

CLINICIANS' PERCEPTIONS OF SUPERVISION EMPHASIS
AND ITS INFLUENCE ON THE SUPERVISORY RELATIONSHIP
IN PRIVATE MENTAL HEALTH AGENCIES IN VIRGINIA

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ABSTRACT

Private community-based mental health agencies fill a vital role in Virginia's health system in that they increase access to care and provide a wide range of services. In order to operate and receive state funding, these private agencies are responsible for abiding by regulations set forth by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Medical Assistance Services (DMAS). Supervision, as defined by DBHDS and DMAS, features a more administrative approach, requiring supervisors to review policies and ensure procedural compliance. In contrast, supervision as defined by counselor educators leans more towards a clinical approach whereby a more experienced member of the profession will guide the supervisee in professional development through the enhancement of skills and techniques. The issue of interest herein is that little is known about how supervisors in private community-based mental health agencies are navigating these multiple areas of supervisory emphasis.

This quantitative inquiry focused on understanding clinicians' perceptions of supervision emphasis and its influence on the supervisory relationship in private mental health agencies in Virginia. Three research questions were developed to determine (a) the influence of clinicians' perceptions of supervision emphasis on the supervision working alliance, (b) the relationship between a supervisor's licensure status (Licensed Professional Counselor versus other designations) and the influence on the supervisory working alliance, and (c) the influence of

supervisor responsibilities of hiring/terminating staff and/or conducting performance evaluations on the working alliance. Instruments used in this study included a demographic questionnaire, the Supervisor Emphasis Rating Form-Revised (SERF-R), and the Working Alliance Inventory-Revised (WAI-R). Analysis methods utilized in this study included multiple regression, T-tests, and analysis of variance.

Three key findings emerged from this investigation. The first finding is that multiple regression results showed that the professional behaviors mean score in the SERF-R could explain 13% of variance in the WAI-R. The second key finding is that supervisors with the credential of Licensed Professional Counselor had a higher mean working alliance score than those with other professional licensures. The final key finding is that there was no significant difference in the working alliance between clinicians whose supervisors were responsible for certain administrative tasks and those clinicians whose supervisors had no such responsibilities. The implications of this study, its limitations, and suggestions for future research are detailed herein.

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Do not go where the path may lead, go instead where there
is no path and leave a trail.

-Ralph Waldo Emerson

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CHAPTER ONE: INTRODUCTION

Rationale

It was a crisp fall day in 2013 in the bucolic mountains surrounding historic Bath County, Virginia, when Senator Creigh Deeds was outside delivering a bucket of oats to feed his blind, companion horse. He heard his 24 year-old son, Gus, call out his name. As Senator Deeds called back to his son, he turned his back and was subsequently attacked with a knife by Gus, who inflicted him with blows and lacerations that would leave him fighting for his life in the very woods he called home. Gus would later die that day of a self-inflicted gunshot wound and Virginia would face another mental health crisis of epic proportions. The main source of the controversy? A mental health professional had evaluated Gus under an emergency custody order a mere twelve hours before he attacked his father and took his own life. But because of a reported lack of bed space in both public and private psychiatric hospitals in Virginia, Gus was released into the custody of his father, where the next morning tragedy would unfold (McCrummen, 2014).

Ever since that heartbreaking day, Senator Deeds has made it his mission to reform mental health care in the Commonwealth of Virginia. Senator Deeds belief that “The system failed my son” (p. 1) increased his determination to ensure that mental health reforms could be put into place to prevent another family from losing a child struggling with mental illness (Pershing, 2014). Specifically, Deeds advocated lengthening the amount of time a person could be held on a psychiatric hold from six hours to twelve hours, establishing a central registry where psychiatric hospitals could record their bed space, and increasing access to community-based mental health services (McCrummen, 2014).

The move toward increased access to community-based mental health services began long before Gus Deeds took his own life and Senator Deeds vowed to increase funding and access to public and private community mental health centers. In 1963 President John F. Kennedy passed the Community Mental Health Act, which provided funding for the establishment of community mental health centers throughout the United States (National Council for Behavioral Health, n.d.). Since that time, private community-based mental health agencies have filled a vital niche in community-based mental healthcare systems in that they increase access to care and provide a wide range of services. Just like their public counterparts, private agencies must abide by a long list of regulations set forth by the Department of Behavioral Health and Developmental Services (DBHDS), the Department of Medical Assistance Services (DMAS), and other funding streams and stakeholders (e.g., the administration and supervision of mental health programs). In addition, both public and private mental health clinicians and supervisors must adhere to agency guidelines and ethical codes from their respective professional organizations (e.g., American Counseling Association) in order to provide the most effective mental health services.

The myriad of regulations, guidelines, and expectations for mental health services and supervision in private community-based mental health agencies leaves even the most seasoned professional perplexed. These various requirements have the potential to derail the emphasis on clinical care, change the supervisory emphasis to meeting these various regulations, and ultimately negatively impact the working alliance between the mental health clinician and the supervisor. And given the importance of supervision in honing the clinical skills and administrative functions of junior clinicians, it is vital that we understand the conditions under which this relationship can flourish. However, little research exists that examines the

supervision practices of private community-based mental health agencies. Also important to this investigation is the urgent need to shift focus from meeting DBHDS and DMAS regulations to understanding the actual content, perceptions, and functions of supervision in private community-based mental health agencies. Based on these exigencies, this study was designed to explore how clinicians employed by private community-based mental health agencies in Virginia perceive the supervisory emphasis. This investigation was also designed to explore the influence of a clinician's impression of the supervisory emphasis on the working alliance between the clinician and the supervisor.

