinical supervision for addiction counselors that can provide more data reflecting how it impacts the addiction counselor's professional development is what this study discovered.

Methods

The purpose of the study was to provide more evidence regarding addiction counselor satisfaction with the frequency and quality of clinical supervision received. The study examined the clinical supervision for addiction counselors based on professional credentials and years of experience. This study also analyzed the components of clinical supervision that predict higher

ratings of satisfaction among addiction counselors. The following research questions were addressed:

1. How satisfied are addiction counselors with the frequency and quality of clinical supervision?

Hypothesis 1. Frequency and quality of clinical supervision will be a significant predictor of satisfaction with clinical supervision.

2. What components of clinical supervision predict a higher level of satisfaction among addiction counselors?

Hypothesis 2. Addiction counselors will rate structure and support at a higher level than other components as predictors for satisfaction with clinical supervision.

3. How do years of experience and professional credentials among addiction counselors predict satisfaction with clinical supervision?

Hypothesis 3. Addiction counselors' years of experience and professional credentials will contribute to their level of satisfaction with clinical supervision.

Participants and Procedures

This study utilized a convenience sample of 112 addiction counselors who are working in outpatient, inpatient or residential substance abuse treatment settings. Addiction counselors who are employed in any substance abuse treatment setting were solicited to participate in the study through an email invitation from this researcher, an email listserv, and the profession organization where they current hold a membership. These counselors varied in years of

experience, gender, age, ethnic group, education and training, recovery status, and location, although ethnic group and recovery status data was not collected.

The survey was completed via an online format which consisted of demographic questions, the 40 item Counselor Evaluation of Supervisor (Borders & Leddick, 1987; Powell & Brodsky, 2004) and the 8 item Supervisory Satisfaction Questionnaire (SSQ) (Ladany, Hill, Corbett, & Nutt, 1996). It was developed using the Qualtrics (Qualtrics, 2018) software program that records the participant responses and compiles the data to allow for data analysis. Each survey began with a confidentiality statement that was electronically signed by the participant by selecting "yes" to continue completing the survey or "no" to decline to participate. Any participants selecting "no" where transferred to an "end of survey" message and exited out of the instrument. Upon completion of the entire survey participants were given the opportunity to enter a raffle to win a $50 gift card. Entering the raffle consisted of the participants being instructed to click on a link located at the end of the survey. The link consisted of one item instructing the participant to provide their email address as their entrance into the raffle. Participants' email addresses were entered in a separate survey file to protect confidentiality.

Addiction Counselors responding to the survey were informed that they are required to currently be working with people who are enrolled in treatment for substance use disorder issues. Upon review of the surveys, there were 84 completed surveys and 28 incomplete surveys. The incomplete surveys consisted of missing data which appeared to be result of participants starting the survey but did not complete it.

Instrumentation

The Counselor Evaluation of Supervisor consists of answering 40 scale items on a Likert scale ranging from 1 (extremely dissatisfied) to 7 (extremely satisfied). The Cronbach's alpha is

0.99 which is good, was conducted by the researcher. After a thorough search of the literature, there were no previous studies found that had used this instrument. The SSQ consists of answering 8 scale items on a Likert scale ranging from 1 (poor) to 4 (excellent) for each participant. The Cronbach's alpha is 0.96 which is good (Tromski-Klingshirn & Davis, 2007). The demographic information consisted of completing 13 items of categorical and continuous data pertaining to the counselor, the counselor's supervisor, and the clinical supervision sessions. The demographic data provided the information on the counselors' years of experience and professional credentials to determine a relationship among ratings on satisfaction with clinical supervision.

Results

There were 84 surveys completed by addiction counselors. The participants consisted of 60 (71%) females and 24 (29%) males. All age ranges were represented which consisted of 18-80 years old. Addiction counselors in the age range of 36-45 represented the largest group at 28.6% (see Table 2). The participants reported that 43% are currently employed as addiction

Table 2

Participant Demographics

	Addiction Counselor =N (%)	
Demographic	Female	Male
Gender	60 (71.4)	24 (28.6)
Age		
18-25	2 (2.4)	0
26-35	19 (22.6)	7 (8.3)
36-45	17 (20.2)	7 (8.3)
46-55	10 (11.9)	7 (8.3)
56-65	10 (11.9)	3 (3.6)
66-80	2 (2.4)	0
Occupation		
Addiction Counselor	25 (29.8)	11 (13.1)
MH Counselor	13 (15.5)	5 (6.0)

Other	22 (26.2)	8 (9.5)
Addiction&MH Counselor	8 (9.6)	3 (3.6)
BH Counselor	1 (1.2)	0
BH Case Manager	1 (1.2)	0
Clinical Manager	1 (1.2)	0
Co-occurring Counselor	1 (1.2)	2 (2.4)
Counselor Educator	1 (1.2)	0
Doctoral student	1 (1.2)	2 (2.4)
Drug Court Coordinator	1 (1.2)	0
LPC	1 (1.2)	1 (1.2)
LPC & Art Therapist	1 (1.2)	0
Medical Social Worker	1 (1.2)	0
Opiate Prevention Coord.	1 (1.2)	0
Registered Nurse	1 (1.2)	0
Student & Therapist	2 (2.4)	0
Counselor identity		
Addiction Counselor	22 (26.2)	12 (14.3)
MH Counselor	22 (26.2)	5 (6.0)
Rehabilitation Counselor	1 (1.2)	1 (1.2)
Other	15 (17.9)	6 (7.1)
All of the above	1 (1.2)	1 (1.2)
BH Counselor	1 (1.2)	0
BH Specialist	0	1 (1.2)
LPC & Art Therapist	1 (1.2)	0
Addiction&MH Counselor	1 (1.2)	3 (3.6)
Clinical Counselor	1 (1.2)	0
College Counselor	1 (1.2)	0
Counselor	1 (1.2)	0
Drug Court Counselor	1 (1.2)	0
LPC	2 (2.4)	1 (1.2)
Future counselor educator	1 (1.2)	0
Reg. Clinical Counselor	1 (1.2)	0
Highest Degree		
Bachelor's	5 (6.0)	2 (2.4)
Master's	45 (53.6)	20 (23.8)
Doctorate	7 (8.3)	2 (2.4)
Other	3 (3.6)	0
2 years of college	1 (1.2)	0
2nd year doctoral student	1 (1.2)	0
ABD	1 (1.2)	0
Years of experience		
1 yr or <	9 (10.7)	2 (2.4)
2-5	15 (17.9)	8 (9.5)
5-10	15 (17.9)	8 (9.5)
10-20	13 (15.5)	4 (4.8)
20-30	5 (6.0)	2 (2.4)

