AN ABSTRACT OF THE DISSERTATION OF

Lisa Langfuss Aasheim for the degree of Doctor of Philosophy in Counseling presented on March 16, 2007.

Title: A Descriptive Analysis of the Tasks & Focus of Individual Supervision in an Agency Setting.

Abstract approved:

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Individual supervision is a widely accepted practice in the counseling profession, yet the tasks and focus of individual supervision in an agency setting remain largely uninvestigated. The tasks and focus areas inherent to agency supervision are especially important to counselors, counselor educators, agency administrators, and licensing boards, all of whom are involved in shaping the practices of such supervision. The quality and focus of agency supervision may have a direct impact on counselor development, service delivery, and, most important, client care. The purpose of this quantitative descriptive analysis was to determine which tasks of clinical and administrative supervision are occurring during a typical individual supervision session and the proportion of supervision time spent on administrative versus clinical tasks. The Agency Supervision Questionnaire (ASQ), a paper-and-pencil survey designed for this study, consisted of eleven questions which gathered demographic data about the participants,

data about their individual supervision and work experience, and data about the tasks and focus of their individual supervision. The 321 respondents who provided usable data (74.5% response rate) indicated that their supervision tasks are widely varied. Clinical tasks most often included Client Treatment Planning, Clinical Problem Solving, and Therapeutic Interventions. Administrative tasks indicated most frequently included Employee Performance Evaluation, Caseload Management, and Workload. Participants also indicated a wide variance in responses about the proportion of supervision time spent focused on clinical tasks. Over 31% of respondents indicated that 90% or more of their typical supervision session focused on clinical tasks, while 26.5% indicated that 10% or less of their session was spent focused on clinical tasks. The mean response was 55%. Implications for the counseling profession and suggestions for future research are presented.

A Descriptive Analysis of the Tasks & Focus of Individual Supervision in an Agency Setting

by

Lisa Langfuss Aasheim

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I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

Lisa Langfuss Aasheim, Author

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A DESCRIPTIVE ANALYSIS OF THE TASKS & FOCUS OF INDIVIDUAL SUPERVISION IN AN AGENCY SETTING

CHAPTER ONE: INTRODUCTION

Overview

Many new counselors complete graduate school and enter the counseling field without a clear understanding of postgraduate supervision (Magnuson, Norem & Wilcoxon, 2000). Magnuson (1995) states that counselor educators repeatedly fail to link emerging professionals with mentors, ongoing professional development opportunities, and "*really* good training experiences" (Magnuson, 1995, p. 93). One participant in Magnuson's (1995) study asked "So, what is supervision supposed to be? I just haven't the foggiest idea" (Magnuson, 1995, p.92).

Supervision of counselors has been described as an essential, mutually advantageous, and impossible task (Borders & Brown, 2005; Bernard & Goodyear, 2004; Zinkin, 1989). Supervision is a key component of counselor growth and ongoing development (Feltham & Dryden, 1994; Hawkins & Shohet, 2000; Magnuson, Norem, & Wilcoxon, 2002; Campbell, 2006) and impacts counselors' attitudes, clinical style, and practice (Allen, Szollos, & Williams, 1986; Magnuson, Norem & Wilcoxon, 2002). Effective supervision has been shown to increase counselor skill levels, decrease risk to clients, and facilitate professional development and ethical functioning (Campbell, 2006; Cormier & Bernard, 1982). Ineffective supervision may result in stagnation or a decrease in counselor skill development, potential ethical and legal violations, and, ultimately, increased risk of harm to clients (Ellis, 2001; Nelson & Friedlander, 2001).

The mental health professions value supervision enough that all require emerging professionals to receive one to five years of supervised practice before receiving professional credentials (Falvey, 2001). Beginning and developing counselors in CACREP-accredited programs are required to receive supervision as they begin to work with clients during practicum and as they develop greater autonomy during internship (CACREP standards, 2001). Further, an increasing number of states require counselors to receive supervision while providing counseling services as a prerequisite to licensure (Pearson, 2000). Counselor supervision has been referred to as "our major device for co-accountability" (Proctor, 1994, p.328) and as a "distinct field of preparation and practice" (Dye & Borders, 1990, p.32).

Many mental health professionals are likely to supervise at some point during their career (Bernard & Goodyear, 1998; Campbell, 2006). However, supervisor training is often limited in availability and applicability (Borders & Bernard, 1991). Further, there is little agreement in the literature about which theory or model of supervision is most effective (Holloway, 1995). Despite the limited applicability of supervisor training and the deficiency of efficacy data, many authors, researchers and educators have called for increasingly systematic and effective training for clinical supervisors (Borders & Bernard, 1991; Campbell, 2006; Holloway, 1982; Holloway, 1995; Leddick & Stone, 1982). The Council for Accreditation of Counseling and Related Educational Programs (CACREP) requires that students in counselor education doctoral programs receive formal instruction in clinical supervision (CACREP, 2001), and supervision instruction has been recommended for master's level counselors-in-training as well (Borders & Bernard, 1991).

In response to repeated calls for systematic and thorough supervision training, the Association for Counselor Education and Supervision (ACES) formed a committee entitled the Supervision Interest Network in the 1980s. This network created and recommended the Ethical Guidelines for Counseling Supervisors (Borders & Brown, 2005). The ACES Executive Council endorsed these guidelines and formally adopted them in March, 1993, as a way to guide and inform supervisors in their practice (Borders & Brown, 2005; Hart, Borders, Nance, & Paradise, 1995).

These guidelines clarify the ethics involved in the responsible delivery of effective clinical supervision. The guidelines focus on client welfare and rights, the supervisory role, and the program administration role that is at times held by a supervisor (Supervision Interest Network/SINACES, 1993). The guidelines recommend that supervisors should utilize the following sequence when making decisions regarding supervision and supervisory tasks: relevant legal and ethical standards, client welfare, supervisee welfare, supervisor welfare, and program or agency service and administrative needs (Supervision Interest Network/SINACES, 1993).

In the preceding list, client, supervisor and supervisee welfare all take precedence above administrative and agency needs. However, the literature indicates that administrative tasks may predominate supervision sessions, potentially at the expense of supervisee development and growth (English, Oberle, & Byrne, 1979; Herbert, 1997). Administrative tasks in supervision center on meeting agency and bureaucratic needs (Haynes, Corey, & Moulton, 2003), while clinical tasks focus on counselor and client needs (Kaiser, 1997). Despite the inherent disparities, these two activities often seem to exist within the same job description (Holloway, 1995; Powell, 2004). In these cases,

agency and/or administrative needs may take precedence above clinical focus and supervisee development. Supervisees have reported dissatisfaction with such practices and indicate in several studies a preference for a clinical focus during supervision as opposed to an administrative one (Crimando, 2004; English, Oberle, & Byrne, 1979; Herbert & Trusty, 2006). One study of rehabilitation counselors found that counselors who indicated their supervisor "always" took an administrative role (engaging in administrative tasks) were most dissatisfied with their "clinical" supervision experiences. This same study indicates that counselors who were much more satisfied with supervision when their supervisors "often, rarely, or never" engaged in administration roles and focused instead on clinical tasks (Herbert & Trusty, 2006, p.74).

The Association for Marriage and Family Therapy (AAMFT) has specified in its "Responsibilities and Guidelines for AMMFT Approved Supervisors and Supervisor Candidates" that administrative supervision (in this case, supervision that does not focus on the quality of therapy being provided to the client), is not an acceptable component of clinical supervision (AAMFT, 1993). The guidelines put forth by the Supervision Interest Network (discussed earlier) do not mandate a separation of administrative and clinical roles, but instead state that:

> Supervisors who have multiple roles (e.g., teacher, clinical supervisor, administrative supervisor) with supervisees should minimize potential conflicts. When possible, roles should be divided amongst several supervisors. When this is not possible, careful explanation should be conveyed to the supervisee as to the expectations and responsibilities associated with each supervisory role. (Section 2.09)

The literature on clinical supervision reveals incongruence amongst authors regarding the tasks and functions of supervision. Clinical tasks may include case conceptualization, evaluating and enhancing core counseling qualities (e.g., warmth, immediacy, confrontation skills), developing emotional awareness, ensuring adherence to ethical standards, clarifying treatment goals and developing treatment plans and strategies to address such goals (Holloway, 1995; Campbell, 2006). Administrative tasks within a supervision session may include reviewing billing logs, reviewing client eligibility for services, monitoring case-service expenditures, ensuring adherence to agency policy and procedures, reviewing employment status, vacation time requests, and addressing case management issues (Borders & Brown, 2005; Herbert & Trusty, 2006; Yegdich, 1999).

Some models suggest that administrative tasks are inherent to the individual counseling supervision process. Proctor's (1986) three-function interactive model posits that one of the three primary functions of supervision is engagement in tasks including clinical audits and managerial functions. Kadushin (1985) introduced a model of supervision delineating the supervisor as someone who provides educational, supportive, and administrative support. The supervisor might recruit employees, delegate work, and serve as a change agent in the larger organization.

Other supervision models do not include administrative tasks. Watkins's Supervision Complexity Model (1994) address principle developmental issues in the supervisor, yet does not focus on administrative tasks as part of the supervisor's role. Similarly, Holloway's (1995) Systems Approach to Supervision does not focus on administrative tasks as inherent to supervision. Although the model allows for such tasks

to be included as needed, the author strongly urges supervisors to remain differentiated in terms of clinical versus administrative roles.

The field of counselor education and supervision lacks a clear operational definition of clinical supervision (Faugier, 1994; Holloway & Hosford, 1983; King, 1999) so the inclusion or exclusion of administrative tasks from supervision is neither "right" nor "wrong". Instead, the lack of consensus about the practices of supervision leads to confusion and debate amongst researchers in the literature (Ellis, 1991; Holloway & Hosford, 1983). This confusion is further complicated by the lack of data describing individual clinical supervision beyond it's practice in master's level, pre-service preparation. The balance of administrative tasks versus clinical tasks during supervision in a typical agency setting remains unknown. Many authors presume that various tasks occur (Campbell, 2006; Holloway, 1995; Powell, 2004), but to date there are no studies that directly address and describe the functions of counselor supervision in an agency setting.

A glance through the literature reveals many different definitions and functions of clinical supervision, many of which appear unclear or contradictory (Davy, 2002; Ellis, 1991; Holloway & Hosford, 1983; King, 1999). Individual supervision is most commonly referred to as *clinical supervision* (Campbell, 2006; Davy, 2002; Holloway, 1995), yet often involves both clinical and administrative tasks. To ensure operational clarity throughout this proposal, the following terms will be used:

Supervision: *Supervision* will refer to a meeting that takes place between two individuals, one designated as the supervisor (trainer) and the other as the supervisee or trainee

(Holloway, 1995). For the purposes of this dissertation, *supervision* will refer specifically to individual supervision only, not group supervision.

Administrative Tasks: For the purposes of this paper, *administrative supervision* and *administrative tasks* will be used synonymously to refer to supervision activities that are managerial in nature and focus on managerial tasks. These tasks include, but are not limited to, bookkeeping, employment features (e.g., hiring, reprimands, vacation requests, human resource issues, employment reviews, compensation), productivity issues, and managerial needs focusing on agency functioning (*not* client welfare or efficacy of therapeutic service) (Campbell, 2006; Falvey, 1987; Holloway, 1995; Powell, 2004). This type of supervision helps the supervisee function more effectively within the organization, with the overall intent of helping the organization run smoothly (Powell, 2004).

Clinical Tasks: *Clinical Supervision* will refer to supervision that is purely clinical in nature, focusing on the well-being and functioning of the counselor's clients, the therapeutic relationship, and therapist's needs for growth and development so as to better serve clients. This supervision focuses on therapeutic needs of the client and developmental and consultative needs of the clinician as opposed to needs of the agency, supervisor, or manager (Borders & Brown, 2005; Campbell, 2006; Holloway, 1995; Powell, 2004).

Counselor Supervision: This writer will use the term *counselor supervision* to describe the individual supervision sessions that are commonly referred to as "clinical" supervision. The use of this term acknowledges that the functions inherent in these sessions may be administrative, purely clinical, or mixed in nature. (For the purposes of

this paper, this term is synonymous with *Clinical Supervision, Supervision,* and *Individual Supervision*).

In that supervision should promote personal development, accountability, competency, and skill development in the supervisee while allowing the supervisor to maintain "accountable helping services" (Bradley & Kottler, 2001, p.7), leading researchers in the field have called for further investigation into supervisory practices and the efficacy of such practices. While supervision is typically studied in the context of pre-service counselors who are obtaining a masters degree in counseling or related professions, this dissertation study will address individual clinical supervision as it occurs in agency settings with master's level counselors and their supervisors. Once a greater understanding of the tasks of supervision in agency settings is established, researchers can begin to address the specific supervisory needs of agency counselors and supervisors alike.

Statement of the Problem

Counseling professionals maintain differing views about the function of and tasks inherent to "clinical" supervision (Bernard & Goodyear, 2004; Holloway, 1995). Counselor educators and student supervisors provide perhaps the most pure form of clinical supervision; that is, the act of supervising counselors in training as these counselors perform clinical tasks with the intent of increasing professional competency to optimally serve clients (Bernard & Goodyear, 2004; Haynes, Corey & Moulton, 2003). When counselors-in-training make entry into the world of community counseling clinics, clinical supervision may take on a vastly different meaning due to a variety of systemic features. First, the organizational demands of the agency may dictate how clinical

supervision occurs, who performs this vital function, and whether the supervisors serve multiple roles with the same supervisee. Second, the qualifications of the supervisor are of key significance. Next, the supervisor's view of the function of counselor supervision is noteworthy. If a supervisor views supervision as a prime time to accomplish administrative goals, the counselor's need for clinical guidance may not be met.

A plethora of articles and books recommend and endorse various theories and practices of counselor supervision (Bernard & Goodyear, 2004; Campbell, 2006; Hawkins & Shohet, 2003). However, many of the theories, models and techniques contained in these works specifically address the needs of counselors-in-training who are currently receiving supervision as part of an overall learning experience. The literature does not specifically address how such practices ought to be addressed to be useful and applicable in an agency setting. As the field of clinical supervision expands and the value of supervision becomes more accepted, it is imperative that models, theories, and techniques of supervision address the specific needs of supervisees and supervisors actually working in the counseling field, specifically in agency settings. Several authors prescribe methods by which counselor supervision should occur (e.g., Stoltenberg, McNeil, & Delworth, 1998; Watkins, 1997), yet there is no evidence of research describing what the tasks of individual counselor supervision in agency settings actually are. A descriptive analysis of the tasks of supervision in a typical agency setting will allow researchers to develop and adjust models, techniques, and suggest effective practices. Little research describes the practice of supervision within agency settings. Futhermore, the literature suggests clinical supervision may contain both clinical and administrative tasks, yet the typical proportions of these tasks is not known.

Rationale for the Study

A description of what is occurring in agency supervision and the proportions of administrative versus clinical tasks is important because a predominance of administrative tasks may be detrimental to both counselor and client.

A theory of supervision practice, according to Sergiovanni (1983), should be concerned with four questions:

1. What is reality in a given context?
2. What ought to be reality?
3. What do events that constitute this reality mean to individuals and groups?
4. Given these three dimensions, what should supervisors do?

(Sergiovanni, 1983, p. 177)

This study addresses the first of these four questions, as the final question (What should supervisors do?) cannot be answered without taking into account information yielded from the first three inquiries. This study describes the reality in a given context: that is, what happens during individual supervision in an agency setting.

The practice of counselor supervision beyond formalized training programs remains largely uninvestigated except through the self-report of credentialed supervisors or pre-licensed supervisees (Borders & Cashwell, 1995; Gabbay, Kiemle & Maguire, 1999; Schultz, Ososkie, Fried, Nelson & Bardos, 2002; Usher & Borders, 1993). Both represent a biased group and are not necessarily representative of the larger population practicing and receiving supervisory services. Instead, this study examines supervision by an investigation of the applied settings in which supervision occurs. That is, a descriptive examination of the components of the actual practices of supervision that occurs under

the designation "clinical supervision." This study provides a descriptive account of what tasks and functions occur during individual supervision between a supervisor and post-master's level supervisee at an agency setting. In addition, this study describes supervisees' perceptions of the proportion of time spent in supervision on administrative and clinical tasks.

Knowing what occurs during clinical supervision leads to more applicable and generalizable research about supervision and its efficacy. The literature currently provides a small array of findings about the efficacy of counselor supervision in the development of counselors (Lambert, 1980; Lambert & Arnold, 1987; Wiley & Ray, 1986). However, these findings are often based on the study of "pure" clinical supervision sessions; that is, supervision that occurs without the intrusion of administrative tasks (e.g., Stoltenberg & Delworth, 1988; Worthington, 1987). These findings can not be generalized into the greater population, however, if counselor supervision in applied settings such as agencies does not occur in the same manner as the settings in which the efficacy of supervision was originally studied. Sutton and Page (1994) remind readers that supervision "bridges the gap between the basic counseling competence developed in counselor education programs and the advanced skills necessary for complex or acute cases encountered in the reality of the work setting" (p.33). However, supervision studies are typically done with students still in those counselor education programs. Although supervision is intended to bridge the gap between school and applied work setting, the research remains largely focused on supervision in training programs.

Licensing requirements may also be affected by a better understanding of clinical supervision practices. Most states require that counselors receive between 1 and 5 years of pre-licensure clinical supervision so that clinical skills, adherence to ethical standards, and professional development can all be enhanced prior to licensure (AAMFT, 1993; Campbell, 2006). However, if supervision focuses on non-clinical tasks such as administrative and organizational needs, it may be that the requirements for "clinical" supervision are not meeting the intended purpose.

The counselor supervision literature is filled with calls for more scientific rigor and more empirical basis with regard to clinical supervision models, practices, and theories (Carifio & Hess, 1987; Ellis, 1991; Magnuson, Norem & Wilcoxon, 2000). However, it is difficult at best to study a construct that remains as ill-defined as *"clinical supervision"* does. Descriptive data that illustrates the actual practice of clinical supervision in agency settings may help move researchers toward a better understanding of the operational features of supervision practices. According to Kerlinger (1986), a theory must have interrelated constructs with operational definitions that clearly describe the function and relationship of the existent variables. Without clearer definitions and understanding of the phenomena related to *clinical supervision*, the calls for increasingly scientific study will remain unheeded (Ellis, 1991; Holloway & Hosford, 1983). Once operational definitions are solidified, it will be easier to engage in scientific exploration of the efficacy of supervision models (Ellis, 1991). Researchers may also study the fidelity of supervision practices in relationship to the available supervision models. A clearer description of what happens in agency supervision will help inform those who create models of supervision, educate supervisors, and create licensure requirements to

develop practices that take into consideration the actual conditions and tasks of agency counselor supervision.

In sum, this study benefits the field of knowledge about counselor supervision in that it provides a descriptive account of the tasks and functions of individual supervision as it occurs in an agency setting. it will be useful to know the proportion of time spent on administrative versus clinical tasks during supervision. Clinical supervision is supposed to be the vehicle by which counselor supervisee and client needs are met (Magnuson, Norem & Wilcoxon, 2000; Powell, 2004). However, individual supervision is sometimes a time in which the supervisor's, agency's and larger organizational needs are met at the expense of supervisee development and client protection. The literature contains numerous assumptions about post-masters supervision and little research to support such assumptions, so this descriptive account is both novel and useful in supporting future research and adjusting current models to better fit the actual needs and practices of agency supervisees, supervisors, and clients.

Research Question

The research questions posed in this study emerge from a careful review of the literature and a thoughtful analysis of what data would best contribute toward future progress in the field of clinical supervision. The Agency Supervision Questionnaire (ASQ) was designed to address the following research inquiries:

Research Question One:

What administrative and clinical tasks occur in an agency setting during individual supervision sessions?

Research Question Two:

What are supervisees' perceptions of the proportion of time spent on administrative tasks and clinical tasks during individual supervision in an agency setting?

Glossary of Terms

As discussed previously, the field of clinical supervision is wrought with numerous terms lacking operational clarity. For purposes of this study, a list of terms and their definitions are provided.

Administrative Supervision

Supervision that is managerial in nature and focuses on managerial tasks. These tasks include (but are not limited to) bookkeeping, employment features (e.g., hiring, reprimands, vacation requests, human resource issues, employment reviews, compensation), productivity issues, and managerial needs that focus on agency functioning (*not* client welfare or efficacy of therapeutic service) (Campbell, 2006; Falvey, 1987; Holloway, 1995; Powell, 2004). This type of supervision helps the supervisee function more effectively within the organization, with the overall intent of helping the organization run smoothly (Powell, 2004, p.5)

Agency

Agency is often considered synonymous with *Social Service Agency* or *Community Mental Health Center*. A non-school, social service counseling setting where counselors provide counseling services to clients under the umbrella of a larger organization and are *not* engaging in private nor group practice at that setting

Applied Counseling Settings

Public or Private organizations of counselors such as community mental health centers, hospitals, schools, and group or individual private practice settings (ACES Ethical Guidelines for Counseling Supervisors, 1995).

Clinical Supervision

Clinical Supervision will refer to supervision that is purely clinical in nature, focusing on the well-being and functioning of the counselor's clients, the therapeutic relationship, and therapist's needs for growth and development so as to better serve clients. This supervision focuses on therapeutic needs of the client and developmental and consultative needs of the clinician as opposed to needs of the agency, supervisor, or manager (Borders & Brown, 2005; Campbell, 2006; Holloway, 1995; Powell, 2004).

Competence

A proficiency requiring appropriate training and experience in the service delivery of supervision and clinical expertise (Haynes, Corey & Moulton, 2003)

Function

A kind of action or activity proper to a person or thing; the purpose for which something is designed or exists; to perform a specialized action or activity (Stein, 1975)

Needs

Deficiencies in something useful or necessary to satisfy certain requirements (Middleman & Rhodes, 1985)

Supervisees

Counselors-in-training in university programs at any level who are working with clients in applied settings as part of their university training program, and counselors who have completed their formal education and are employed in an applied counseling setting (ACES Ethical Guidelines for Counseling Supervisors, 1995)

Supervision

A meeting that takes place between two individuals, one of them designated as the supervisor (trainer) and the other as the supervisee or trainee (Holloway, 1995)

Supervisors

Counselors who have been designated within their university or agency to directly oversee the professional clinical work of counselors. Supervisors also may be persons who offer supervision to counselors seeking state licensure and so provide supervision outside of administrative aegis of an applied counseling setting (ACES Ethical Guidelines for Counseling Supervisors, 1995)

Task

A definite piece of work assigned or expected of a person. (Stein, 1975)

CHAPTER TWO: REVIEW OF THE LITERATURE

This chapter will examine the literature related to clinical supervision as related to the following areas: (1) the importance of clinical supervision, (2) an historical overview of counselor supervision, (3) definitions of clinical supervision, (4) the tasks and functions of administrative and clinical supervision, and (5) support for the study. This literature review will examine whether the literature provides descriptive clarity about the tasks, functions, and operation of counselor supervision in agency settings.

The Importance of Clinical Supervision

Clinical supervision is a vitally important component of counselors' professional development and ongoing functioning (Bernard, 1997; Borders & Leddick, 1988; Drapela, 1983; Gabbay, Kiemle, & Maguire, 1999; Powell, 2004). Clinical supervision is crucial in the strengthening of clinical competence (Adelson, 1995; Campbell, 2006), the development and maintenance of cultural competence (Bernard & Goodyear, 2004; Campbell, 2006), and the delivery of ethically sound services (Herlihy, 2006; Vasquez, 1992). Furthermore, counselor supervision has profoundly positive effects on the level of burnout and job satisfaction in the helping professions (Alonso, 1983; Hancox, Lynch, Happell, & Biondo, 2004).

Developing and Maintaining Clinical Competence

Counselor supervision is essential in developing and maintaining clinical competence (Borders & Leddick, 1988; Cross & Brown, 1983; Hansen, Pound & Petro, 1976; Page & Wosket, 2001). The supervisor's job is primarily to create a relationship and environment in which the supervisee can learn essential skills that then transfer into

the therapeutic exchange with clients (Holloway, 1995). Furthermore, supervisors help supervisees to connect the science and practice of counseling psychology (Holloway & Wolleat, 1994), a task that is growing increasingly important with the strengthening emphasis on the utilization of evidence-based practices in agency settings (ACA Code of Ethics, 2005; Blume, 2005).

Supervision may additionally be used with counselors who need specialized or remedial training and guidance (Cobia & Pipes, 2002). Counselors working with a specific population usually benefit from ongoing clinical supervision with a supervisor who specializes in working with that population. For example, Culbreth (1999) and Powell (2004) each indicate that addictions counselors benefit from and prefer supervisors who are skilled in working with addictions. Similarly, Coll (1995) found that community college counselors prefer supervision from individuals well-versed in the professional development needs of community college counselors.

Clinical Supervision in Agency Settings

The literature reflects an absence of knowledge about what supervision in an agency setting actually focuses on. Instead, the majority of research about supervision practices focuses on master's level training in an educational or internship setting (e.g., Daniels, D'Andrea, Kim, 1999; Freeman & McHenry, 1996). However, agency counselors are likely to have very different practical and clinical experiences than counselors in other settings. Agency counselors face a plethora of presenting problems that range from adjustment disorders to severe mental health disorders and are considered to be the most diverse of all applied counseling settings (Cormier & Hackney, 2005).

Usher and Borders (1993) note that practitioners in the counseling field are becoming increasingly aware of the importance of clinical supervision throughout a counselor's career, not just as a vital tool for counselors-in-training. This is especially relevant for agency counselors who deal with heavy caseloads, challenging working conditions, and a wide array of presenting problems (Cormier & Hackney, 2005). Although counselor supervision is often referred to as a component of master's level counseling training (e.g., Kurtz, Marshall, & Banspach, 1985), supervision also greatly helps counselors to maintain their skill level after completing their degree (Spooner & Stone, 1977). Furthermore, supervision has been found to help increase counselor self-confidence (Gray, Ladany, Walker, & Ancis, 2001), thus allowing counselors the self-efficacy to work with a wider range of individuals with increasing effectiveness (McNeill, Stoltenberg, & Pierce, 1985). This is especially beneficial considering the diversity and wide range of challenges that are present in an agency setting. Through supervision, counselors may feel increasingly empowered in their interpersonal effectiveness (Holloway, 1995) and are likely to feel more supported in their work with clients (Kennard, Steward, & Gluck, 1987).

Developing and Maintaining Multicultural Competence

Supervisors are largely responsible for a supervisee's cultural development and the delivery of culturally competent services (Campbell, 2006; Estrada, Frame & Williams, 2004). If a counselor supervisor is not culturally competent, the supervisee is likely to remain stagnant in such development (Herlihy, 2006). McNeill, Hom & Perez (1995) and Vasquez and McKinley (1982) highlight the development of cultural competence as a key function of the supervisory relationship. Specifically, a supervisor's

role is to help a supervisee develop a sense of professional identity while developing a sense of cultural identity. The supervisor facilitates the supervisee's integration of cultural awareness and knowledge with emerging clinical expertise.

Supervisors are encouraged to integrate cultural variables into the supervision process through discussion and open examination of such variables (Hays & Chang, 2003; Estrada et al., 2004). Nearly half of all supervisees reported that their clinical supervisors seemed hesitant to discuss and examine cultural variables (Constantine, 1997). According to Herlihy (2006), supervisors who remain silent about cultural variables are sending an implicit message to their supervisees that cultural variables are not acceptable topics of discussion. Hays and Chang (2003) recommend that supervisors create an open atmosphere of discussion by engaging in self-disclosure and personal reflections about how heritage and cultural practices affect practice and relationships therein. Supervisors may also engage supervisees in direct and open conversation about their cultural identity and its effect on the counseling process (Haynes et al., 2003). A supervisor's openness and competence directly impact the supervisee's level of multicultural competence (Bernard & Goodyear, 2004). Supervisors who focus on their own cultural identity development have been found to provide more effective and culturally competent supervision (Helms & Cook, 1999; Ladany, Brittan-Powell, & Pannu, 1997; Ladany, Hofheinz, Inman, & Constantine, 1997)

Supervisors who fail to address their levels of cultural competence and identity development are likely to perpetuate misdiagnosis, stereotyping, and culturally inappropriate practices by their supervisees (Hays & Chang, 2003). When a counselor is unable to appropriately and skillfully place client behaviors and words into a culturally-

appropriate context, there is an increased risk of the counselor pathologizing the client as resistant, problematic, or mentally ill. Daniels, D'Andrea, and Kyung Kim's (1999) case study about a cross-cultural supervision situation provides an analysis of potential consequences when cultural factors in the supervisory practice are minimized. The authors state that culture influences counseling goals and the counselor's way of being with a client. These important features naturally extend to the supervision process and should be recognized as central and critical components of counselor supervision.

Further, Page and Wosket (2001) recommend actively engaging in open dialogue and efforts to eliminate *culture blindness*. *Culture blindness* in counselor supervision is evident when a supervisor minimizes or ignores differences between the supervisor and supervisee and/or supervisee and clients. The supervisor simply ignores the importance and potential impact of such differences. Gonzalez (1997) encourages supervisors to take a supervisor-as-partial-learner role, thus learning about the supervisee's cultural variables and related experiences while role modeling openness to differences, cultural and otherwise. Such a stance allows for the acknowledgement of power differences in the supervisory relationship, yet also allows for an open exchange of information and expertise (Daniels, D'Andrea, & Kim, 1999; Gonazalez, 1997).

Finally, counselor supervisors have the duty to review and enforce ethical principles with their supervisees (Borders & Brown, 2005; Holloway, 1995). Several of the items in the American Counseling Association's 2005 Code of Ethics (ACA, 2005) involve cultural competence. Supervisors who are abiding by the expectation that they review the code of ethics with their supervisees will undoubtedly review the introductory

section that reads:

> Counselors actively attempt to understand the diverse cultural backgrounds of the clients they serve. Counselors also explore their own cultural identities and how these affect their values and beliefs about the counseling process. (p.3)

Supervisors who are actively encouraging supervisees to follow the aforementioned ethical guidelines are contributing both to the supervisee's development of cultural competence and ethically sound practice.

Implications for Ethical Practice

One key purpose of clinical supervision is to ensure that the supervisee is engaging in sound ethical practices (Campbell, 2006). Clinical supervision has been shown to affect the supervisee's level of ethical competence and, consequently, increases the quality of service delivery to the client (Cormier & Bernard, 1982; Herlihy, 2006). Counselor supervisors are ethically bound to ensure the well-being of the clients with whom the supervisee is working (Cormier & Bernard, 1982), while at the same time honoring the growth and continual development of the supervisee. So, supervisors take care to role model and provide ongoing evaluative feedback to supervisees with regard to optimal ethical practices (Borders & Brown, 2005; Cormier & Bernard, 1982).

Supervisees engaged in supervision will likely be encouraged to examine issues of informed consent, dual relationships, confidentiality, and ethical service provisions (Cormier & Bernard, 1983; Borders & Brown, 2005). Supervisors have the opportunity to provide training to supervisees and can engage in practice activities regarding ethical issues (Cormier & Bernard, 1982). Further, the supervisor can observe the client through

a variety of observation methods so as to provide immediate feedback and evaluation about ethical dilemmas as they arise (Remley & Herlihy, 2005). For instance, supervisors may elicit self-reports from supervisees about ethical dilemmas or the content of prior sessions. More ideally, supervisors can make use of live supervision or technology-based supervision techniques (Campbell, 2006). Some of these techniques include bug-in-the-ear, live supervision, co-counseling, the use of audio- and videotape, and observation mirrors (Borders & Brown, 2005; Milne & Oliver, 2000). Supervisors also serve as gatekeepers to the profession, meaning that they are responsible for keeping unethical practitioners away from the profession (and thus, away from clients) (Pearson & Piazza, 1997).