30-40	3 (3.6)	0
Certified or Licensed		
Yes	37 (44.0)	17 (20.2)
No	16 (19.0)	4 (4.8)
Other	7 (8.3)	3 (3.6)
BCACC&CCPA	1 (1.2)	0
CAADC	0	3 (3.6)
In the past	1 (1.2)	0
LMFT	1 (1.2)	0
LPC&LGPC	1 (1.2)	0
NCC	1 (1.2)	0
P-LMHC	1 (1.2)	0
Pending exam	1 (1.2)	0
Current setting		
Outpatient	40 (72.7)	15 (27.3)
Inpatient	3 (50.0)	3 (50.0)
Residential	9 (81.8)	2 (18.2)
Jail-based	1 (100.0)	1 (100.0)
TC	4 (66.7)	2 (33.3)
Other	13 (72.2)	5 (27.8)
College Counseling Ctr	2 (2.4)	1 (1.2)
Court	2 (2.4)	0
Doctoral Student	0	1 (1.2)
Hospital	1 (1.2)	0
Insurance company	1 (1.2)	0
Integrated care facility	0	2 (2.4)
Primary Care office	1 (1.2)	0
Prison	1 (1.2)	0
Private practice	3 (3.6)	0
Re-entry	1 (1.2)	0
Type of treatment		
Individual Therapy	53 (72.6)	20 (27.4)
Group Therapy	42 (67.7)	20 (32.3)
Psycho-education	40 (67.8)	19 (32.2)
Family Therapy	18 (69.2)	8 (30.8)
Crisis Intervention	28 (71.8)	11 (28.2
Other	8 (80.0)	2 (20.0)
Complementary therapy	1 (1.2)	0
Drop in counseling	1 (1.2)	0
Emotional support	1 (1.2)	0
Graduate Student	0	1 (1.2)
MAT	1 (1.2)	1 (1.2)
Relapse prevention group	1 (1.2)	0
Women in drug court	1 (1.2)	0
Time working in current position		

1 month-1year	16 (19.0)	7 (8.3)
1-3 years	16 (19.0)	9 (10.7)
3-6 years	11 (13.1)	2 (2.4)
6-10 years	9 (10.7)	3 (3.6)
10 years +	8 (9.5)	3 (3.6)
Supervisor gender		
Male	20 (23.8)	6 (7.1)
Female	39 (46.4)	16 (19.0)
Do not wish to disclose	1 (1.2)	2 (2.4)
Supervisor highest degree		
HS Diploma	1 (1.2)	0
Associate's	1 (1.2)	0
Bachelor's	4 (4.8)	3 (3.6)
Master's	41 (48.8)	18 (21.4)
Doctorate	11 (13.1)	3 (3.6)
Other	2 (2.4)	0
LPC	1 (1.2)	0
Unknown	1 (1.2)	0
Supervisor counselor identity		
Addiction Counselor	15 (17.9)	7 (8.3)
MH Counselor	25 (29.8)	12 (14.3)
Rehabilitation Counselor	2 (2.4)	0
Other	18 (21.4)	5 (6.0)
All of the above	0	1 (1.2)
BH Counselor	1 (1.2)	0
BH Specialist	0	1 (1.2)
Clinical Supervisor	1 (1.2)	0
Counselor educator	1 (1.2)	0
Insurance company CM	1 (1.2)	0
LCSW	2 (2.4)	1 (1.2)
Leadership	1 (1.2)	0
LPC	2 (2.4)	1 (1.2)
MFT	1 (1.2)	0
Addiction&MH Counselor	1 (1.2)	0
Psychologist	2 (2.4)	0
RN	1 (1.2)	0
Social Worker	1 (1.2)	0
Type of supervision received		
Clinical	22 (26.2)	8 (9.5)
Administrative	8 (9.5)	4 (4.8)
Clinical & Administrative	27 (32.1)	11 (13.1)
No clinical or administrative	1 (1.2)	1 (1.2)
Other	2 (2.4)	0
Consultation	1 (1.2)	0
Blank	1 (1.2)	0
Frequency of Supervision		

Weekly	32 (38.1)	10 (11.9)
Monthly	12 (14.3)	6 (7.1)
Every 2-3 months	2 (2.4)	2 (2.4)
Unscheduled	6 (7.1)	4 (4.8)
Other	8 (9.5)	2 (2.4)
2-3 times per week	1 (1.2)	0
b/t weekly&monthly	1 (1.2)	0
Bi-weekly	4 (4.8)	1 (1.2)
NA	1 (1.2)	0
No-weekly	1 (1.2)	0

Note. *N* = 84; MH=Mental Health, BH=Behavioral Health, LPC=Licensed Professional Counselor, ABD=All But Dissertation, BCACC=British Columbia Association of Clinical Counsellors, CCPA=Canadian Counselling and Psychotherapy Association, CAADC=Certified Advanced Alcohol and Drug Counselor, LMFT=Licensed Marriage & Family Therapist, Coord=Coordinator, LGPC=Licensed Graduate Professional Counselor, NCC=National Certified Counselor, P-LMHC=Pending Licensed Mental Health Counseling, MAT=Medication Assisted Treatment, CM=Case Manager, LCSW=Licensed Clinical Social Worker, MFT=Marriage & Family Therapist, RN=Registered Nurse

counselors, 21% are employed as mental counselors and 36% reported their current employment as other, which includes clients who present with substance use disorder issues. The "other" category consisted of the following occupations: both addiction and mental counselor (9), behavioral health counselor (1), behavioral health case manager (1), clinical manager (1), co-occurring substance abuse counselor (3), counselor educator (1), private practice (1), doctoral candidate/doctoral student (2), drug court coordinator(1), licensed professional counselor (LPC)/Art therapist (1), LPC (1), medical social worker(1), opiate prevention coordinator (1), registered nurse (RN) (1), and student/therapist (2). Participants' level of education consisted of 7 (8%) having a bachelor's degree, 65 (77%) have completed a master's degree, 9 (11%) have a doctorate degree, and 3 (4%) reported other which consisted of two years of college (1), second year doctoral student (1), and an "all but the dissertation" student (1) (see Table 2). The number of years of experience varied from less than one year to 40. Counselors reported 2-5 years of

experience and 5-10 years of experience each at 27.4% which were the largest groups represented. In addition to years of experience, 54 (64%) counselors reported having a substance abuse certification or license and those who did not have a substance abuse certification reported having an LPC (1), licensed marriage and family therapist (LMFT)(1), National Counselor Certification (NCC) (1), British Columbia Association of Clinical Counsellors (BCACC) and Canadian Counselling and Psychotherapy Association (CCPA) (1), LPC and LGPC (1), Pending-Licensed Mental Health Counselor (P-LMHC) (1), or pending examination (1). Moreover, the participants' amount of time working in their current position consisted of 30% who have worked in their position for the past 1-3 years closely followed by one month-one year at 27% and 10 years or more at 13%.

The characteristics of addiction supervisors as reported by the addiction counselors consist of 55 (65%) female, 26 (31%) male, and 3 (4%) did not disclose the supervisor's gender. The supervisors' level of education was reported as 70% have a master's degree, 17% have a doctoral degree, 8% have a bachelor's degree, 1% with an associate's degree, 1% with a high school diploma, 1% with an LPC, and 1% reported that the supervisor's level of education was unknown. The supervisor's counselor identity was reported as 26% addiction counselor, 44% mental health counselor, 2% rehabilitation counselor, and 27% selected other which includes "all of the above" (1), behavioral health counselor (1), behavioral health specialist (1), clinical supervisor (1), counselor educator (1), insurance company case manager (1), LCSW (3), leadership (1), LPC (3), marriage and family therapist (1), mental health and addiction counselor (1), psychologist (2), RN (1), and social worker (1).