Implications for Career Satisfaction and Burnout Prevention

Burnout and career dissatisfaction are common occurrences in the helping professions (Altun, 2002; Powell, 2004). Burnout can result in counselors who feel cynical, hopeless, worthless and severely limited in their ability to truly help their clients (Kottler, 1993). Powell (2004) illustrates the emotional intensity encountered by a counselor who experiences their first client suicide, child sexual abuse, or bereavement event. Intense experiences of this nature as well as the organizational and systemic difficulties experienced by new counselors can be mitigated in part through the help of a supportive supervisor (Alonso, 1983). Further, counselors are likely to move through the cyclical stages of disillusionment that lead to professional burnout (Edelwich & Brodsky, 1980). These stages begin with enthusiasm, quite common amongst emerging counselors. The next stage is stagnation, followed by frustration. Clinical supervisors meeting the core standards for competence outlined by *The New Handbook of Counseling Supervision*

(Borders & Brown, 2005) should be adept at helping counselors through these stages as signs of each stage emerge. Supervisors provide support to counselors at all stages of their professional development and, at times, focus mainly on the systemic and administrative features of work and work life that the counselor may be struggling with (Holloway, 1996; Powell, 2004).

Additionally, agencies currently are better able to keep counselors from switching jobs because of recent economic recessions (local and national) and the impact of managed care (Powell, 2004). Counselors feel increasingly compelled to maintain in their current position, yet may not be satisfied or effective in their practice. According to one study done by Edelwich and Brodsky (1980), most helping professionals vehemently responded in the negative when asked if they would like to be working in their same position in the same agency in ten years. These same respondents reluctantly admit that, in ten years, they may still be in the same job at the same agency, though. Clinical supervision is considered to be one prime mechanism by which the resulting stagnation, frustration, and apathy can be overcome (Powell, 2004). Clinical supervision increases overall job satisfaction, creativity and coping skills while decreasing work-related stress and strain (Hancox, Lynch, Happell, & Biondo, 2004; Teasedale et al., 2000).

The literature regarding supervision suggests that it is important because it helps strengthen and maintain clinical competence and allows for remediation and individualized skill building. In addition, supervision specifically helps agency counselors who contend with a diverse clientele and a wide array of presenting problems. Supervision helps these counselors gain and maintain multicultural competence and

adherence to ethical and legal standards of practice. Similarly, supervision helps counselors enhance job satisfaction and decrease career burnout.

Historical Overview of Counselor Supervision

Counselor supervision has undergone a variety of transformations since its emergence. Supervisors originally took on the role of psychoanalyst and teacher and supervision closely resembled a therapy session, a practice nearly unheard of a century later. Through the decades, supervision and supervisors have continually changed focus and priorities, although the general goal remains intact: to help counselors provide better service to their clients.

The Emergence of Counselor Supervision

Counselor supervision has its roots in the psychoanalytic discussion groups of the early 1900s when supervision was considered an integral part of the psychotherapeutic process (Burley, 1998; Davy, 2002). Supervisors performed teaching and instructional duties while engaging in psychoanalysis with the supervisee (Leddick & Bernard, 1980). The focus of supervision sessions was on exploring intrapsychic and interpersonal processes as a function of the therapeutic relationship (Davy, 2002). Significant emphasis was placed on countertransference and analyst reactions to client ordeals (Stein, 1991). Supervisors paid special attention to the role of unconscious processes and relational interactions that may not have been in the counselor's awareness at the time of the client interaction (Casement, 1985). Some researchers attribute current confusion about the roles and functions of a supervisor to this early role-blending at supervision's inception (Carroll, 1996; Yegdich, 1999).

In the 1950s, the focus of supervision drastically shifted as psychoanalysis fell from favor (Davy, 2002). Instead, supervision became closely integrated with the theories and models of therapeutic practice (Freeman & McHenry, 1996). Some of these models clearly paralleled major counseling theories (Friedlander, Siegal, & Brenock, 1989). The emphasis of supervision shifted from analysis to skills training and professional development (Truax & Carkhuff, 1967; Holloway, 1995).

The 1970s brought forth another wave of supervision marked by theoretical and practice frameworks that emphasized tasks, roles, training, and counselor professional development via stages (Carroll, 1996; Hess, 1986). In the 1970s and 1980s, developmental models of supervision were introduced. One such model is the Supervisor Complexity Model (SCM) (Watkins, 1997). The Integrated Development Model (Stoltenberg, McNeil, & Delworth, 1998) also received much attention in the literature. Social Role Models also appeared in the literature (e.g., Kadushin, 1985). These role theories specifically address the role of the clinical supervisor and the relationship between the supervisory role and the functions of supervision. Bernard's Discrimination Theory (1979) synthesizes earlier research to produce three primary roles for supervisors working with counselor-trainees: the teacher-student approach (based on the findings of Walz & Roeber, 1962, who examined supervisor's reactions to a counseling interview), the counselor-client approach, and the consultant approach (based on Hackney's 1971 pre-practicum skill building model).

In the 1980s, a flurry of scholarly activity emerged regarding clinical supervision models and practices. *The Counseling Psychologist* published two special issues focused on counselor supervision. Developmental theories were of significant interest in the

1980s and at least 16 non-psychotherapeutic, developmental models were introduced to the emerging field of clinical supervision (Freeman & McHenry, 1996). Researchers reviewed and scrutinized these theories (e.g., Holloway, 1988; Worthington, 1987), and evidence of some scholarly debate about such theories can be found in publications such as *Professional Psychology: Research and Practice* (1987). In addition, ACES (Association for Counselor Educators and Supervisors) initiated projects aimed at identifying core competencies for counselor supervisors (Borders, 1989). Supervisors were being examined in terms of competence at supervision as opposed to simply being competent at therapy and hoping the implicit competence would transfer to effective counselor supervision (Dye & Borders, 1990; Holloway & Carroll, 1996).

The 1990s brought about a different scholarly viewpoint; that is, researchers shifted their focus to examining the structure of the supervisory processes, relationships therein, and efficacy of supervisory practices (Bernard & Goodyear, 1992; Holloway & Carroll, 1996; Holloway & Neufeldt, 1995). There was additional focus on the emergence and acceptance of counselor supervision as a professional specialty (Dye & Borders, 1990). Finally, counselor educators and supervisors turned their attention to the vital importance of culturally competent counseling and supervision practices (e.g., Ivey, Ivey & Simek-Morgan, 1997; Pope, 1995). Daniels, D'Andrea, and Kim (1999) provided a case study examining the perils of cross-cultural supervision with a supervisor who fails to discuss cultural differences in the supervisory dyad, and Dinsmore and England (1996) review the extent to which multicultural counselor training occurs in CACREP-accredited programs. The trend toward accepting supervision as a profession unto itself continued into the 2000s.

Magnuson, Norem, and Wilcoxon (2000) contend that supervisors in this century have a plethora of text materials to inform their supervisory practices. They cite scholarly journals such as *Counselor Education and Supervision* and *The Clinical Supervisor* as key sources of information for those doing supervision. Concerns expressed about deficiencies in information related to clinical supervision (e.g., Carifio & Hess, 1987; Goodyear & Bradley, 1983) no longer remain as counselor supervision has emerged into a field complete with informative texts and journals, national credentialing processes, a Code of Ethics, and a set of standards of practice (Magnuson, Norem, & Wilcoxon, 2000; Borders & Brown, 2005). The commitment to cultural competence continues (e.g., Myers, Sweeney & White, 2002) and attempts to professionalize and standardize counselor supervision marches on with the release of a new handbook for supervision (Borders & Brown, 2005) and continued scholarly debate about the very nature of counselor supervision (Davy, 2002; Powell, 2005).

In the last century, counselor supervision evolved and developed into a unique field of study, complete with its own code of ethics, national credential, and code of ethics (Borders & Brown, 2005). Although this field has gained increasing credibility and profession status over the last several decades, the practice still lacks a well-developed body of research and supporting literature.

Supervision Defined

Researchers in the field of counselor supervision have asked that a unified, operational definition of clinical supervision be created to replace the dozens of definitions currently present in the literature (Ellis, 2001; Lambert & Arnold, 1987). Many of these definitions are incomplete, contradictory, and difficult to operationalize for research purposes (Ellis, 1991; Holloway & Hosford, 1983; King, 1999). This section will discuss some of the more common definitions of clinical supervision as evident in the literature. This section concludes with a discussion of clinical supervision of mental health workers in related disciplines.

The Definitional Debate

There are a myriad of definitions available for the term *clinical supervision*. Authors in the counseling profession provide varied and at times conflicting definitions of supervision and its functions (Davy, 2002; Kottler, 1993). Lyth (2000) remarks that despite the many definitions and models of supervision that have been developed, the term itself remains ill-defined. However, that author proposes that, based on the literal meaning of the words *clinical* and *supervisor*, clinical supervision could be defined as "a controlling mechanism instituted to oversee directly the skills utilized in the treatment of patients" (Lyth, 2000, p.723). That same author goes on to comment that the literature about clinical supervision in practice describes a reality that is not aligned with the aforementioned definition. Similarly, MacDonald (2002) notes the incongruence between definition and practice. That is, there is no clear definition of the meaning of the term *clinical supervision*, yet the term carries strong implications for practice and tasks therein.

Often times the term *clinical supervision* is defined by the tasks and roles that the author of the definition seeks to include. Bernard and Goodyear (2004) define clinical supervision as an intervention provided by a seasoned member of the field to less experienced counselors in the course of an ongoing, evaluative relationship (Bernard & Goodyear, 2004). That relationship aims to improve professional functioning of the newer counselor, monitor professional services rendered by the newer professional, and screen those who are attempting to enter the field. This definition is widely accepted and cited by numerous authors, many of whom use this definition for research and discussion purposes (e.g., Freeman & McHenry, 1996; Getz, 1999; Pearson, 2001).

An additional definition is detailed by Remley, Benshoff and Mowbray (1987) who describe supervision as regularly held meetings where a developing professional is supervised by a more trained and experienced professional. The purpose of these meetings is to supervise the counseling processes between the less-seasoned professional and his or her clients. This definition is similar to Bernard and Goodyear's and includes the supervisor's training and experience level as important supervisor qualities.

The facilitation of therapeutic competence through a viable relationship is a common theme in many of the available definitions. Loganbill, Hardy, and Delworth (1982) define supervision as "an intensive, interpersonally focused, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in a another person" (p. 14) This definition speaks to the widely-supported idea that supervision is primarily about creating the conditions for optimum client care (Bradley & Ladany, 2001; Worthen & McNeill, 1996; Worthington & Stern, 1985). Clairborn and Etringer (1995) offer a similar view and state that supervision is a process

of social influence resulting in behavioral and attitude changes in the supervisee. The authors hope that these changes will then directly benefit clients.

Inskipp and Proctor (1994) define supervision as "a working alliance between a supervisor and a counselor…in which the counselor can offer an account or recording of her work: reflect on it: receive feedback and where appropriate guidance." The authors further state that the purpose of such an alliance is to help the counselor achieve ethical competence, confidence, and creativity so as to best provide optimal client service.

Providing optimal client service is the theme of yet another definition of "clinical" supervision. In this case, supervision is described as "a quintessential interpersonal interaction (whereby) the Supervisor meets with another, the Supervisee, in an effort to make the latter more effective in helping people" (Hess, 1980).

Supervision has additionally been defined as a "learning alliance that empowers the trainee to acquire skill and knowledge relevant to the profession and to experience interpersonal competence in the supervisory relationship" (Holloway & Acker, 1987, p.) Drapela (1983) also focused on competence when he defined clinical supervision as a process of overseeing, guiding, and evaluating professional activities for the purpose of ensuring a high quality of counseling services for the clients served. Clinical supervision has also been defined as a practice in which a supervisor assists counselor in working more effectively with clients to achieve successful outcomes (Herbert, 2004). Although readers are left to speculate about whether "successful" is defined by the supervisor, supervisee, or client, there is little doubt that the author is focusing on supervision as a tool for competence-building.

Several definitions of clinical supervision focus on the ethical obligations of practitioners to ensure that they are engaging in supervision activities. One example of this is from the British Psychological Society Division of Counselling Psychology. This definition states that supervisory support is an ethical requirement of every practitioner. Further, that same practitioner must ensure that supervision is from a well qualified professional (British Psychological Society Division of Counselling Psychology, 1998, p.6).

Cobia and Pipes introduced a general statement about clinical supervision in proposing that "supervision is sometimes used to refer to all types of practice oversight, including monitoring and consultation" (2002). In this definition, the authors are referring to providing direct service to the counselor through professional oversight. Drapela's (1983) aforementioned definition also includes a focus on direct service versus indirect service. That is, clinical supervision can be additionally defined as providing direct benefit to the counselor/supervisee, and indirect benefit to the client served by such counselor.

Lambert and Arnold acknowledged the difficulty in creating an operational definition of "clinical" supervision for the purpose of research, so created an operational definition for use in their 1987 review of research and the supervisory process. The authors state that supervision is a facet of "the overall training of mental health professionals that deals with modifying their actual in-therapy behaviors" (p. 217). That attempt at an operational definition did not halt commentary about supervision remaining a poorly defined construct (Faugier, 1994).

The definitions available to describe supervision address the tasks and functions of supervision, the supervisory relationship, the implications of supervision on ethical and clinical functioning, the focus of supervision, and the duties of the supervisor. Supervision researchers have yet to agree upon a unified definition, although there have been repeated calls to do so (Davy, 2002, Holloway, 1995). This concern appears global in nature and affects related helping professions around the world.

Clinical supervision is defined slightly differently at times across disciplines, although the practices therein remain largely the same. Severinsson and Hallberg (1996) examined clinical supervision in psychiatric nursing. The authors state that clinical supervision is "a pedagogical process, where the participants…are raising questions, exploring, explaining and systematizing experiences from clinical care in a professional context" (p.151). This definition is similar to the definition provided by Rolfe (1990) who states that clinical supervision is a formal process in which one nurse works with a more experienced nurse to reflect about practice and refine therapeutic skills. The UKCC (United Kingdom Central Council for Nursing, Midwifery and Health Visiting) highlights clinical supervision not as an exercise of managerial control or supervision, but instead as a supportive tool for psychiatric nurses to develop skills and knowledge throughout their careers (1994). In addition, this council did not endorse a specific model of supervision but instead supported specific functions of supervision such as reflective practice, increasing understanding of professional issues, and improve standards of care (Lister & Crisp, 2005). Further, the NHSME (National Health Service Management Executive) in the United Kingdom defines clinical supervision as the "developmental

opportunity for the individual practitioner to develop and sustain effective practice (while also focusing) to ensure their practice is safe (1993, p.3).

Clinical supervision is not only an ill-defined term but is clearly an ill-defined practice (Lyth, 2000). In that there are a myriad of definitions to describe the practice, functions, and tasks of clinical supervision, there remains no field-wide consensus as to what tasks and functions are inherent to the actual practice of clinical supervision (Holloway, 1996). Instead, *clinical supervision* is a term that varies in operational definition depending on the individual using or interpreting the term: to some it may include purely clinical foci, and to others, clinical foci may be intermingled with administrative tasks.

The research regarding clinical supervision fails to provide a unified operational definition of clinical supervision as it occurs in practice, agency or otherwise (Faugier,1994). The literature that defines and examines supervision is confusing, unclear and, at times, contradictory (Bernard, 1979; Faugier, 1994; Lyth, 2000). There have been multiple calls for better research on the efficacy of clinical supervision (Ellis, 1991; Wampold & Holloway, 1997), yet without clear operational definitions of the construct the research is likely to be inherently flawed (Holloway, 1995; Milne & Westerman, 2001; Yegdich, 1999). Researchers, supervisors, and supervisees are left to wonder whether supervision truly is clinical in nature or if clinical supervision is a misnomer.

Supervision: Administrative, Clinical, or Both?