Most of the participants, 55 (65%), reported currently employed in an outpatient treatment setting. Furthermore, 21% reported working in other settings such as college counseling center

(2), courts (2), hospital (1), insurance company (1), integrated care facility (1), primary care office (1), prison (1), private practice (4) and re-entry (1). Table 2 shows the types of treatment the addiction counselors provided. Interestingly, 87% reported providing individual therapy, 74% reported providing group therapy, 70% provide psycho-education, 31% provide family therapy, 46% provide crisis intervention, 11% provide other treatment services to include complementary therapy (1), drop-in counseling (1), emotional support (1) , medication assisted treatment (MAT) (1), and relapse prevention services (1), women in drug court (1) , and graduate student (1).

Participants reported whether they received clinical supervision in the current employment. They reported receiving clinical supervision only (36%), administrative supervision only (14%), clinical and administrative supervision (45%), no clinical or administrative supervision (2%), and other supervision (2%) which was reported as consultation.

The frequency of supervision sessions reported by participants consisted of weekly (50%), monthly (21%), every 2-3 months (5%), unscheduled (12%), and other (12%) which was described as bi-weekly (5), between weekly and monthly (1), 2-3 times per week (1), not applicable (NA) (1), and no weekly (1).

Descriptive statistics were conducted for the Supervision Satisfaction Questionnaire (SSQ) and the Counselor Evaluation of Supervisor (CES) questionnaire (see Table 3). The SSQ items

Table 3
Descriptive Statistics of Independent variables and Dependent variable

Characteristic	N	Mean	Std. Deviation	Skewness	Kurtosis
CES TOTAL SCORES	84	205.7619	7.27664	-.464	.263
SSQ TOTAL SCORES	84	23.5476	7.27664	-.464	-1.031

FREQOFCS	84	2.1429	1.44908	.962	-.588
YEARSOFEXP	84	2.9405	1.29272	.387	-.402
CREDEN1	84	4.0952	.57286	1.191	3.575
CREDEN2	84	1.4762	.70243	1.155	-.015

Note. CES=Counselor Evaluation of Supervisor; SSQ=Supervision Satisfaction Questionnaire; FREQOFCS=frequency of clinical supervision; YEARSOF EXP=years of experience; CREDEN1=highest degree completed; CREDEN2=certified or licensed as an addiction counselor.

were answered on a scale of 1 (low rating) to 4 (high rating) and the mean scores on individual items ranged from 2.83 to 3.02. The CES items were answered on a scale of 1 (extremely dissatisfied) to 7 (extremely satisfied) and the mean scores on the individual items ranged from 4.05 to 5.98. In order to effectively manage the data from both questionnaires for the analysis, the SSQ and CES ratings were recoded into total scores. The descriptive statistics for the SSQTOTAL included a minimum score of 8.00 and a maximum of 32.00, a mean of 23.55, standard deviation of 7.28, and variance of 52.95. The CESTOTAL descriptive statistics were a minimum of 69.00 and a maximum of 280.00, a mean of 205.76, standard deviation of 54.66, and variance of 2987.32.

A Pearson correlation was conducted to confirm a relationship between frequency (M = 2.14, SD = 1.45), quality (M = 2.92, SD = 1.02), and satisfaction with clinical supervision (M = 20.63, SD = 6.31). The frequency variable was not found to have a significant correlation with quality and satisfaction ratings, $r(82) = .045$, $p = .68$, *ns*. A Pearson correlation was also conducted on the relationship between quality and satisfaction with clinical supervision did reveal a significant correlation, $r(82) = .938$, $p < .001$. A hierarchical regression analysis (see Table 4) was

Table 4

Hierarchical Multiple Regression Analyses Predicting Satisfaction on SSQ (N=84)

Step and Predictor variable	R^2	ΔR^2	*B*	SE *B*	β

Step 1					
QUALITY TOTAL	.880	.880*	5.802*	.236	.938
Step 2					
QUALITY TOTAL					
FREQOFCS	.881	.001	.117	.197	.023
Total R^2	1.761				

Note. SSQ=Supervision Satisfaction Questionnaire; QUALITY TOTAL=Quality of Supervision FREQOFCS=frequency of clinical supervision

*$p < .001$

conducted on these variables resulted in ratings on the quality of clinical supervision explaining 88% of the variance in satisfaction with clinical supervision ratings. Therefore, the ANOVA results indicated quality of clinical supervision was a significant predictor of satisfaction with clinical supervision, $F(1, 82) = 602.17$, $p < .001$, $R^2 = .88$ and when frequency was added as predictor the ANOVA results were also significant, $F(2, 81) = 298.90$, $p < .001$, $R^2 = .88$. However, model 1 of the coefficients table did find that quality of supervision did contribute variance that was significant, $b = .237$, $\beta = .938$, $p < .001$, and the frequency variable did not contribute any additional variance to the level of satisfaction, $b = .117$, $\beta = .023$, $p = .553$. The frequency of clinical supervision reported by addiction counselors does not impact their level of satisfaction with clinical supervision, but addiction counselors' ratings on the quality of clinical supervision received had a direct impact on satisfaction with clinical supervision.

A regression analysis (see Table 5) revealed the average CES scores (M=205.76, SD = 54.66) and SSQ scores (M = 23.55, SD = 7.28) were moderate to high on the corresponding Likert

Table 5
Regression Analyses Predicting Satisfaction on SSQ (N=84)

Model and Predictor variable	R^2	ΔR^2	*B*	SE *B*	β
Step 1					
CES TOTAL	.835	.835*	.122*	.006	.914
Total R^2	.835				

Note. CES=Counselor Evaluation of Supervisor

*$p < .001$

scales. A Pearson correlation was conducted to confirm the relationship between the components of clinical supervision and satisfaction with clinical supervision. This did reveal a significant correlation between CES scores and SSQ scores, $r(82) = .914$, $p < .001$. The regression analysis also showed that CES scores accounted for 83.5% of the variance in SSQ scores which was statistically significant, $F(1, 82) = 415.92$, $p < .001$, $R^2 = .84$. The regression model further validated that the addiction counselor's ratings on the CES were a significant predictor of ratings on the SSQ. Addiction counselors who reported consistently receiving the components of clinical supervision on the CES also reported a higher level of satisfaction with clinical supervision.

Addiction counselors' years of experience ($M = 2.94$, $SD = 1.29$) and professional credentials, highest degree completed ($M = 4.09$, $SD = .573$), and certification or license as an addiction counselor ($M = 1.48$, $SD = .702$) were examined to determine how much they impact their SSQ scores. A Pearson correlation (see Table 6) was conducted and revealed that there was

Table 6

Correlations for research question 3 (N=84)

Variable	1	2	3	4
SSQ TOTAL	---	.107	-.102	-.059
YEARSOFEXP		---	.154**	-.260
CREDEN1			---	.185***
CREDEN2				---

Note. SSQ=Supervision Satisfaction Questionnaire; FREQOFCS=frequency of clinical supervision; YEARSOF EXP=years of experience; CREDEN1=highest degree completed; CREDEN2=certified or licensed as an addiction counselor.

**$p < .01$, ***$p < .05$

not a significant relationship between years of experience, $r(82) = .107$, $p = .166$, *ns*, professional credentials, $r(82) = -.102$, $p = .177$, *ns* (highest degree completed), , $r(82) = -.059$, $p = .298$, *ns* (certified of licensed as an addiction counselor) and SSQ scores. A significant correlation was found between years of experience and certified or licensed as an addiction counselor, $r(82) = -.260$, $p = .008$. A significant correlation was found between highest degree completed and certified or licensed as an addiction counselor, $r(82) = .185$, $p = .046$, as well. The results of the multiple regression analysis (see Table 7) showed the effect of years of

Table 7

Hierarchical Multiple Regression Analyses Predicting Satisfaction on SSQ (N=84)

Step and Predictor variable	R^2	ΔR^2	*B*	SE *B*	β
Step 1	.012	.012			
YEARSOFEXP			.604	.618	.107
Step 2	.026	.014			
YEARSOFEXP					
CREDEN1			-1.546	1.410	-.122
Step 3	.026	.000			
YEARSOFEXP					
CREDEN1					
CREDEN2			-.039	1.218	-.004
Total R^2	.064				

Note. YEARSOF EXP=years of experience; CREDEN1=highest degree completed; CREDEN2=certified or licensed as an addiction counselor.

experience and professional credentials had an effect of 2.6% and were not statistically significant among the three variables ($b = .703$, $\beta = .125$, $p = .289$ (years of experience), $b = -1.535$, $\beta = -.121$, $p = .296$ (highest degree completed), $b = -.039$, $\beta = -.004$, $p = .974$ (certified or licensed as an addiction counselor)). Overall, the participants' satisfaction ratings on the SSQ does not appear to be impacted by their credentials or years of experience working as an

addiction counselor. The predictors are correlated with one another in such a way that the credentials or years of experience variables did not offer any significant amount of unique variance in explaining the dependent variable.

Discussion

Addiction counselors' perceptions of clinical supervision practices was examined in this study using addiction counselors' responses to demographic questions, the Counselor Evaluation of Supervisor and the Supervision Satisfaction Questionnaire. The frequency and quality of clinical supervision sessions were studied with satisfaction ratings from the SSQ. This study examined addiction counselors' ratings on the CES on their perceptions of structure and support received in clinical supervision and the impact on satisfaction ratings on the SSQ as well. This study also looked at the impact of addiction counselors' years of experience and professional credentials (highest degree completed and certification or licensed as an addiction counselor) and satisfaction responses from the SSQ.

The impact of frequency and quality on level of satisfaction with clinical supervision was examined in research question one. Similar to previous findings (Best et al., 2014), the frequency of clinical supervision reported did not have a significant impact on SSQ scores. Best et al. (2014) found that the frequency variable did not show a significant contribution to the variance for job satisfaction. Although the majority of addiction counselors indicated receiving clinical supervision on a weekly basis, it appears that this level of frequency does not automatically suggest that addiction counselors have a preference for how often clinical supervision occurs. This may be due to sample size or the frequency options provided on the survey. For example, bi-weekly supervision was not a response option, but was added in the "other" category for this survey item. It is possible that counselors selected a frequency that was

closest to the clinical supervision currently received and elected only from the response choices available. Furthermore, addiction counselors did not have the option to select zero for frequency of clinical supervision, although 14% (n = 12) reported receiving administrative supervision only and 4% (n = 2) reported receiving no clinical or administrative supervision.

The perceived quality of clinical supervision was examined through the SSQ and was recoded to separate from the other SSQ scores. The quality ratings and level of satisfaction ratings were significant. This is similar to with previous research using the SSQ finding that counselor supervisees were very satisfied by the quality of the clinical supervision they received (Tromski-Klingshirn & Davis, 2007). Although the full hypothesis was not supported, it is notable that two-thirds of the addiction counselors indicating moderate to high quality ratings also selected moderate to high satisfaction ratings.

Research question two examined the impact of addiction counselors' ratings of perceived structure and support in clinical supervision from the CES on satisfaction ratings from the SSQ. There was a significant relationship between CES and SSQ responses which is similar to previous findings by Schmidt (2012) in which substance abuse counselors reported from former research more satisfaction with supervision when their supervisor incorporated building a supportive relationship and showing that they understand the substance abuse counselors' experience. The CES asked addiction counselors to provide ratings on the structure of clinical supervision received by their current supervisor (e.g. "My clinical supervisor structures supervision appropriately", "My clinical supervisor adequately emphasizes the development of my strengths and capabilities", and "My clinical supervisor deals appropriately with the content in counseling sessions"), and the support received in clinical supervision (e.g. "My clinical supervisor helps me feel at ease with the supervision process", "My clinical supervisor provides

me with specific help in areas I need to work on", and "My clinical supervisor enables me to express opinions, questions, and concerns about my counseling"). The CES is a recommended instrument for use with addiction clinical supervision (Powell & Brodskey, 2004). The significant main effect helps to demonstrate that addiction counselors who indicated higher ratings on the CES also had higher satisfaction ratings on the SSQ. Likewise, addiction counselors who indicated low ratings on the CES also had lower ratings on the SSQ. The CES was used to ensure that addiction counselors were aware of the which components of clinical supervision they were rating their clinical supervisor before they provided overall satisfaction ratings. This finding provides evidence on the specific components of clinical supervision that contribute to addiction counselors' professional development. Past research finding that counselors job performance is positively impacted by task proficiency, sponsorship, acceptance-and-confirmation, and mentoring, and have recommended more research to examine the benefits of effective clinical supervision and professional development for addiction counselors (Laschober, Eby, & Sauer, 2013).

The effect of years of experience and professional credentials on level of satisfaction with clinical supervision were examined in research question three. There was no significant effect found for years of experience as an addiction counselor and level of satisfaction with clinical supervision. The largest group of responses for this variable was one-third of the addiction counselors reporting five to ten years' experience working as an addiction counselor. There may not have been enough responses across all categories of years of experience to uniquely impact SSQ ratings. There was also no significant effect for professional credentials when grouped with years of experience to predict level of satisfaction with clinical supervision. Although there was a significant correlation found between years of experience, highest degree completed, and

certified or licensed as an addiction counselor, it was not supported in the regression analysis. Interestingly, this sample of addiction counselors did reveal a trend of more counselors in the field with reporting at least a master's degree (n = 65, 73%) and holding a certification or license as an addiction counselor (n = 54, 65%). This highlights one of the concerns from previous research which identified the lack of education and credentialing standards for substance abuse counselors as compared to mental health counseling (Kerwin et al., 2006). Laschobor, Eby, and Sauer (2013) also examined effective clinical supervision and job performance for substance abuse counselors which included 52 percent of the counselors having at least a master's degree and 55 percent being certified or licensed as a substance abuse professional. Although the credentials of addiction counselors were well represented in this study, in regard to time in their current position, the smallest group was "10 years or more" (13%) which may be representative the history of turnover in the addiction counseling field (Eby & Laschober, 2014; Schmidt, 2012).