The literature has only recently begun to reflect an acknowledgment of the differences in administrative and clinical tasks of supervision (Campbell, 2006; Falvey, 1987; Holloway, 1996; Powell, 2004). However, social workers have been practicing and

reporting on clinical and administrative supervision practices for several decades (e.g., Kadushin, 1974; Cherniss & Egnatios, 1978). Social workers readily acknowledge the dual roles that clinical supervisors play: that is, clinical supervisors typically have *administrative* and *clinical* tasks which all fall under the heading *clinical supervision.* In the counseling field, some authors consider clinical supervision to be an activity devoid of administrative tasks. Bond and Holland (1998) consider supervision to be a process of emotional support "which is divorced from management" (Lister & Crisp, 2005, p. 59), while Browne and Bourne (1996) insist that clinical supervision must include managerial functions. Many models of clinical supervision do not acknowledge the potential administrative tasks that may affect the supervisory process (e.g., Bernard's Discrimination Model, 1979). However, some researchers (Borders & Brown, 2005; Herbert & Trusty, 2006; Page, Pietrzak, & Sutton, 2001) have explicitly delineated between the tasks inherent in each form of supervision: that is, clinical supervision involves clinically-oriented tasks and administrative supervision involves administrative tasks as discussed in the following section.

Tasks & Functions of Supervision

The various functions and tasks of counselor supervision may include teaching, training, clinical functions, evaluation, and administrative tasks, although there is not one unified operational definition of "clinical" supervision. In this section, operational variables of clinical and administrative supervision are explored in terms of tasks and functions.

Task + Functions = The Process of Supervision

In the Systems Approach to Supervision (SAS) Model, the process of supervision as a combination of *what* to do and *how* to do it (Holloway, 1995). More specifically, the tasks are the "what to do" components and the functions are the "how to do it" components. Supervision *tasks* are the relevant pieces of work expected in the process (Holloway, 1995) and are the *goals* of supervision, while supervision *functions* are the actions or activities inherent to the process (Stein, 1975).

Tasks

The SAS model provides five categories of supervisory tasks. Concurrently, *The New Handbook of Counseling Supervision* (Borders & Brown, 2005), offers a list of supervisory tasks that may occur during the supervision process. The following list utilizes the categories provided by the SAS Model. Included in each category are the tasks proposed by the SAS model, the tasks described in *The New Handbook of Counseling Supervision,* and relevant tasks extracted from the literature regarding the purpose and goals of clinical supervision. The tasks will be grouped into five categories as suggested by the SAS Model. The categories are: Counseling Skill Development, Case Conceptualization, Professional Role Development, Self-Evaluation, and Emotional Awareness.

1. Counseling Skill Development: Borders and Brown (2005) place significant emphasis on the development of counseling skills as an integral part of the supervision process. These counseling skills may include identifying and working with communication patterns, personalization, and the ability to have appropriate empathy (Holloway, 1995).

Counselor supervision also focuses on developing skills through engaging the counselor in self-reflection and self-awareness and increasing therapeutic empathy and empathic responses (Payne, Winter, & Bell, 1972). Counselors must also learn skills such as pacing, dealing with resistance, responding to a wide range of client emotions, challenging, facilitating change, and implementing appropriate therapeutic approaches (Borders & Brown, 2005; Meier & Davis, 2005). It is also necessary that counselors solidify an *analytic attitude*; that is, the attitude of warmth, empathic, respectful, and interested helping professional (Adelson, 1995).

Supervision sometimes appears to parallel the counseling process as supervisors facilitate attitude and behavior changes in their supervisees. Morrisey and Tribe (2001) explored this phenomenon and found that supervision and the counseling process often mimic each other. That is, the same processes that occur in the supervision sessions also occur in the supervisee's counseling sessions. This parallel process lends support to the supervisory practice by which supervisors facilitate the development and enhancement of a therapeutic climate between counselor and client through the use of foundational counseling skills during supervisory sessions (Lambert, 1974).

2. Case Conceptualization: Case conceptualization is a necessary ability of counselors and is especially useful in understanding the complexity of the therapeutic relationship (Borders & Brown, 2005; Meier, 2003). This is when the supervisor and supervisee engage in a process of attempting to understand and make meaning of the client's psychosocial history, background, and presenting problems (Holloway, 1995). It is necessary that a supervisee both learn how to conceptualize his or her own cases as

well as those of other counselors, as case conceptualization is often the starting point of an effective treatment plan (Borders & Leddick, 1987; Meier & Davis, 2005; Paul, 1986).

3. Professional Role: This is how the supervisee uses appropriate external resources, applies relevant ethical and practice principles, and engages in professional tasks (such as recordkeeping and procedural knowledge). Additionally, the supervisee's interprofessional relationships are considered paramount in the supervision and developmental process (Holloway, 1995).

4. Self-Evaluation: This is how a counselor engages in an ongoing process of evaluating and recognizing his competence, efficacy, and abilities (and the limitations therein) (Holloway, 1995). The supervisee recognizes client progress and lack thereof and maintains a willingness to develop and adjust to increase effectiveness of service delivery.

5. Emotional Awareness: This task involves the supervisee's level of self-awareness of thoughts, feelings, and behaviors resulting from working with the client and supervisor. Emphasis is placed on both Intra- and Interpersonal awareness (Holloway, 1995).

Functions

The SAS Model of Supervision delineates five primary categories of the functions (activities) of supervision. The following categories include information from the SAS model, *The New Handbook of Counseling Supervision* (Borders & Brown, 2005), and from the literature regarding supervisor functions and roles. The categories are: Monitoring and Evaluating, Instructing and Advising, Consulting, Modeling, Supporting and Sharing.

1. Monitoring and Evaluating: The supervisor maintains the responsibility of formative and summative evaluation of the supervisee's work (Holloway, 1995). Some methods by which supervisors evaluate and monitor a counselor's work include: live supervision, the use of audio- and videotape, and cotherapy (Borders & Cashwell, 1992). Self-report is a somewhat unreliable yet frequently used method wherein counselors describe the session and related internal and external processes (Bernard & Goodyear, 1992; Borders & Cashwell, 1992; Borders & Leddick, 1987).

2. Instructing and Advising: The instructing and advising function occurs when the supervisor is providing opinions, information, and professional suggestions based on expertise. Holloway and Poulin (1995) refer to this as the "student-teacher" function and highlight the power differential that exists when this function is active. Training is often highlighted as a key function of clinical supervision. Maddison (1972) describes the trainee-supervisor relationship as the primary key to a successful supervision experience. Lambert and Ogles (1997) describe training and supervision as a unified, combined construct of the counseling supervision process. In fact, many articles and publications about clinical supervision use the words *supervisee* and *trainee* interchangeably, thus implying that the terms *supervisor* and *trainer* are also synonymous (e.g., Clarke, 1999; Holloway & Neufeldt, 1995; Yourman, 2003). This indicates a widespread acceptance of clinical supervision as an operation that includes training and teaching as core functions. Training and teaching are central tasks in several models of supervision. The Integrated Developmental Model (IDM) of supervision (Stoltenberg, McNeill, & Delworth, 1998) involves the supervisor maintaining a teaching role until mastering the basic tasks of supervision. Milne and Westerman (2001) conclude that supervisors need to make use of

a wide range of instructional techniques to be most effective, and the Association for Counselor Education and Supervision's Handbook of Counseling Supervision (1987) details the utilization of a microtraining approach to enhance trainee skill development.

3. Consulting: This function is active when a supervisor and supervisee are interacting in a collaborative, bi-directional communication pattern that elicits problem solving and clinical support skills (Holloway, 1995). The difference between consultation and supervision is that the evaluative component is absent during purely consultative interactions (Campbell, 2005), although this component cannot entirely be removed during consultation with a counselor supervisor who ultimately has the responsibility to evaluate the supervisee.

4. Modeling: The supervisor models optimal clinical behavior both overtly and covertly during the course of supervisory interactions and throughout the supervisory relationship. Again, power differentials are highlighted and minimized so as to best enhance mutual collaboration and sharing (Holloway, 1995).

5. Supporting and Sharing: The supervisor supports the supervisee's personal and professional development through empathic attention, encouragement, and confrontation that is skillfully and appropriately applied (Holloway, 1995). Hart and Nance (2003) state that *support* and *direction* are key functions of supervision that underlie all supervision styles. In this case, *supportive behaviors* are supervisory behaviors that build rapport and show empathy with the supervisee. *Direction behaviors* are when the supervisor challenges, instructs, or questions the supervisee (Hart & Nance, 2003; Steward, Breland, & Neil, 2001).

Administrative Tasks and Functions

In addition to the clinical responsibilities outlined in the literature, the literature indicates that counselor supervision often involves various administrative responsibilities (Campbell, 2005; Holloway, 1996; Powell, 2004). These functions could be enveloped into the "Professional Role" category outlined above, yet the activities inherent to administrative supervision have less to do with professional development and more to do with administrative upkeep. These administrative responsibilities do not seem directly related to supervision, such as filing billing claims or dealing with employment issues (like granting sick leave or disciplinary action) but may be inherent to the clinical supervisor's role, especially if that supervisor employed both as a clinical supervisor and an employment manager (Falvey, 1987).

Clinical Supervisors as Administrators

Holloway (1995) discusses the complications of supervisors acting as administrators. That is, a supervisor employed as both an employment manager and a clinical supervisor is in a dual relationship that may be difficult to navigate (Holloway, 1995; Rinas & Clyne-Jackson, 1988). When the *clinical supervisor* and *manager* roles are interchangeable, supervisors risk violating Holloway's encouragement to keep the supervisory role primary above all others.

Administrative Tasks

Two widely accepted administrative tasks include evaluative components (also known as *performance monitoring*) and managerial duties such as paperwork monitoring and caseload management (Hawkins & Shohet, 2000; Page & Wosket, 2001). Many supervisors serve as quality assurance monitors not just for the supervisee but for the

companies or agencies they work for (Davy, 2002). Emener (1978) expressed concern that supervisors are often preoccupied with administrative duties to the detriment of the supervision relationship.

Holloway & Wolleat (1994) define administrative supervision tasks as including the following: "overseeing, directing, and evaluating the work of clinicians, students, and staff in a bureaucratic organization. Their first objective is to assist the organization in running smoothly (p. 24). Specifically, administrative functions are staff recruitment and selection, work assignment and delegation, monitoring and evaluation (Kadushin, 1985). Hart (1982) indicates that administrative tasks include managerial requirements wherein the clinical supervisors function as administrators. These tasks, along with others found in the literature, include the following:

1. Accountability: The issue of accountability has dramatically changed the practice of clinical supervision in that supervisors now often have to ensure that the needs of the agency, Health Maintenance Organizations (HMOs), other third party payers, and treatment evaluators are all being met (Falvey, 1987; Powell, 2004).

2. Employee Issues: Often times, clinical supervisors may be the employment administrator (or direct employer) of the supervisee (Holloway, 1996). In these cases, the clinical supervisor may be in charge of hiring and firing, employment appraisals and evaluations, caseload management, and vacation/time-off approvals (Campbell, 2005; Kadushin, 1985; Holloway, 1996).

3. Financial Issues: Counselor supervisors may be charged with administrative tasks including financial issues (Campbell, 2005). In these cases, the supervisor may be

somewhat torn between making decisions that are fiscally sound versus clinically appropriate (Campbell, 2005; Holloway, 1996).

In the 1987 *Handbook of Administrative Supervision*, endorsed and published by the Association for Counselor Education and Supervision, Falvey notes that supervisors often engage in a "myriad of tasks for which they have no formal supervision or training" (p.2). Further, these supervisors are often caught in a conundrum between the administrative needs that sustain an organization and the clinical needs of the line staff and counselors who they supervise.

Finally, it must be noted that administrators who also provide clinical supervision are caught in an ethical dilemma that may affect the quality of their performance as administrators, supervisors, and agents of client welfare (Falvey, 1987). Specifically, issues of trust, dependency, and authority become increasingly prevalent when the clinical supervisor is serving in an administrative capacity, resulting in a "middle management muddle" (Feldman, 1980).

Research on Current Practices in Agency Supervision

There are few studies that detail the logistics or activities of counselor supervision in an agency setting (Borders & Usher, 1992). Recall that this study defines an "agency" as a non-school, social service counseling setting where counselors provide clinical services to clients under the umbrella of a larger organization (excluding private and group practice). Most studies focus on clinical supervision of master's level counselors-in-training (e.g., Freeman & McHenry, 1996) rather the experiences of master's-level agency counselors.

One study examined post-degree supervision in terms of existing and preferred practices (Borders & Usher, 1992). The researchers surveyed nationally certified counselors (NCCs) to determine how often they receive supervision, in what setting, and from whom. In addition, researchers examined the qualifications of the supervisors and the supervisees' motivation for supervision. The study did not address the specific practice of agency counselors as those respondents comprised 9% of the respondents. The study also did not address what specific activities occurred during those supervision sessions. However, the authors did find that 32% of all respondents were receiving no supervision at their work site, while an additional 34.8% were receiving supervision at least once a month. It is notable that the authors state that this study "represents the first national study of post-degree supervision of counselors" (p. 597), and that to date the literature still does not provide a detailed glimpse into what the actual supervisory practices are in community counseling agencies.

An examination of substance abuse counselors (Culbreth, 1999) reveals that supervisees in an addictions treatment setting receive supervision typically in an individual format, weekly, mainly because it was required by their work setting. Supervisees were reported to prefer supervision that is proactive and intentional rather than reactive, and may have a higher satisfaction level with supervision if the supervisors spent more time on the goals, topics, and interventions preferred by the supervisees.

Cross-Profession Supervision

Supervisees in agency settings may be supervised by a variety of professionals. There is little research that illustrates and describes whether supervision as it occurs in agency settings is typically cross-professional. Bernard and Goodyear (1992) state that

the supervisory dyad ought to be members of the same profession so that the supervisee is best able to absorb the necessary socialization into the profession. If the supervisee and supervisor are not of the same profession, there is a negative impact on the supervisee's professional identity development.

A study by Borders and Usher (1992) reveals that the majority of respondents (out of 357 Nationally Certified Counselors) state that they are supervised by non-counselors. Some of these supervisors were in related professions (such as psychologist and psychiatrists) and some were fairly unrelated (e.g., administrators, social workers).

The literature illustrates the importance of clinical supervision throughout a community counselor's career. Clinical supervision may help a counselor improve and maintain clinical competence, cultural competence, and serves as an ethical and legal safeguard. Clinical supervision may also help prevent burnout, reduce stress, and increase job and career satisfaction. Although there is little consensus on the definition of clinical supervision, most researchers tend to define supervision by describing the tasks and functions of supervision. These tasks may include administrative or clinical purposes.

CHAPTER THREE: METHODOLOGY

Research Questions

The purpose of this non-experimental, descriptive study was to describe the administrative and clinical tasks that occur during individual supervision sessions in agency settings. This study addresses the following research inquiry:

- Research Question #1: What administrative and clinical tasks occur in an agency setting during individual supervision sessions?
- Research Question #2: What are supervisees' perceptions of the proportion of time spent on administrative tasks and clinical tasks during individual supervision in an agency setting?

The primary goal of this researcher was to provide descriptive data that describes the tasks of supervision that occur in typical agency supervision sessions. This researcher also intended to describe the supervisees' perceptions of the proportion of time spent on administrative versus clinical tasks during individual supervision in an agency setting. Quantitative methods were the most appropriate in fulfilling the purposes of this study.

Research Design

The Agency Supervision Questionnaire (ASQ) was designed specifically by this researcher for the purposes of addressing the research questions in this study. The ASQ is a self-administered, paper-and-pencil survey that was mailed to master's-level and above clinicians who may have been currently working in agency/community mental health settings and may have been receiving individual "clinical" supervision.

The survey was designed to elicit descriptive data about the administrative and clinical tasks that occur during individual supervision sessions in an agency setting. Further, this survey also was designed to reveal descriptive data about the supervisees' perception of how much time is devoted to clinical tasks during individual supervision.