One unexpected finding showed individual, group, and psycho-education, which have been staples of addiction counseling services, it is interesting that more, if not all, of the counselors did not indicate providing these services.

Limitations

A few limitations were identified during the course of this research. The first limitation is related to the survey instrument and self-report by participants. The full online survey consisted of 63 questions to be completed by each participant. It was discovered that there were 26 cases that were incomplete at the end of data collection. The incomplete data consisted of participants electronically signing the confidentiality consent form but did not provide responses to any of the questions. Some participants provided responses to the demographic questions but did not

complete the CES or SSQ sections of the instrument. As an online survey, it is unclear whether the incomplete data was due to the participant intending to return to the survey to complete it, whether there were questions that they did not want to complete, or whether participants discovered they were not eligible to complete the survey after beginning the instrument. To protect confidentiality, it was not possible to contact any of the participants whose survey was incomplete so those had to be discarded. Among the participants who did complete the survey, it is not possible to confirm that they are working as addiction counselors or have the credentials reported. Some responses to the survey did demonstrate the participants adding their specific education level or professional credential if it was not listed as a survey response.

A second limitation that was discovered was related to participants indicating they were not receiving any clinical supervision, but were receiving administrative supervision only (14%), no clinical or administrative supervision (4%), or something else which has also been found in previous research (Best et al., 2014; Schmidt, 2012). The CES and SSQ are designed counselors who are receiving clinical supervision specifically. It may have been more accurate to transfer the participant to the end of the survey when one of those supervision options were selected or send the participant to a section on the survey with questions related to lack of clinical supervision or job satisfaction. Since these participants did provide responses to all questions it is unknown whether responses were based on past clinical supervision, perceptions of administrative supervision currently received, or lack of understanding about the components of clinical supervision. It is also possible that participants in this category did not understand the instructions provided for the survey.

The sample size (N=84) analyzed for this study fell just below the target minimum participants of 85 in order to achieve the recommended effect size to be generalized across all

populations of addiction counseling. However, addiction counselors completing this online survey were from various regions across the US and Canada. Recruitment of addiction counselors consisted of direct emails inviting participants to complete the instrument, posting an email announcement on the counseling listserv, and emailing counseling and substance abuse professional organizations to request that the link to the survey be distributed to their members. Some professional organizations required a fee for distributing the email and survey link which limited the researcher's ability to use those resources. The researcher was able to contact addiction professionals in various regions around the US and Canada. The majority of the participants invited to participate were in the state of Virginia.

The use of the CES instrument was also a limitation of the study. Borders and Leddick (1987) initially published this instrument in the *Handbook of Counseling Supervision*. The researcher carefully reviewed each of the questions which consisted of the specific characteristics of clinical supervision practices to appropriately test the research hypothesis. However, following a search of previous studies, the past use of this instrument could only be verified in the *Clinical Supervision in Alcohol and Drug Abuse Counseling* (Powell and Brodskey, 2004) manual. This helped lend some evidence to the value of using the CES with the addiction professional population. The validity and reliability were calculated by the researcher which demonstrated a high alpha level and significant correlations between the instrument components. It was important that the research participants were able to directly reference the components of clinical supervision in order to best understand how to rate their level of satisfaction. Furthermore, other clinical supervision instruments that have been used in past research were not available to the researcher.

The last limitation that was noted was that this study did not collect data on race or ethnic groups among the participants. This was the researcher's decision and it is important to recognize that this limits the ability to measure the diversity of the participants and obtain new diversity data related to the addiction counseling field. As a result, it is unknown how much identified race or ethnic groups among the participants influenced their responses on the survey.

Implications for addiction counselors

Growing awareness of the impact clinical supervision has on addiction counselors' performance and treatment outcomes cannot be understated. This study does show that addiction counselors value clinical supervision which benefits professional development and provides an opportunity for effectively adopting evidence-based practices (Best et al., 2014). The most recent opiate epidemic has brought the devastation of addictive disorders to the forefront. Addiction counselors can use these and similar findings to advocate for themselves to continue to obtain the support needed to provide effective counseling skills for people struggling with this chronic and complex health issue. It is important for addiction counselors to remember that clinical supervision is a benefit to professional development, not something to be practiced haphazardly or only if time from a busy caseload permits. It is also important for addiction counselors to know whether their respective supervisors have been formally trained in clinical supervision.

This study provided evidence that the profession continues to be dominated by female addiction professionals with a graduate level education and certification or licensure credentials. Addiction counselors can also learn from this research that education level and professional credentials have not been significant factors in their perception of satisfaction with clinical

supervision. It is recommended that addiction counselors communicate with their supervisors to determine the most effective supervision support based on their individual professional goals.

Implications for Clinical Supervision for Addiction Counselors

Clinical supervision for addiction counselors is occurring but continues to struggle for approximately one-third of the profession. This study found that addiction counselors reported on average, moderate to high levels of satisfaction with clinical supervision, but showed that 18% (n = 16) are not receiving any clinical supervision. It is important for addiction counselors and addiction clinical supervisors to recognize the negative impact poor clinical supervision practices can have on the addiction counselor's professional development as well as treatment outcomes. The challenge of working with persons who need to make significant changes to how they live their lives, often with minimal resources, makes the addiction counselor a vital part of the individual's recovery. The level of complexity in this counseling profession also challenges addiction counselors and clinical supervisors to maintain strong counseling skills and receive support and mentoring to ensure that they are providing the most effective services for their clients (Laschober, Eby, Sauer, 2013). In order for the gap in receiving administrative supervision only or no supervision to close it may be necessary for the profession to adopt universal standards for all addiction practitioners. This could give more addiction counselors the opportunity to use their voice when they recognize the need for effective clinical supervision.

It is important for the addiction counseling profession to make an overall commitment to all addiction counselors receiving clinical supervision and training addiction clinical supervisors to understand all aspects of performing supervision skills unique to this field (SAMHSA, 2009). This study provides recent data on the smaller percentage of addiction counselors (n = 11, 13%) remaining in their current position beyond 10 years. The risk of ongoing turnover in this

workforce is an issue clinical supervisors should not ignore. It would be beneficial for addiction clinical supervisors to develop a system of receiving feedback from the addiction counselors they work with to maintain awareness of the importance of their role and to help identify training needs (Willis, 2010). Feedback for the supervisor provides an opportunity to foster accountability for professional development that can be modeled for the counselor. Ramos-Sanches et al. (2002) recommended the importance of supervisors receiving feedback to help prevent negative supervision experiences. Since addiction treatment is the only treatment service that terminates a client for lack of progress with the exact issue that brought them to treatment, it can be misleading to counselors who may not understand that they play a significant role in the success of the client's treatment experience (Najavits, Crits-Christoph, & Dierberger, 2000). Effective clinical supervision practices can help addiction counselors maintain awareness of the dynamics of the counselor's role in addiction treatment success and failures.