Population & Sample

Participants in this study were AMHCA (American Mental Health Association) members who may work in an agency /community mental health setting. AMHCA members hold a masters degree with a major study in counseling from a regionally accredited college or university (AMHCA, 2006). At the time of this study, AMHCA reported having 5,680 active members (Infocus Marketing, 2006). The marketing group designated to maintain AMHCA's membership mailing list, InFocus Marketing, indicated that this researcher was unable to get a list of counselors who work specifically in an agency setting (InFocus, 2006), so oversampling would be needed to ensure an adequate response from the target population (counselors who work in agency settings). This was additionally monitored by the item on the ASQ that asks respondents to indicate whether they are employed at an agency setting.

InFocus Marketing provided this researcher with a mailing list of randomly assorted names generated via their computerized random sorting method. This writer was required to buy mailing addresses in groups of 1000, yet the marketing firm agreed to send 600 randomly assorted names in one envelope, then the remainder of the names in a separate envelope which this writer did not use. This ensured a randomized selection technique which facilitates greater generalizability of study results (Dillman, 2000).

Sample Size

The sample size was determined based on Dillman's (2000) sample size recommendation table. According to the table, the recommended number of completed and useable surveys when the population being sampled from is 6,000 (rounded up from 5860 active AMHCA members) is 361 when there is a 50/50 split in variation with respect to the characteristic of interest and 236 when there is an 80/20 split. The 50/50 split is recommended to increase generalizability in a potentially less homogeneous responding population (Dillman, 1994). The sample size N=361 is with a +/- 5% rate of sampling error and is derived from the total population of AMHCA members (n=6000).

This recommended sample size number (N=361) is similar to the sample size recommended by Krejcie & Morgan (1970) who recommend a sample size of 360 for a population of 6,000. This researcher sought statistical consultaton at the Portland State University Statistical Consulting Laboratory and worked with Professor Douglas Neeley who also recommended a minimum of 360 respondents (personal communication, Sept 19, 2006).

This researcher mailed surveys to a sample of 600 potential respondents. Counselor Educator and Committee Member Cass Dykeman (Oregon State University) recommended oversampling as a means of getting an adequate response rate for generalizability purposes (C. Dykeman, personal communication, February 21, 2006). Professor Douglas Neeley (Portland State University) recommended sampling 600 potential respondents to yield an adequate return size (D. Neeley, personal communication, May 8, 2006).

In the initial batch of mailings, 3 pieces of mail were returned as undeliverable. One additional piece was returned in the second round of mailings, for a total of 4

undeliverable addresses. 504 surveys were returned; 321 were usable as the respondents were agency counselors, 18 potential respondents opted out by sending the survey back (14 indicated that they were retired and no longer practicing; 3 gave no reason for the opt-out, and 1 indicated she had switched careers), and 160 responses were unusable since the respondents indicated they were either in private practice, school counselors, or worked in other non-agency settings. 5 surveys were deemed unusable because the survey responses were unclear or too confounded (such as in the case of the respondent who checked off three work settings). The total number of usable responses was 321.

Instrument: Agency Supervision Questionnaire (ASQ)

This study was conducted through the use of the Agency Supervision Questionnaire (ASQ) (Appendix 1), a paper-and-pencil self-administered survey designed by this researcher specifically to address the research questions posed in this study. The survey is composed of eleven questions beginning with questions designed to elicit respondent interest (per Dillman, 2000) then is followed by additional questions designed to elicit descriptive data about what functions and tasks occur during a typical agency supervision session. These tasks and functions are extracted from the Systems Approach to Supervision (SAS) (Holloway, 1992) and from the *New Handbook of Counseling Supervision* (Borders & Brown, 2005), as well as from the literature on clinical supervision.

The first two questions gathered data that indicate whether the respondent is a member of the target population. The next two questions gathered information about the frequency and duration of supervision. The next four questions were demographic and gathered information about ethnicity, gender, and state of employment, as well as number

of years of post-master's counseling experience. The second page contained two sections, Section A which listed 24 clinical tasks, and Section B which listed 24 Administrative tasks of supervision. These lists were created based on the literature about clinical supervision, recommendations from the doctoral committee, and feedback from the pilot study. Respondents checked off which tasks occur in a typical supervision session. Respondents were given an opportunity to list any additional tasks that may not have been included. Finally, respondents were asked to assign a percentage value to the amount of time spent on clinical tasks (those listed in Section A); the remaining percentage points are automatically assigned to Section B (administrative tasks)

Limitations of the survey

This survey method was limited in that this researcher was unable to pre-sort the mailing list to exclude non-members of the target population. This resulted in a need to oversample so as to draw enough respondents from the target population. A mailing technique such as the one used in this research is costly, so this writer was unable to oversample beyond the recommend sample size of 600 to attempt to ensure a greater number of responses from the target population. The survey method is also limited in that it is descriptive research, so causal attributions can not be drawn from the results (Gall, Gall, & Borg, 2005).

Research Procedures

Pretesting Methods

Pretesting methods were employed to ensure valid survey construction (Dillman, 2000). The pretest included the following stages as suggested by Dillman (2000): review by knowledgeable colleagues, administration of a small pilot study, then a final check of

the survey design followed by final approval from the doctoral committee. Three people unrelated to the study were asked to take the survey as respondents so that any errors or wording anomalies may be caught and corrected. The three people, agency counselors who were actively receiving clinical supervision, provided this researcher with feedback that was used to adjust the survey instrument. The doctoral committee and other experts in the field of clinical supervision also provided this researcher with feedback about the construction and content of the survey, then the doctoral committee approved the final version prior to administration.

Data Collection.

Once approval from the Institutional Review Board (IRB) at Oregon State University was granted, this researcher followed procedures recommended by Dillman's (2000) Tailored Design Method.

First, the sample population was sent a brief pre-notice letter to respondents four days before mailing the questionnaire (Appendix 2). Next, the questionnaire, version one (Appendix 1) was mailed along with a detailed cover letter (Appendix 3) and a self-addressed, stamped return envelope. One week later, a thank you postcard (Appendix 4) was sent to respondents thanking them for returning the questionnaire. Three weeks after the thank you postcard was sent, a replacement questionnaire was mailed to encourage non-respondents to respond.

In an effort to increase response rates, this writer used personalization methods including handwriting all addresses for the first two rounds of mailing and using first class stamps rather than bulk mail (Dillman, 2000). All letters included a real signature of the researcher rather than an electronic or pre-printed signature.

Data Analysis

This researcher consulted with Doug Neeley, a professor of Statistics at Portland State University who specializes in Statistical Consulting, for assistance preparing for and completing the data analysis components of this study. The data were entered by this researcher into SPSS for Windows Version 12.0, into a database created by this researcher for the purposes of providing descriptive data for this study. Data was entered weekly, then double checked directly after data entry for accuracy. Finally, at the conclusion of the study, data was triple checked for accuracy by a graduate student hired by this writer to do this task.

First, descriptive data from questions one and two were examined to determine whether the survey was usable. If the respondent was deemed to not be part of the target population, the survey was placed in an "unusable" box for safekeeping and the respondent's data was not entered into the database. If the respondent was deemed to be part of the target population, all data was entered.

Descriptive data was gathered from all question items on the survey and was analyzed using SPSS 12.0. The results were double checked by the statistical consultant and a graduate assistant in the statistical consultation office. Each question was analyzed separately and neither comparisons nor inferences can be drawn between items due to the nature of this study.

Limitations of the Study

This study contained several limitations, some inherent to survey research and some unique to this study. Survey research maintains an inherent risk of self-report bias, minimization and embellishment (Gall, Gall, & Borg, 2005). There is also a risk of

respondent error. Specifically, if respondents indicated accidentally that they are agency counselors when they may have intended to check another response. There may also be some selection bias if students who are not yet practicing in the field responded. This poses a threat to external validity (generalizability) in that those students may receive a very different quality of supervision than actual post-Master's employees receive, yet the results are lumped in with other descriptive data that represents the tasks occurring in clinical supervision in an agency setting. An additional threat to validity exists in the nature of the survey construction. Specifically, the tasks listed in Sections A and B may be interpreted differently than this researcher intended.

Reliability may also be compromised depending on when the respondent completes the survey. If a respondent has just engaged in an atypical supervision session, he or she may be primed to answer the tasks questions or final percentage question differently than if he/she just engaged in a typical supervision session. Although respondents are prompted to consider their *typical* supervision session, a priming or recency effect may interfere with the accuracy of their report. This threat to reliability may have been decreased through the use of a test-retest method, but that was impractical given the nature of this survey design and data collection process.

CHAPTER FOUR: RESULTS

This study aimed to provide descriptive data, so the results of this study are presented in a descriptive, non-evaluative format. The descriptive results address the two research questions: (a) What administrative and clinical tasks occur in an agency setting during individual supervision sessions, and (b) What are supervisees' perceptions of the proportion of time spent on administrative tasks and clinical tasks during individual supervision in an agency setting?.

Characteristics of the Sample

Return Rate

The data presented in these results was gathered from the 321 usable surveys mailed back to this researcher by members of the target population. The initial sample size was 600. There were 4 letters returned as "undeliverable." There were 504 total respondents resulting in an initial return rate of 85%. However, 321 of those 504 returned surveys were deemed usable, resulting in an initial usable survey rate of 54%. Per Dillman's method of calculating response rate when sampling from a population of potential unusable respondents (Dillman, 1994), the response rate is 74% (600 minus 165 unusable minus 4 undeliverable results in 431 potential target population respondents; 321 usable responses divided by 431 potential equals 74.47% response rate).

Demographic Data

Of the 321 respondents, 27.4% were male (n=88), 71.7% were female (n=230), .3% was transgender (n=1), and .6% (n=2) declined to respond. In terms of ethnicity, 4.4% identified as American Indian/Alaskan (n=14), 8.4% identified as Black, Non-Hispanic (n=27), 76.9% identified as White, Non-Hispanic (n=247), 1.2% identified as

Asian/Pacific Islander (n=4), 6.5% identified as Hispanic (n=21), and 2.2% identified as Other (n=7). 0.3% declined to respond (n=1).

Respondents represented all 50 states in the United States except for North Dakota. The most represented states were Florida, 7.8% of respondents (n=25), Massachusetts, 7.5% of respondents (n=24), and New York, 6.5% of respondents (n=21). Following, Oregon and Washington each had 4.4% of the respondents (n=14 each), followed by California and Virginia with 3.1% (n=10 each). All other states had fewer than 10 respondents, with Missouri and Pennsylvania at the lowest end of the range with .3% each (n=1).

Respondents were asked about their number of years of post-master's counseling experience (see Figure 1). Responses ranged from 0 years (4.7%, n=15) to 40 years (.3%, n=1). The most common response was 1 year, reported by 12.5% of the respondents (n=40). Next, 7.2% reported 4 years (n=23). 50% of the responses fell below 4 years of post-Master's experience, while the remaining 50% ranged from 4 years to 40 years.

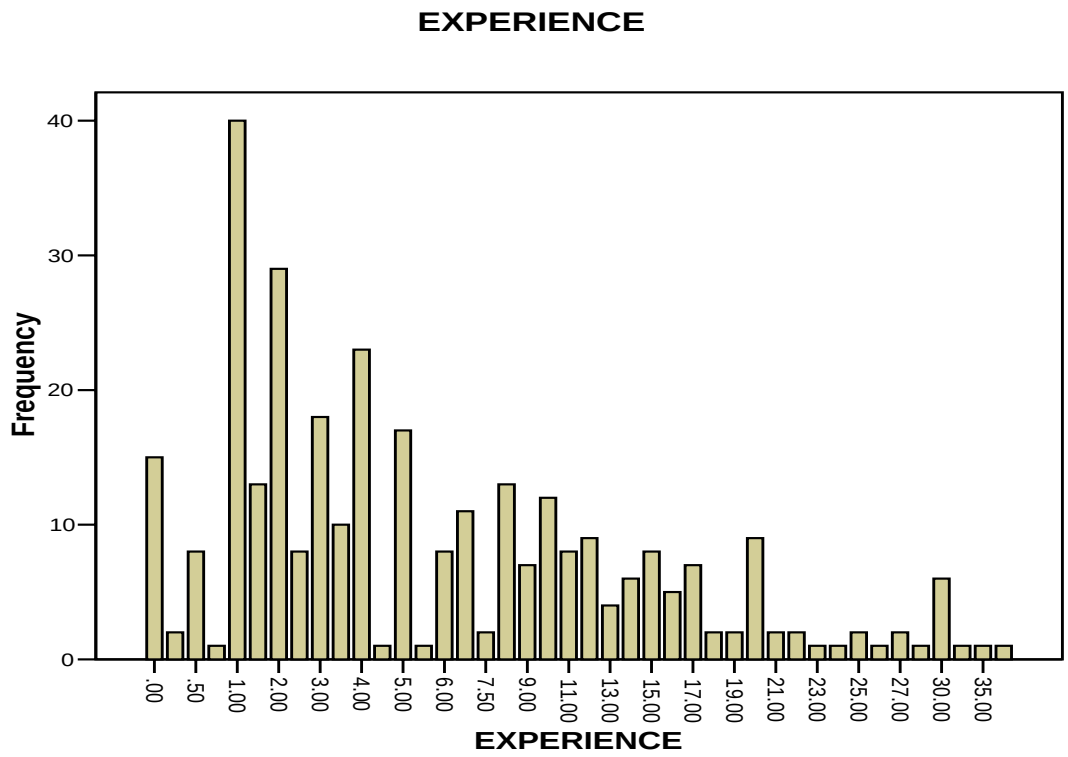
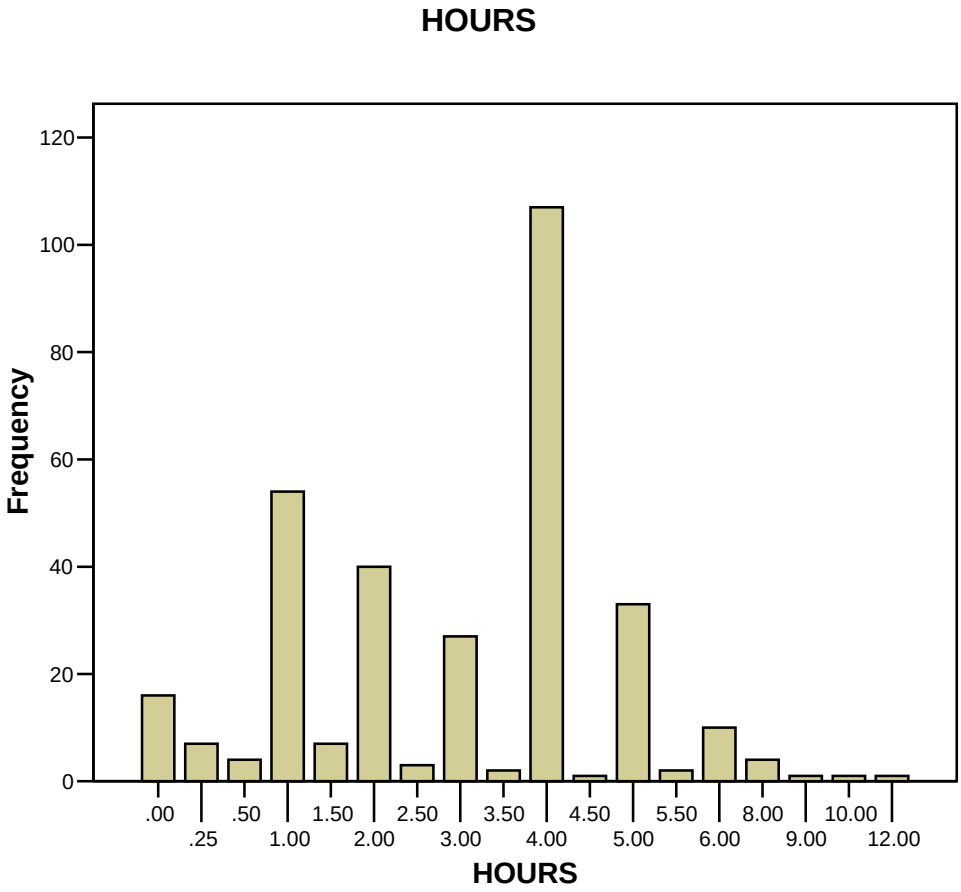


Figure 1. Years of Post-Master's Experience

Amount of Supervision

Respondents were asked how many hours per month (average) they receive individual supervision. The majority, 33.3%, reported 4 hours per month (n=107). Next, 16.8% reported 1 hour per month (n=54). 12.5% reported 2 hours per month (n=40), and 10.3% reported 5 hours per month (n=33). 8.4% reported 3 hours a month (n=27), and 5% reported zero hours as a monthly average (n=16). The highest number in the range was 12 hours (n=1, 0.3%) (see Figure 2).

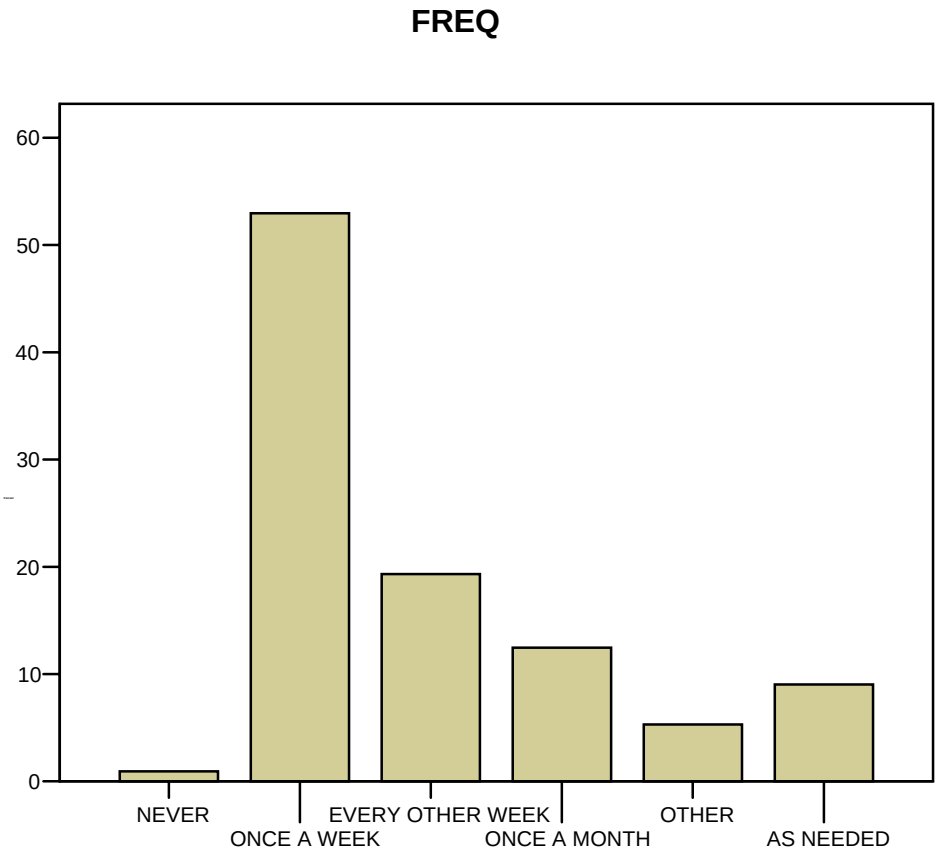


Hours Spent in Supervision

Figure 2. Average Number of Hours of Supervision per Month

Respondents were also asked how often they typically meet with their supervisor. 53.9% of respondents indicated that they meet with their supervisor weekly (n=170), 19.3% reported every other week (n=62), and 12.5% reported once a month (n=40). The remaining 15.2% all checked the "other" box, and 100% of the respondents who checked the "other" box indicated an additional explanatory response in the space provided. This allows for further analysis of that remaining 15.2%. 3 respondents (.9% of the total respondents) indicated they "never" receive supervision, 29 respondents (9% of the total)

indicated that they receive supervision as needed, and the remaining 17 (5.3% of the total) gave varying answers such as “once every quarter at review time” or “once every 6 weeks”.



Frequency of Individual Supervision

Tasks of Supervision

Research question one asks “Which administrative and clinical tasks occur during supervision?” Question 9, sections A and B, of the ASQ address that question.

Clinical Tasks

Section A of the ASQ specifically lists the clinical tasks of supervision. Respondents indicated that the most commonly practiced clinical activities in supervision are Client Treatment Planning (74.1 % indicated this is an activity of the typical supervision session), Clinical Problem Solving (64.8%), and Therapeutic Interventions (60.7%). The least commonly reported activities were Multicultural Competence/Skills (29%), The Clinical Supervision Contract (17.1%), and Reviewing Audio/Videotapes of Session (7.5%). See Figure 3 for exact number of yes/no responses for each item.

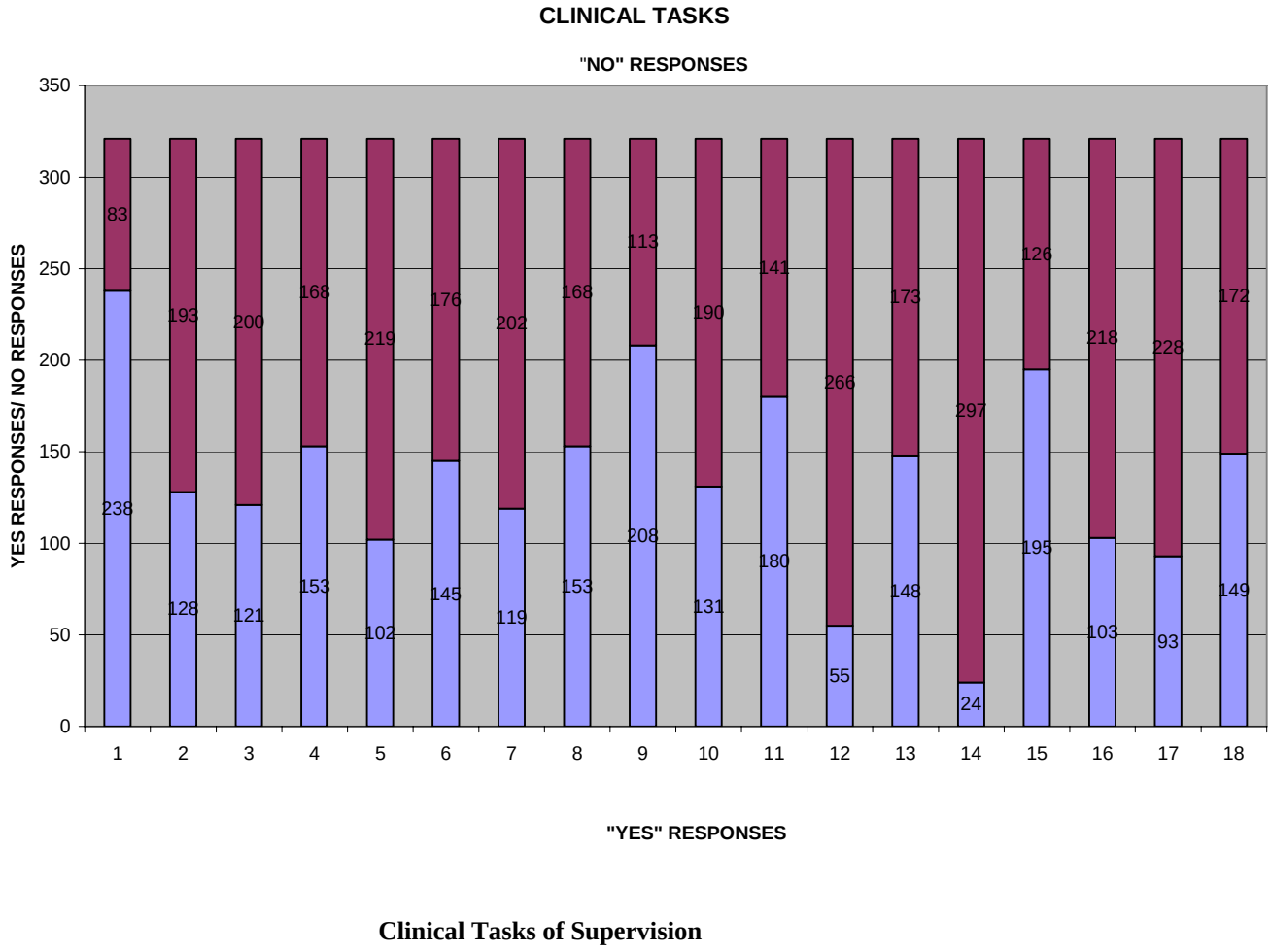


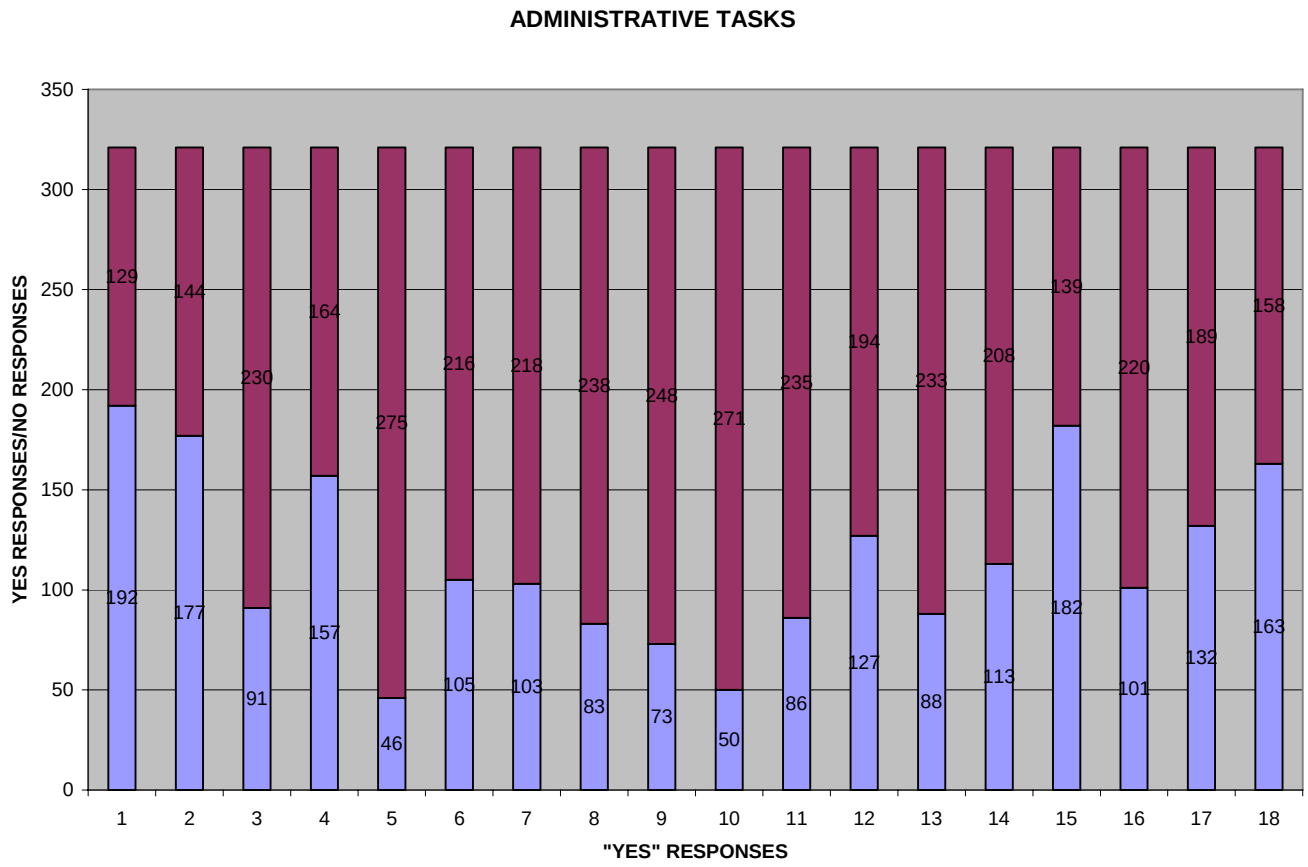
Figure 3. Yes/No Responses for Clinical Tasks of Supervision, Section A of the ASQ.

Figure 3 Legend:

1: Client Treatment Planning
2: Transference/Countertransference
3: Your Model of Therapy
4: Evaluation of Counseling Skills
5: Relationship Building
6: Relationship Building (with Clients)
7: Therapeutic Client Termination
8: Counseling Techniques
9: Clinical Problem Solving
10: Case Conceptualization
11: Ethical Dilemmas
12: The Clinical Supervision Contract
13: Client Emotions
14: Review Audio/Video of Session
15: Therapeutic Interventions
16: The Client's Change Process
17: Multicultural Competence/Skills
18: Communication Skills (with Clients)

Administrative Tasks

Section B of the ASQ specifically lists the administrative tasks of supervision. Respondents indicated that the most commonly practiced administrative tasks during supervision included Employee Performance Evaluation (59.8%), Caseload Management (55.1%), and Workload (56.7%). The least commonly reported activities included Employment/Policy Violations (14.3%) and Sick Leave (15.6%). See Figure 4 for exact number of yes/no responses for each item.



Administrative Tasks of Supervision

Figure 4. Yes/No Responses for Administrative Tasks of Supervision, Section B of the ASQ.

Figure 4 Legend:

1: Employee Performance Evaluation
2: Caseload Management
3: Billing Logs
4: Frustrations Specific to the Agency
5: Employment/Policy Violations
6: Salary/Compensation
7: Program Outcome Evaluation
8: Employment Related Conflicts
9: Employee Conduct
10: Sick Leave
11: Non-Clinical Documentation
12: Agency Budget Issues/Finances
13: Job Advancement
14: Employee Scheduling Issues
15: Workload
16: Vacation Request
17: Productivity Review
18: Training Attendance

Additional Responses

Question 10 of the ASQ allowed respondents to list additional tasks and topics that may have been omitted from the checklists in question 9. Responses were as follows:

ADDITIONAL TASKS

	Frequency of Response
AGENCY & INSURANCE PAPERWORK	1
CASE STUDIES	1
CBT	1
COMMUNICATION WITH OTHER AGENCIES	1
CUSTOMER SERVICE, CORPORATE COMPLIANCE	1
DIFFERENTIAL DIAGNOSIS, TRIAGE	1
DOING TRAININGS	1
EMDR	1
EMOTIONS, BURNOUT	1
FINANCES	1
FRUSTRATION	1
GOSSIP	1
GRAD STUDENT ISSUES	1
GRIPING ABOUT CLINIC	1
GROUP CURRICULUM	1
GROUP SKILLS	1
HARD TO GET SUPERVISION	1
INSURANCE	2
ISSUES	1
LEGAL ISSUE-GUARDIANSHP	1
LEGAL RISK MANAGEMENT	1
LEGISLATION ISSUES	1
LIC BOARD COMPLAINT	1
LICENSURE ISSUES	1
MAKING NEW TRAININGS	1
MANAGEMENT OF AGENCY	1
MARKETING, POLITICS	1

MEDICARE ISSUES	1
MEDICATIONS	1
MANAGEMENT OFSUPERVISEES	1
NEW AGENCY POLICIES	1
NEW RESEARCH	1
OUTREACH FOR VETS	1
PERSONAL ISSUES	3
PHILOSOPHY OF CHANGE	2
PLANNING GROUPS/TRAININGS	1
PREPPING TO WATCH VIDEOS	1
PROGRAM PLANNING, DATABASE	1
PROVIDING SUPERVISION TO OTHERS	1
RESEARCH CONDUCTED	1
RUMORS/EMPLOYEES	1
USING THERASCRIBE	1
UTILIZATION REVIEWS	1
Total	47

Figure 6. Additional Tasks reported on the survey

This researcher did not interpret these responses to determine whether they are appropriately considered "tasks" of supervision. Due to the descriptive nature of this report, this researcher is reporting the responses exactly as they were written by the respondents.