Previous studies (Culbreth & Cooper, 2008; Laschober, Eby, & Sauer, 2013) have examined addiction counselor and supervisor relationship and how it impacts addiction counselors' job performance. Although the research was able to use a large sample size, there is concern about whether addiction counselors are accurately reporting if their needs are being met when they are aware that they are being examined in the same study with their supervisor. It is important to continue the gather research data on addiction clinical supervision to provide clinical supervisors with the most recent knowledge about the impact of the clinical supervision they provide.

Implications for Counselor Educators

This study provides more evidence of the clinical supervision practices in the addiction counseling field as reported from the voice of addiction counselors. It important for counselor educators to be aware of the limited research in this area of counseling. Although consistent

clinical supervision known to be the appropriate practice for counselors in training and is required by CACREP (2016) standards, as gatekeepers, it is important to maintain awareness of the research focusing on supervision practices beyond the structured training level. The issue of addiction counselors not receiving clinical supervision impacts the present and the future of addiction counseling. It could also be argued that limited or lack of clinical supervision for addiction counselors impacts the entire counseling profession. Counselor educators can continue to educate future counselors about the quality of the clinical supervision they receive and model the importance of providing effective clinical supervision.

This study also shows that with the expansion of addiction counseling among other behavioral health treatment providers (n = 30, 36%), which results in differences in commitment and skillset regarding clinical supervision. Counselor educators can help future counselors understand how to advocate for effective communication and support through clinical supervision throughout their careers. Although the limitations of the study have been identified, this research provides the opportunity for counselor educators to participate in future research aimed at addressing the clinical supervision needs for addiction counselors and provide more empirical evidence on how to improve clinical supervision practices that fit the unique needs of this population.

Future Research

Research examining clinical supervision from the voice of the addiction counselor continues to be limited. It is important for them to know that clinical supervision is just as important after practicum and internship experiences as it is during, as well as the important role it has in their professional development. One recommendation is to expand the current study by increasing the sample size. Along with increasing sample size, the use of an additional quantitative instrument to examine the impact of clinical supervision across treatment settings could determine any

differences in clinical supervision practices based on the treatment setting. An increased sample could also provide the opportunity to discover relationships among the demographic data such as the unexpected impact of years of experience on professional credentials.

Another recommendation is to conduct more qualitative or mixed methods research which can help capture themes related to addiction counselors' experiences with clinical supervision. It may also be beneficial to conduct longitudinal studies to addressing gatekeeping similar to the study by Fulton et al. (2016). Although this study reported a small percentage of participants reporting no clinical supervision, it would add value to the research to collect qualitative data on addiction counselors and the treatment settings that have resulted in the lack of clinical supervision. This may also bring awareness to addiction treatment settings that do not require clinical supervision (Schmidt, 2012) which also brings into question what addiction counselors want from clinical supervision and the adoption of evidence-based practices (Best et al., 2014) when clinical supervision is not a priority.

Future research is also recommended in order to share the most recent benefits with the addiction counseling community during professional conferences and trainings. This can demonstrate to addiction counselors and supervisors the value of communication and support (Schmidt, 2012) on professional development while also treating clinical supervision as a priority. The addiction counseling field can learn more about the significance of maintaining clinical supervision and not primarily latest drug and alcohol statistics. West and Hamm (2012) recommend the establishment of minimum supervision standards. Although standards have been developed for graduate students completing practicums and internships, there is no evidence that the same standards are universally practiced post graduate school.

Conclusion

The frequency and quality of clinical supervision, the components of clinical supervision, years of experience as an addiction counselor, and professional credentials were examined to determine how they impact satisfaction with clinical supervision. The purpose of the study was to provide more evidence to the limited research on clinical supervision for addiction counselors while identifying areas that can predict satisfaction with clinical supervision. The quality and components of clinical supervision were found to be significant predictors of satisfaction with clinical supervision. The regression analysis found CES scores predicted SSQ scores. However, there is no evidence from previous research that the instruments for this study have been used together to measure clinical supervision satisfaction. This warrants further investigation to determine how these instruments help identify the components of clinical supervision that are most important to their professional development.

This study found that addiction counselors value the quality and the structure and support received in clinical supervision. Frequency of clinical supervision, years of experience, and professional credentials did not have a significant impact on level of satisfaction. This may suggest that addiction counselors value clinical supervision regardless of the frequency and their credentials. In other words, if addiction counselors are generally satisfied with clinical supervision received, they are satisfied with the frequency as well. This study also revealed that most of the participants have at least a master's degree and hold a certification or license. They reported that the majority of their supervisors have at least a master's degree and are certified or licensed as well. Additionally, there were a percentage of clinical supervisors who have a doctoral degree. This apparent trend can be beneficial to the addiction profession. Although level of educational credentials does not guarantee appropriate supervision training, addiction counselors appear to be more trusting of the clinical supervision received due to equivalent

education levels. The findings from this study do contribute to the limited research in this area and warrants future research with an increased sample size and collecting additional qualitative data.

As reported in previous research (Best et al., 2014; Culbreth, 1999; Schmidt, 2012), this study found that clinical supervision for addiction counselors is occurring. Most of the addiction counselors indicated being satisfied with the clinical supervision received. However, there continues to be a part of the addiction counseling community who are not receiving clinical supervision. There are more addiction counselors working with a minimum master's degree which confirms that clinical supervision standards were practiced when the counselors were in training. Nonetheless, in programs that do not require clinical supervision, do not have addiction professionals who are appropriately trained to provide clinical supervision, or do not make clinical supervision a priority, there should be strong concern for treatment outcomes and staff burnout. The relevance of improving professional development standards for addiction counselors and their clinical supervisors is warranted.

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APPENDICES

APPENDIX A

INFORMED CONSENT

OLD DOMINION UNIVERSITY

PROJECT TITLE: Addiction Counselors' perceptions of Clinical Supervision Practices

INTRODUCTION

The purposes of this form are to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those who say YES. This study, Addiction Counselors' perceptions of Clinical Supervision Practices, is being conducted as an online survey.

RESEARCHERS

Kaprea Johnson, PhD
Associate Professor of Counseling
Darden College of Education
Counseling & Human Services Department

Marla Newby, MS
Doctoral Student-PhD in Counseling
Darden College of Education
Counseling & Human Services Department

DESCRIPTION OF RESEARCH STUDY

Several studies have been conducted looking into the subject of exploring the perceived satisfaction with clinical supervision for addiction counselors from their supervisors. None of them have explained the potential relationship between the counselor's years of experience and professional credentials, frequency and quality of clinical supervision, and the overall components of clinical supervision. Researchers have recommended that more attention be brought to the issue. Although this issue is becoming more well known, the voice of the addiction counselor has been limited.