Proportion of Time Spent on Clinical Tasks

The final question of the ASQ addresses the second research question of this study: What proportion of time in supervision is spent on clinical versus administrative tasks? 100% of the 321 usable surveys indicate a response to this question. Respondents were given a blank space in which to fill in a percentage. All respondents filled in an appropriate percentage ranging between 0 and 100%. 6.9% of respondents (n=22)

indicated that 0% of their supervision time is spent on clinical tasks, while 9% (n=29) of respondents indicated that 100% of their time in clinical supervision was spent on clinical tasks. The mean response was 55% and the most commonly reported responses were 10% (n=40; 12.5% of respondents) and 50% (n=34, 10.6% of respondents). 26.5% of respondents (n=85) indicated that 10% or less of the typical supervision session focused on clinical tasks, while 31.1% of the respondents (n=100) indicated that 90% or more of their typical supervision session focused on clinical tasks. Figure 5 provides a graphic view of the dispersion of responses.

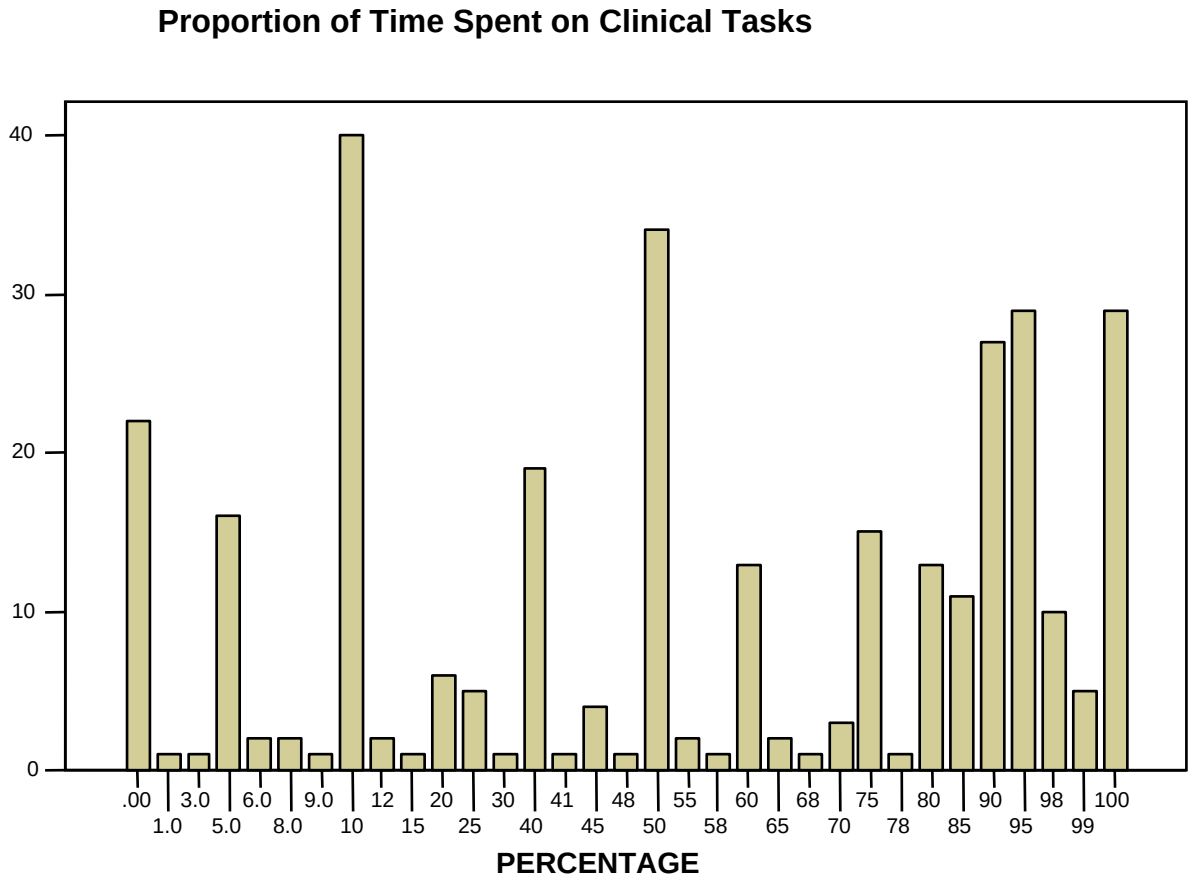


Figure 5. Responses to ASQ question 11: What percentage of your average supervision

session is spent on clinical tasks?

Summary

This results section provided a descriptive analysis of the responses provided on the 321 surveys completed by agency counselors who currently receive clinical supervision so as to address the two primary research questions of this study. The first question inquires about which administrative and clinical tasks occur in an agency setting during individual supervision sessions. The respondents provided descriptive information about which tasks were more common in their supervision sessions and which were less frequently experienced. The second research question inquires about supervisees' perceptions of the proportion of time spent on administrative tasks and clinical tasks during individual supervision in an agency setting. The results of this study indicate a trimodal distribution. That is, 26.5% of respondents spend 10% or less of their supervision time focused on clinical tasks, 23.2% reported that between 40 and 60% of their session is spent focusing on clinical tasks, and an additional 31.1% stated that 90% or more of their session is spent on clinical tasks.

CHAPTER FIVE: DISCUSSION

This study was designed to provide descriptive data about individual supervision in an agency setting. Specifically, this study sought to address the following two areas of inquiry: (a) What administrative and clinical tasks occur in an agency setting during individual supervision sessions? and (b) What are supervisees' perceptions of the proportion of time spent on administrative tasks and clinical tasks during individual supervision in an agency setting?

This study provided information that addresses these two research questions. In this discussion section, the results of this study will be discussed along with implications for the field of counseling and counselor education. Next, the researcher will make recommendations for future research. The limitations of this study are addressed throughout.

Results

This section will address the following: (a) generalizability of results (b) the demographic data; (c) the clinical and administrative tasks of supervision; and (d) the proportion of supervision time spent on clinical tasks.

Generalizability

The recommended sample size for generalizability into the larger population is 360 (with a 50/50 split in variation) or 236 (with an 80/20 split), according to Dillman (2000). This mailing yielded a final total of 321 usable surveys. The response rate was very sound, with a total response of 508 returned surveys. However, many of the surveys were deemed unusable in that the respondents were not part of the target population,

agency counselors, or were agency counselors who did not receive supervision. Questions 1 and 2 of the ASQ addressed these variables, and 160 surveys were deemed unusable because of the respondents' answers. Given that, this researcher was unable to obtain data from enough qualified respondents to meet the recommendation of 360 complete, usable surveys. However, despite this limitation, the information provided by these respondents is new information to the field; that is, much of this information has not been introduced to the field through any formalized data collection avenue. Instead, the information is speculative or anecdotally-driven. So, the information provided, while not optimally generalizable, is still of informational value to members of the profession.

Demographic Data

The majority of respondents were female (71.7%) as opposed to male (27.4%) or transgender (.3%). This is not surprising considering the field's reputation for being rather inundated by females. It is unlikely that gender has any significant impact on the data reported in the survey, but might be worthy of further investigation in future research. 76.9% of the respondents identified as White, Non-Hispanic, while the remaining respondents (except for one who declined to respond) identified as one of the minority categories, perhaps in parallel to the ethnic makeup of the United States in general. In a perhaps similar parallel, of the 10 respondents from California, 4 identified as White, Non-Hispanic, while the remaining 6 identified as Black or Hispanic, once again similar to the ethnic makeup of the larger population of the state. This could indicate a solid representative sample whose results could be fairly generalizable to counselors practicing in that state.

Surveys were mailed to a random assortment of potential respondents in all 50 states of the United States. Forty nine states were represented via responses. No responses were received from North Dakota. States on the West Coast had higher than average numbers of respondents (California, n=10, Oregon, n=14, Washington, n=14). This may be in part because respondents on the west coast recognized Oregon State University as a West Coast/Pacific Ten Conference University so felt some familiarity or supportive allegiance, although the greatest number of respondents are all practicing in states across the country (Florida, New York, Massachusetts).

Respondents with 1 year of counseling experience were the most well-represented (n=40, 12.5%). This may be because newer clinicians may be more apt to be members of professional organizations and may be more likely to be working in an agency setting, as most states require licensure prior to initiating private practice. Commonly, counselors gain licensure by working in agency settings with individual supervision. So, it may be that the unusable responses (especially the respondents weeded out because they are private practitioners) contain a higher number of more experienced counselors, while the agency population contains less experienced counselors more frequently than experienced ones. Over half of the respondents reported having less than 10 years of experience in the field. This seems congruent with the high burnout rates found in agency counseling which can often lead to short career spans (Farber, 1983).

When asked to indicate how many hours of supervision they receive per month, 33.3% of the respondents indicated that they receive an average of 4 hours of supervision per month. This was the most common answer, followed by 16.8% who reported only receiving one hour of supervision per month. This is especially concerning in terms of the

large number of clients that many agency counselors work with, and given the fact that agency supervisors may be deemed negligent for not keeping up with the full caseload of each of their supervisees (Falvey, 1985). One respondent reported receiving 12 hours of supervision per month. This researcher is uncertain about the accuracy of that answer and wonders if the respondent misinterpreted the question, as that amount of individual supervision seems excessive, but possible.

To better assess how supervision occurs in agency settings, the survey asked respondents to report the frequency of individual supervision. 53.9% of the respondents reported that they meet with their supervisor weekly. This seems at first glance a bit incongruent with only 33.3% of supervisees reporting that they receive 4 hours of supervision per month on the average, but some respondents provided written information and comments on their surveys that may help to better understand this phenomenon. One respondent wrote in the margin next to this question "I get a half hour each time if I'm lucky". Given this response, the supervisee would report four incidents of supervision (one per week), yet a total of only two hours of supervision. Another respondent wrote "We go over an hour if I need it". This would explain how this same respondent reported 6 hours of supervision per month with meetings once a week. Several supervisees receive two hours of supervision every other week. So, the amount of time spent in a supervision session seems to vary, although this researcher did not ask specifically for respondents to indicate the average length of each supervision session. Since, the AACD (American Association for Counseling and Development) model licensure bill says that supervisors need to maintain weekly supervision sessions (Bloom

et al., 1990), it is concerning that only slightly over half of the respondents actually receive such regular supervision.

The Clinical Tasks of Supervision

The ASQ contained a checklist of 18 items describing the tasks of clinical supervision. Each respondent either checked the line next to the item to indicate "yes", that task has been discussed in the typical supervision session, or left the item blank to indicate "no." The most commonly reported task was Client Treatment Planning (74.1% indicated "yes"). This is not surprising considering the necessity of treatment planning processes in most agency settings. Treatment planning often is a key factor in getting insurance and other third party reimbursement, and is often reviewed by a supervisor to ensure that the treatment plan is written in a way that will keep third party payers funding sessions. Further, treatment plans are a way that supervisors can measure client growth and change. Finally, treatment plans, in many agency settings, are now being used as a tool that both the client and counselor work on together (Seligman, 2004). At times, agencies require signatures of the counselor, client, and supervisor on the treatment plan. Given the preceding variables, it may be that Client Treatment Planning, although listed as a clinical task, may actually serve as much of an administrative purpose as clinical. This may be cause for the large number of responses. The number of responses may also be inflated due to survey construction. Treatment planning may be thought of as an internal process that occurs on a moment-by-moment basis to help a counselor guide a session and facilitate change, or it may be interpreted as a more formalized process written on paper and submitted to others for approval. The survey item did not clarify

this, so internal validity may have been hampered by this lack of clarity and the results may have been affected.

It seems quite logical that Clinical Problem Solving (64.8%) and Therapeutic Interventions (60.7%) were the next two commonly reported responses. These items both refer to tasks inherent to all counseling processes (Seligman, 2004) and it makes sense that they would be common tasks of counseling as some respondents reported that they see their supervisor as "someone to go to whenever I get stuck trying to help someone change" or "ideally, my supervisor is there when I can't figure out what next to do". A number of respondents reported that they see their supervisor "as needed" (n=29, 9%). It may be that the reason that the supervisor is "needed" is because of the need for an additional, objective opinion to help counselors get through a clinical dilemma or to decide upon which therapeutic intervention would be most helpful given a client concern. Similarly, 56.1% of respondents reported that Ethical Dilemmas was a task typically engaged in during clinical supervision. However, the ACES Standards for Counseling Supervisors clearly indicates that there needs to be ongoing discussion of legal and ethical issues and concerns (Dye & Borders, 1990), so the "yes" responses for this question should clearly be nearly 100% rather than a mere 56%.

Supervisors are now strongly encouraged to review audiotapes or videotapes of sessions (Dye & Borders, 1990). However, only 7.5% indicated that reviewing video/audiotapes occurs in the typical supervision session. In a 1995 study of supervision, researchers found that most supervisors at that time relied primarily on self-report rather than direct oversight (Borders & Cashwell, 1995), despite the fact that many state boards recommend more stringent oversight via audio or video review (Borders & Cashwell,

1992) since self-report tends to be an inaccurate and unreliable (Bernard & Goodyear, 1992; Borders & Leddick, 1987).

Supervisors are encouraged to have a written supervision contract that is treated as a living document and is referred to often (Campbell, 2006), yet only 17.1% of respondents agreed that the supervisory contract was a part of supervision. This percentage may be lower than if a survey question asked "Do you have a supervisory contract or agreement?" It may be that supervisees and supervisors discuss an agreement, but perhaps only once or twice at the start of the supervisory relationship and not as part of the typical session.

Although multiculturalism is considered the fourth force in counseling (Pederson, 1991), only 29% of respondents indicated that this is part of an average supervision session. One respondent wrote "I don't do multicultural counseling". Another respondent stated "My colleague talks about his heritage so I've learned a lot about Natives, but I don't have any clients like that". Another counselor wrote "My supervisor helps me to be color blind. We have a policy about that." This is especially concerning considering the potential risks involved when supervisors do not help develop and maintain cultural competence in their supervisees. That is, the supervisee is likely to misdiagnose, engage in stereotyping and bias, and engage in culturally inappropriate practices (Hays & Chang, 2003). The American Counseling Association's 2005 Code of Ethics (ACA, 2005) requires cultural competence. Supervisors and supervisees who do not integrate multiculturalism into their typical supervisory agenda may be in violation of ethical codes of practice.

The Administrative Tasks of Supervision

The most frequently reported administrative task of supervision was Employee Performance Evaluation (59.8%). This is especially concerning in terms of suggestions made by leader in the field of clinical supervision to divide the purely managerial tasks from the clinical ones so as not to compromise the quality and utility of the supervisory relationship (Borders & Leddick, 1987; Falvey, 1987). Workload (56.7%) and Caseload Management (55.1%) are also commonly reported. These two items may be interpreted as similar tasks if a counselor equates workload with number of clients or clinical contacts. If a counselor is seeing more clients, it stands to reason that the workload will be higher because of additional client contact and additional case management and documentation time.

Employment issues such as Employment/Policy Violations (14.3%) and Sick Leave (15.6%) were reported the least commonly. This is not surprising given the construction of the initial question in which employees are asked to indicate which tasks occur in a typical session. These tasks may be more sporadic, but at times still occur in the course of individual supervision, despite urges in the literature to not incorporate administrative tasks into clinical supervision (Borders, 1986; Harrar, Vandecreek & Knapp, 1990; Holloway, 1992).

Additional Tasks

Respondents were asked to list any additional tasks that may have been omitted from the prior lists. Responses included some tasks that may be duplicates of items on the prior list, or may be interpreted differently. These include “CBT” (n=1) and “EMDR” (n=1), which may be encompassed in clinical supervision tasks such as “Therapeutic

Interventions". Others included "personal issues" (n=3) and "issues"(n=1) which may be clinical in nature and may fall under "Transference/ Countertransference", and "hard to get supervision" (n=1) which may not be a task at all; it may have been a comment. On the contrary, it may be a topic of discussion in a supervision session as well.