If you decide to participate in this research study you will join a study involving research of completing two brief online questionnaires which will include reporting your personal experiences and related issues to the research topic. You will be asked to provide demographic information, complete questionnaires about your satisfaction with clinical supervision in your employment as an addiction counselor, and your attitudes about the importance of clinical supervision in the addiction counseling profession. Your responses will be compiled with responses from other participants in order to protect your anonymity. If you say YES, then your participation will last for up to 20 minutes once you

have accessed the questionnaires online. Approximately 150 addiction counselors will be participating in this study.

EXCLUSIONARY CRITERIA

You are receiving this invitation to participate in the survey because you have worked in the field as an addiction counselor. If you have not worked as an addiction counselor, please disregard this email.

RISKS AND BENEFITS

RISKS: If you decide to participate in this study, I do not anticipate any risks to you participating in this study other than those encountered in day-to-day life.

BENEFITS: The main benefit to you for participating in this study is the opportunity for you to use your voice regarding the importance of clinical supervision for you career path. Other counselors and supervisors may benefit by learning about the impact of clinical supervision on professional development and client outcomes.

COSTS AND PAYMENTS

The researchers want your decision about participating in this study to be absolutely voluntary. Yet they recognize that your participation may take some extra time out of your already busy schedule. In order to recognize the value of your time, your email address will be entered into a drawing to win a $50 VISA gift card.

NEW INFORMATION

If the researchers find new information during this study that would reasonably change your decision about participating, then they will give it to you.

CONFIDENTIALITY

The researchers will take “reasonable” steps to keep private information provided while completing the questionnaires, confidential. The researcher will remove identifiers from the information you provide and your online responses are accessible only to the researchers listed above in user name and password protected software. The results of this study may be used in reports, presentations, and publications; but the researcher will not identify you. Of course, your records may be subpoenaed by court order or inspected by government bodies with oversight authority.

WITHDRAWAL PRIVILEGE

It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from the study -- at any time.

COMPENSATION FOR ILLNESS AND INJURY

If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of unforeseen harm arising from this study, neither Old

Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in any research project, you may contact Dr. Kaprea Johnson-757-683-3326,
Marla Newby-757-375-1745, or Dr. Jill Stefaniak, Chair of the DCOE Human Subjects Committee, at jstefani@odu.edu or 757-683-6696

VOLUNTARY CONSENT

By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them:

Dr. Kaprea Johnson-757-683-3326
Marla Newby-757-375-1745

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should call Dr. Jill Stefaniak, Chair of the DCOE Human Subjects Committee, at jstefani@odu.edu or 757-683-6696.

And importantly, by clicking YES below to proceed to the survey, you are telling the researcher YES, that you agree to participate in this study. Upon request the researcher can give you a copy of this form for your records.

INVESTIGATOR'S STATEMENT

I certify that I have explained to this subject the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the subject's questions and have encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

APPENDIX B

DEMOGRAPHIC QUESTIONS

1. Gender?

   Male Female Transgender Do not want to disclose

2. Age?

   18-25 26-35 36-45 46-55 56-65 66-80

3. Current Occupation?

   Addiction Counselor Mental Health Counselor Other

4. Your current counselor identity?

   Addiction Counselor Mental Health Counselor Rehabilitation Counselor Other

5. Highest degree completed?

   HS Diploma Associate's Degree Bachelor's Degree Master's Degree Doctorate

   Other

6. Number of years of experience as an Addiction Counselor?

   1 year or less 2-5 5-10 10-20 20-30 30-40 40-50

7. Are you certified or licensed as an Addiction Counselor?

   Yes No Other certification

8. Current setting where you are employed as an Addiction Counselor?

   Outpatient Treatment Inpatient Treatment Residential Treatment

   Jail-based Treatment Therapeutic Community Other

9. Types of treatment you provide in the setting where you are employed?

   Individual Therapy Group Therapy Psycho-education Family Therapy

   Crisis Intervention Other

10. Amount of time working in current Addiction Counselor position:

    1 month-1 year 1-3 years 3-6 years 6-10 years 10 years or more

11. Gender of you supervisor:

    Male Female Transgender Do not want to disclose

12. Supervisor's highest degree completed:

    HS Diploma Associate's Degree Bachelor's Degree Master's Degree

    Doctorate Other

13. Supervisor's counselor identity?

    Addiction Counselor Mental Health Counselor Rehabilitation Counselor Other

14. Type of supervision received:

    Clinical Supervision Administrative Supervision Clinical and Administrative

    Supervision No Clinical or Administrative Supervision Other

15. Frequency of supervision sessions:

    Weekly Monthly Every 2-3 months Unscheduled Other

APPENDIX C

Figure 7. Counselor evaluation of supervisor.

Supervisor _____ Counselor _____

	Strongly disagree			Somewhat agree			Strongly agree
1. Provides me with useful feedback regarding counseling behavior.	1	2	3	4	5	6	7
2. Helps me feel at ease with the supervision process.	1	2	3	4	5	6	7
3. Makes supervision a constructive learning process.	1	2	3	4	5	6	7
4. Provides me with specific help in areas I need to work on.	1	2	3	4	5	6	7
5. Addresses issues relevant to my current concerns as a counselor.	1	2	3	4	5	6	7
6. Helps me focus on new alternative counseling strategies that I can use with my clients.	1	2	3	4	5	6	7
7. Helps me focus on how my counseling behavior influences the client.	1	2	3	4	5	6	7
8. Encourages me to try alternative counseling skills.	1	2	3	4	5	6	7
9. Structures supervision appropriately.	1	2	3	4	5	6	7
10. Adequately emphasizes the development of my strengths and capabilities.	1	2	3	4	5	6	7
11. Enables me to brainstormsolutions, responses, and techniques that would be helpful in future counseling situations.	1	2	3	4	5	6	7
12. Enables me to become actively involved in the supervision process.	1	2	3	4	5	6	7
13. Makes me feel accepted and respected as a person.	1	2	3	4	5	6	7
14. Deals appropriately with the affect in my counseling sessions.	1	2	3	4	5	6	7
15. Deals appropriately with the content in my counseling sessions.	1	2	3	4	5	6	7
16. Motivates me to assess my own counseling behavior.	1	2	3	4	5	6	7
17. Conveys competence.	1	2	3	4	5	6	7
18. Is helpful in critiquing report writing.	1	2	3	4	5	6	7
19. Helps me use tests constructively in counseling.	1	2	3	4	5	6	7
20. Appropriately addresses interpersonal dynamics between self and counselor.	1	2	3	4	5	6	7

	Strongly disagree			Somewhat agree			Strongly agree
21. Can accept feedback from counselor.	1	2	3	4	5	6	7
22. Helps reduce defensiveness in supervision.	1	2	3	4	5	6	7
23. Enables me to express opinions, questions, and concerns about my counseling.	1	2	3	4	5	6	7
24. Prepares me adequately for my next counseling session.	1	2	3	4	5	6	7
25. Helps me clarify my counseling objectives.	1	2	3	4	5	6	7
26. Provides me with the opportunity to adequately discuss the major difficulties I am facing with my clients.	1	2	3	4	5	6	7
27. Encourages me to conceptualize in new ways regarding my clients.	1	2	3	4	5	6	7
28. Motivates me and encourages me.	1	2	3	4	5	6	7
29. Challenges me to accurately perceive the thoughts, feelings, and goals of my client and myself during counseling.	1	2	3	4	5	6	7
30. Gives me the chance to discuss personal issues related to my counseling.	1	2	3	4	5	6	7
31. Is flexible enough for me to be spontaneous and creative.	1	2	3	4	5	6	7
32. Focuses on the implications and consequences of specific behaviors in my counseling approach.	1	2	3	4	5	6	7
33. Provides suggestions for developing my counseling skills.	1	2	3	4	5	6	7
34. Encourages me to use new and different techniques when appropriate.	1	2	3	4	5	6	7
35. Helps me to define and achieve specific concrete goals for myself during the practicum experience.	1	2	3	4	5	6	7
36. Gives me useful feedback.	1	2	3	4	5	6	7
37. Helps me organize relevant case data in planning goals and strategies with my client.	1	2	3	4	5	6	7
38. Helps me develop increased skill in critiquing and gaining insight from my counseling tapes.	1	2	3	4	5	6	7
39. Allows and encourages me to evaluate myself.	1	2	3	4	5	6	7
40. Explains the criteria for evaluation clearly and in behavioral terms.	1	2	3	4	5	6	7
41 Applies criteria fairly in evaluating my counseling performance.	1	2	3	4	5	6	7

(Borders + Leddick, 1987)

APPENDIX D

SUPERVISION SATISFACTION QUESTIONNAIRE (SSQ)

1. How would you rate the quality of the supervision you received?

1	2	3	4
Excellent	Good	Fair	Poor

2. Did you get the kind of supervision that you wanted?

1	2	3	4
No, definitely not	No, not really	Yes, generally	Yes, definitely

3. To what extent has this supervision fit your needs?

1	2	3	4
None of my needs have been met	Only a few of my needs have been met	Most of my needs have been met	Almost all my needs have been met

4. If a friend were in need of supervision, would you recommend this supervisor to them?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of supervision you have received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly satisfied	Mostly satisfied	Very satisfied

6. Has the supervision you received helped you to deal more effectively in your role as an addiction counselor?

1	2	3	4
No, definitely not	No, not really	Yes, generally	Yes, definitely

7. In an overall, general sense, how satisfied are you with the supervision you have received?

1	2	3	4
Quite dissatisfied	Indifferent or mildly satisfied	Mostly satisfied	Very satisfied

8. If you were to seek supervision again, would you come back to this supervisor?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

* Ladany, Hill & Nutt, 1996

VITA

Marla Harrison Newby, MS, CSAC
Old Dominion University
Department of Counseling and Human Services
2100 New Education Building
Norfolk, VA 23529

EDUCATION

OLD DOMINION UNIVERSITY, Norfolk, VA May 2018
Doctor of Philosophy in Education with a Concentration in Counselor Education
CACREP-Accredited Program
Dissertation: Addiction Counselors' Perceptions of Clinical Supervision Practices

OLD DOMINION UNIVERSITY, Norfolk, VA August 1990
Master of Science-Psychology

NORFOLK STATE UNIVERSITY, Norfolk, VA May 1986
Bachelor of Arts-Psychology

LICENCES/CERTIFICATIONS

CERTIFIED SUBSTANCE ABUSE COUNSELOR June 2001
VIRGINIA (VIRGINIA BOARD OF COUNSELING)
Certification # 0710101635

PROFESSIONAL EXPERIENCE

NORFOLK CIRCUIT COURT JUDGES' OFFICE, Norfolk, VA 2015-present
Drug Court Coordinator, Norfolk Adult Drug Court and Veterans Track

- Coordinate and oversee the various program components and services provided by the multidisciplinary team.
- Manage the Norfolk Adult Drug Treatment Court grant
- Manage the Norfolk Adult Drug Treatment Court Vivitrol Pilot Program grant
- Plan and coordinate with the Drug Court team in developing program design, policies, procedures, and practices
- Ensure that the Drug Court program policies, procedures and practices are in compliance with the rules governing Drug Court in the Commonwealth of Virginia
- Administration of the Drug Court clinical staff as it relates to recruitment, hiring, supervision, training, continuing education and staff development
- Appointed to serve on the Norfolk Evidence Based Decision Making (EBDM) Initiative policy team

SUPREME COURT OF VIRGINIA, Norfolk, VA 2014-2015

Reentry Coordinator, Norfolk Circuit Court Reentry Docket

- Coordinated and supervised the various program components and services provided by the multidisciplinary team
- Planned and coordinated with the Reentry Docket team in developing program design, policies, procedures, and practices
- Ensured that the Reentry Docket program policies, procedures and practices are in compliance with the rules governing Reentry Court.
- Managed the administration of the Reentry Docket team as it relates to recruitment, hiring, supervision, training, continuing education and staff development.
- Appointed to serve on the Evidence Based Decision Making (EBDM) Initiative policy team

NORFOLK COMMUNITY SERVICES BOARD, Norfolk, VA 2011-2014

Forensics Program Administrator, Norfolk Adult Drug Court and Veterans Track

- Planned and managed daily operations and coordination of substance abuse criminal justice programs in accordance with departmental policies and procedures.
- Managed the Norfolk Adult Drug Treatment Court grant.
- Coordinated and provided case management services for the Norfolk Drug Court Veterans Track.
- Departmental liaison for the Norfolk Circuit Court Reentry Docket.
- Maintained consistent oversight of substance abuse forensic treatment program fiscal activities.
- Managed, analyzed, and submitted monthly and annual statistical and outcome reports for three treatment programs for the Director.
- Provided annual performance evaluations for substance abuse forensic treatment program personnel**.**

TEACHING EXPERIENCE

- Co-teaching Master's level course: Addiction Counseling (Fall 2016)
- Guest Lecturer-conducted lecture on assessment and diagnosis, treatment planning, treatment settings, and DSM 5 for a Master's level Addiction Counseling course, James Madison University (October 2016)
- Facilitated Suffolk Department of Social Services "Drugs and the Brain" workshop (October 2016)
- Co-teaching Master's level course: Introduction to Counseling Skills (Summer 2014, 2015, and 2016)

- Adjunct Faculty: Substance Abuse certification training, Old Dominion University Education Professional Development Department (2013)

PRESENTATIONS

- Justice Symposium 2017-Port of Spain, Trinidad: "Creating Positive Pro-Social Behavior through Cognitive Behavioral Interventions"-2017
- Virginia Association for Counselor Education and Supervision Conference-Poster Session: "Addition Counselors' Perceptions of Clinical Supervision Practices"-2017
- National Association of Drug Court Professionals (NADCP) Annual Conference-Presenter: "Reentry Court on Steroids"-2015
- Hampton Roads School Counseling Leadership Team Conference-Poster Presentation: "Addressing Student Substance Abuse: What all School Counselors Should Know!"-2015