The Proportion of Supervision Time Spent on Clinical Tasks

The average amount of time spent on clinical tasks during the typical supervision session was 55% (n=321). However, the range was from 0% (n=22, 6.9% of respondents) to 100% (n=29, 9% of respondents). The mode was 10% (n=40), followed by the second most commonly reported answer, 50% (n=34, 10.6% of respondents). The nature of this study is purely descriptive so no inferences will be drawn from these percentages, although the wide range of responses are certainly noteworthy. The wide range of responses indicates that supervision may include a great deal of clinical focus or very little which points to the inconsistent nature of agency supervision. Over one quarter of the responses fall into the "10% or less" category (26.5%), while over another quarter (31.1%) claim 90% or more of their time in supervision is spent on clinical tasks.

This question allows some room for error in that respondents have no place to indicate other tasks that do not fall under clinical nor administrative supervision. One respondent wrote "We spend half our session gossiping!" Another wrote "We talk about sports a lot, especially when we meet on Mondays". In that this researcher asks only for a percentage regarding clinical tasks, then automatically deducts that percent from 100, then assumes the rest of the percentage is administrative, it may be that some percentage of "other" time is missed.

These results are very concerning considering recommendations from the literature and leaders in the supervision field who encourage supervisors to focus on clinical tasks during supervision, indicating that the ongoing clinical development of the counselor is crucially important for optimal client care and service provision (Borders & Brow, 2005; Holloway, 1996). Carifio & Hess (1987) inform readers that the ideal supervisor, according to several research studies, creates an open, trusting environment in which the supervisor is confident, enthusiastic, open to the supervisee's input, and is serving the supervisee's development and growth as opposed to an external variable (such as training program or agency). Cherniss & Egnatios (1977) found that insight and feeling-oriented supervision styles were more effective and well-received than authoritarian or confrontive styles. If a supervisee's manager is their supervisor, the supervisor/manager may need to employ more of an authoritarian style as a means of performing his or her dual roles of manager and clinical supervisor.

Implications for the Field

Counselors, agency management, counselor educators, and state licensing boards should all be aware of the varied practices of agency supervision suggested by this study. Counselors, upon leaving their training programs, may expect supervision to serve their ongoing developmental needs and their service provision. However, they may find themselves in an agency setting where supervision is conducted in a manner that puts agency needs (administrative tasks) first at the expense of clinical growth and development. Since research indicates that strong supervision helps improve client care and reduce counselor burnout (Cross & Brown, 1983; Kottler, 1993), it is necessary for

counselors to consider the quality of supervision they will receive as they make employment decisions following their graduate training program. Counselor competence is most enhanced when counselors engage in supervision that is designed to ensure a high quality of counseling services for the clients being served by the supervisee (Drapela, 1983), rather than supervision that is designed to meet agency and managerial needs, at times in lieu of client and supervisee needs.

Counselor educators ought to maintain awareness of the wide variance in clinical supervision found in this study, especially when providing selecting internship sites for their program candidates. CACREP standards require interns to receive weekly supervision (CACREP, 2004), and counselor educators need to learn what that supervision actually entails to ensure that the developmental needs of the student are being met via that supervisory process. If a student has clinical supervision every week, yet that supervision focuses mainly on administrative tasks, that student may not be receiving the same educational experience as students receive more pure clinical supervision. This becomes a pattern that is likely to repeat into the students' career; that is, the student learns in graduate school that supervision is administrative in nature, the school appears to be endorsing that by allowing that supervision to count as clinical supervision, so the student expects supervision to be the same after graduation, not knowing that supervision is more beneficial when more clinical in nature. Counselor educators are responsible for educating their students about what clinical supervision is supposed to entail (Borders & Leddick, 1988; Leddick & Stone, 1982).

Agency managers need to also be aware of the variance in supervision activities and the value of supervision in increasing client retention, increasing employee retention

and decreasing burnout, and increasing the overall quality of services provided (Borders & Leddick, 1988; Cross & Brown, 1983; Page & Wosket, 2001). Management may then decide to assist supervisors in their supervision duties, perhaps by eliminating or reducing the dual role issues, allowing for more systemic support of competent supervision practices, and hiring additional supervisors to support management in providing counselor development. Managers in these dual roles may utilize this information, along with the literature regarding competent supervision and ethical counselor practices, to advocate for a reduction of dual roles and conflicting responsibilities.

Finally, state licensing boards could utilize this information as they attempt to regulate counselor licensure. Many licensing boards require an average of one hour of supervision per week for pre-licensure candidates (Borders & Cashwell, 1995), although the results of this study indicate that this practice in not necessarily the norm in agency settings. Few states provide guidelines for what should or what must occur in the course of that supervision. Counselors who are spending the majority or all of their supervision time engaging in clinical tasks may not be meeting the original intent that the licensing board had in creating such supervision requirements. The licensing board may ask for intermittent reports of supervision activities, but since those reports are often filled out by the supervisor, the report may be as inaccurate as the self-reporting methods used in most supervision sessions (Carifio & Hess, 1987).

Recommendations for Future Research

The results of this descriptive study may be interpreted to suggest that many agency supervisors are unclear about the definition of and tasks inherent to clinical supervision. In that the literature indicates that the definition of clinical supervision as it

pertains to the counseling field is still widely misunderstood (Holloway & Hosford, 1983; King, 1999), it may be most beneficial to create an operational definition of clinical supervision as it applies in an agency setting by combining research on the practices in agency supervision combined with recommended practices. This would require a great deal of data about the practices of agency supervision and a thorough analysis of recommended versus actual practices, perhaps followed by a factor analysis of these practices to determine which factors are most prevalent. Of course, prevalence does not equate with importance, as was shown in this study. Although leaders in the field determine videotape observations to be important, there seems to be a low prevalence of audio/video review in actual agency practice.

Next, research similar to this study but on a much larger scale might prove very enlightening. For instance, it would be helpful to run comparison data between supervisee and supervisor responses. It would be useful to factor in supervisor qualifications; that is, do we see more clinical focus when a supervisor is a trained supervisor than when the supervisor is not specially trained in supervision? It would also be beneficial, especially for licensing boards, to break the data down state-by-state and compare responses to supervisor regulations. For instance, Oregon requires that qualified supervisors receive 30 clock hours of training in supervision before supervising licensure candidates. Do these "qualified" supervisors provide more clinically-focused supervision than supervisors who have not received this training?

It would also be informative to compare the data received in this study via the "usable responses" with data from other populations besides the non-target populations: specifically, school counselors and private practitioners. It would be especially useful to

know whether private practitioners receive more clinically-focused supervision than their agency colleagues.

Finally, it would be useful to develop and implement a curriculum for advanced supervision training based on the recommended practices of the supervision field along with the actual practices found to be occurring in agency settings. Supervisors-to-be can be trained in how to deal with potential challenges to providing optimal supervision and can learn about how to balance the dual roles that may be inherent to their position. This curriculum can be evaluated to determine whether the training affects supervisory practices. Further, their supervisees can provide data via surveys or interviews that inform the researcher about the quality of their supervision and the affect such supervision has on their ongoing growth and development along with client care and service provision.

Summary

This descriptive study examined the practice of individual supervision in an agency setting. Specifically, the study describes the clinical and administrative tasks as they occur in supervision, plus the proportion of time spent on clinical tasks during supervision sessions. 321 respondents provided usable data via the ASQ (Agency Supervision Questionnaire), a paper-and-pencil self administered survey designed specifically to gather data for this study. The most commonly practiced clinical tasks of supervision included Client Treatment Planning, Clinical Problem Solving, and Therapeutic Interventions. The least commonly reported clinical activities included Multicultural Competence/Skills. The Clinical Supervision Contract and Reviewing Audio/Videotapes of Session. The most commonly reported administrative tasks included

Employee Performance Evaluation, Caseload Management, and Workload. The least commonly reported administrative tasks included Employment/Policy Violations and Sick Leave. Finally, a trimodal curve was indicated in response to the second research inquiry about proportion of time spent on clinical tasks during the typical supervision session. 26.5% of the respondents indicated that 10% or less of the supervision session was spent on clinical tasks, while 31.1% of the respondents indicated that 90% or more of their typical supervision session focused on clinical tasks. However, the mean response was 55%, with 10.6% of the respondents indicating an even 50% of their session was spent on clinical tasks.

This information is especially valuable to counselors, counselor supervisors, counselor educators, and state licensing boards in that this study describes a wide variance in practices in individual agency supervision. Previously, anecdotal data was available in some of the literature about the varied practices in agency supervision, yet this study provides data describing the varied practices inherent to agency supervision.

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Appendix 1
Agency Supervision Questionnaire

AGENCY SUPERVISION QUESTIONNAIRE (ASQ)

Thank you for completing this survey. Please be sure to complete both pages of the survey.

This survey takes approximately *10 minutes* or less to complete.

1. Do you currently receive *individual* clinical supervision at your workplace? (Check One)

☐ **Yes** ☐ **No**

2. Which of the following best describes your work setting? (Check One)

☐ **Agency** ☐ **School** ☐ **Private Practice** ☐ **Other: _____**

3. How many hours per month (average) do you have individual supervision? _____

4. How often do you typically meet with your supervisor?

☐ **Once a Week** ☐ **Every other week** ☐ **Once a month** ☐ **Other: _____**

5. Your Race/Ethnicity (Check All That Apply):

☐ **American Indian/Alaskan Native** ☐ **Asian/Pacific Islander**

☐ **Black, not of Hispanic Origin** ☐ **Hispanic**

☐ **White, not of Hispanic Origin** ☐ **Other (describe): _____**

6. Gender: ☐ **Male** ☐ **Female** ☐ **Transgender**

7. What state you are employed in? _____

8. How many years of post-master's counseling experience do you have? _____

9. Thinking about your typical clinical supervision session with your current supervisor, which of the following have you and your supervisor discussed and/or worked on together? (Check all that apply)

Section A

____ **Client Treatment Planning**	____ **Case Conceptualization**
____ **Transference/Countertransference**	____ **Ethical Dilemmas**
____ **Your Model of Therapy**	____ **The Clinical Supervision Contract**
____ **Evaluation of Counseling Skills**	____ **Client Emotions**
____ **Relationship Building (with Supervisor)**	____ **Review Audio/Videotape of Session**
____ **Relationship Building (with Clients)**	____ **Therapeutic Interventions**
____ **Therapeutic Client Termination**	____ **The Client's Change Process**
____ **Counseling Techniques**	____ **Multicultural Competence/Skills**
____ **Clinical Problem Solving**	____ **Communication Skills (with Clients)**

Section B

____ **Employee Performance Evaluation**	____ **Sick Leave**
____ **Caseload Management**	____ **Non-Clinical Documentation**
____ **Billing Logs**	____ **Agency Budget Issues/Finances**
____ **Frustrations Specific to the Agency**	____ **Job Advancement**
____ **Employment/Policy Violations**	____ **Employee Scheduling Issues**
____ **Salary/Compensation**	____ **Workload**
____ **Program Outcome Evaluation**	____ **Vacation Request**
____ **Employment Related Conflicts**	____ **Productivity Review**
____ **Employee Conduct**	____ **Training Attendance**

10. Are there any other tasks/topics of supervision that are not included on this list? (Please be detailed & specific):

11. What percentage of your average supervision session is spent on clinical tasks (those described in Section A)?

_____%

Thank You for Your Participation!

Appendix 2
Pre-Letter

Lisa Aasheim, PhD Candidate
SPED/
Community Counseling Clinic
PO Box 751
Portland, OR 97207

Date

Respondent's Name
Mailing Address
City, State, Zip

A few days from now you will receive in the mail a request to fill out a brief questionnaire for an important research project being conducted by Oregon State University's Counselor Education Department.

It concerns the experience of counselors who are working in an agency setting and are receiving individual supervision.

I am writing in advance because we have found many people like to know ahead of time that they will be contacted. The study is an important one that will help counselors, supervisors, agencies, and governing bodies better understand the supervision experiences of counselors in an agency setting. This will ultimately help to improve services to counselors and their clients.

Thank you in advance for your time and consideration. It's only with the generous help of people like you that our research can be successful.

Sincerely,

Lisa Aasheim
Ph.D. Candidate/ Counselor
Counselor Education Department

Appendix 3
Cover Letter

Lisa Aasheim, PhD Candidate
SPED/
Community Counseling Clinic
PO Box 751
Portland, OR 97207

Dear

I am writing to ask for your help in a survey study of individual supervision in an agency setting. This study is part of an effort to learn about the tasks and focus of individual supervision sessions.

You were selected to participate in this study because you are a member of the American Mental Health Counselors Association (AMHCA). I am contacting a small random sample of counselors to ask about the activities that occur during their individual supervision sessions.

Results from this study will be used to help counselors, supervisors, agencies, certification, and licensing boards better understand what occurs during a typical supervision session in an agency setting. Once supervision is better understood from a supervisee's standpoint, supervisors and agencies can work to adjust their practices and focus to serve counselors and their clients in a more effective way.

Please complete the enclosed 10 minute survey and return it in the included envelope. Your answers to this survey are confidential and will be released only as summaries in which no individual's responses can be identified. If you choose to complete the survey, you are acknowledging understanding that your answers will be used in a final research report that is likely to be submitted for publication. This survey is voluntary. If you choose to not participate in the study, please let me know by returning the blank survey in the enclosed stamped envelope. You may refuse to answer any question(s) for any reason. Only a small sample of counselors will receive the questionnaire, so your participation is important to this study.

The answers you provide will be kept confidential to the extent permitted by law. Special precautions have been established to protect the confidentiality of your responses. The number on your questionnaire will be removed once it has been received. (The number is used to contact those who have not returned their questionnaire, so those who have responded are not burdened with additional mailings). There are no foreseeable risks to you as a participant in this project; nor are there any direct benefits. However, your participation is extremely valued.

If you have any questions or comments regarding this study I'd be happy to speak with you further. My phone number is (503)725-4253. I can also be contacted via email at: aasheiml@onid.orst.edu. You may also contact the Primary Researcher by phone (541) 737-5973 or email: deborah.rubel@oregonstate.edu.

Thank you very much for helping with this important study.

Sincerely,

Lisa Aasheim
Ph.D. Candidate/Counselor

Appendix 4
Thank You Postcard

Last week a questionnaire seeking your opinions about individual supervision was mailed to you. Your name was randomly drawn from a list of Nationally Board Certified Counselors.

If you have already completed and returned the questionnaire to us, please accept our sincere thanks. If not, please do so today. We are especially grateful for your help because it is only by asking counselors like you to share your experiences that we can understand what supervision is like in agency settings.

If you did not receive a questionnaire or if it was misplaced, please email aasheiml@onid.orst.edu and another one will be placed in the mail today.

Thank you!

Lisa Aasheim
Ph.D. Candidate/Counselor
Oregon State University

Appendix 5
Replacement Questionnaire Cover Letter

Lisa Aasheim, PhD Candidate
SPED/
Community Counseling Clinic
PO Box 751
Portland, OR 97207

Date

Respondent's Name
Mailing Address
City, State, Zip

About three weeks ago I sent a questionnaire to you that asked about your experiences as a counselor receiving supervision. As of this writing, I have not received your reply.

The comments of people who have already responded help provide a clearer understanding of the focus of individual supervision in an agency setting. These responses indicate that _____.

It is critical that I receive your completed survey. This is needed in order to obtain an accurate depiction of individual supervision practices in your workplace. Although we have sent surveys to counselors across the country, it is only by hearing from nearly everyone that we can be sure our results are truly representative.

I hope that you will complete the enclosed survey soon and mail it in the enclosed self-addressed stamped envelope. However, if you decide that you prefer not to participate in this study, please let me know by returning the blank survey in the enclosed self-addressed stamped return envelope. Or, you can email me at: aasheiml@onid.orst.edu.

If you have any questions or comments regarding this study please feel free to contact me at my email or by phone, 503-725-4620. Thank you for sharing your valuable time.

Sincerely,

Lisa Aasheim
Ph.D. Candidate/Counselor
Counselor Education Department