Context for the Study

Private community-based mental health centers were developed for the purpose of expanding access to mental health services, reducing the number of patients in “traditional” psychiatric hospitals, and expanding the repertoire of services available to the community. President John F. Kennedy is generally credited with increasing the number and importance of community-based mental health centers with the 1963 passage of the Mental Retardation and Community Mental Health Centers Construction Act (National Council for Behavioral Health, n.d.). In Virginia, oversight of private community-based mental health agencies is regulated by the Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Medical Assistance Services (DMAS). DBHDS is responsible for licensing mental health providers in the Commonwealth of Virginia, while DMAS oversees the Medicaid program and managing administrative and reimbursement functions (Department of Behavioral Health and Developmental Services, 2014; Department of Medical Assistance Services, 2014). Both organizations play a vital role in defining and operationalizing policies, procedures, programs,

and supervision for clinicians and supervisors in private community-based mental health agencies in Virginia.

The notion of supervision in a clinical setting can mean different things depending on the actors and the setting. Bernard and Goodyear (1992) suggested a commonly-accepted definition for supervision in counseling and counselor education that will be utilized in the current study. The researchers stated that (a) supervision is conducted by a member of the profession who is more experienced, (b) the supervisory relationship features an inherent hierarchy of power dynamic, and (c) the relationship is not time limited. In addition, Bernard and Goodyear (1992) stated that the purpose of supervision is to monitor the professional work and clinical skills of a junior member of the profession. Although this functional definition may seem intuitive, the function and purpose of supervision can differ based upon the entity consulted. As such, DBHDS and DMAS both play a role in defining supervision for private community-based mental health agencies in Virginia. For example, the requirements for supervision are likely to vary based on the nature of the services and programs provided in DBHDS-licensed agencies. In addition to defining the credentials and education required to be a clinician, DBHDS also mandates the educational and profession requirements needed to be a supervisor and the frequency and duration of supervision (Department of Behavioral Health and Developmental Services, 2011). DMAS monitors adherence to these regulations and discontinues reimbursement for services if regulations are not met (Department of Medical Assistance Services, 2014).

The supervision practiced in community-based mental health agencies can vary in content, focus, and delivery. Two commonly-accepted variations of supervision found in contemporary counseling literature are clinical versus administrative supervision (Bernard & Goodyear, 2014; Henderson, 2009; Tromski-Klingshirn & Davis, 2007). Administrative

supervision is defined as “ensuring adherence to policy and procedure” (Kadushin, 1992, p.14), monitoring compliance, and developing protocols (Henderson, 2009). In contrast, clinical supervision focuses on the clinician’s interpersonal process, specific counseling issues that need to be addressed, and the overall development of clinical skills (Falender & Shafranske, 2004). It must be noted, however, that neither the Department of Medical Assistance Services (2014), nor the Department of Behavioral Health and Developmental Services (2011), make any distinction between clinical and administrative supervision in any of their policies and procedures. Thus, this lack of delineation between the administrative and clinical functions of supervision in private community-based mental health agencies creates ambiguity in the functions and procedures of supervision.

Bernard’s (1979, 1997) discrimination model helps to further define the role of a supervisor during supervision sessions, as well as delineate the focus for clinicians. With respect to the former, a supervisor’s role can be differentiated into consultant, counselor, and teacher. The choice of role(s) is deliberate and situational because it is typically based upon the need of the supervisee and the presenting issue in supervision (Bernard, 1979, 1997; Bernard & Goodyear, 2014). The focus for clinicians includes process skills (clinical skills), case conceptualization skills (understanding themes and identifying objectives), and personalization skills (influence of a clinician’s background and values). The function of supervision (administrative versus clinical), the role of the supervisor (consultant, counselor, and/or teacher), and the focus for clinicians (process, conceptualization, and personalization) can have implications for the effectiveness of supervision and counseling.

Just like their public-agency counterparts, supervisors who work in private community-based mental health agencies often serve dual roles for the clinicians they supervise. Because

DBHDS (2011) policies specify that supervisory tasks must include reviewing caseloads, maintaining detailed progress notes, and formulating individualized service plans, supervisors are routinely tasked to take on administrative roles. In addition, many supervisors also are required to fulfill their clinical responsibilities of monitoring client welfare, helping to develop a clinician's skill set, and engaging in professional development. Although both are important and typically mandated, the dual roles required of supervisors could create an ethical dilemma and impact client welfare and supervisee development (Tromski-Klingshirn & Davis, 2007). Moreover, because the administrative role a supervisor fulfills is hierarchical and has inherent power implications, it may be difficult for the supervisee to be fully open in clinical supervision and not feel judged (Tromski-Klingshirn & Davis, 2007). In short, the dual role of both administrative and clinical supervisor has the potential to influence how clinicians perceive the working alliance developed in the supervisory relationship.

Although a supervisor has some flexibility in what he or she chooses to emphasize in the supervisory relationship, there are specific areas that are typically addressed. Lanning (1986) conceptualized the notion of supervision emphasis through Bernard's (1979, 1997) areas of focus in supervision, which he later presented as the Supervisor Emphasis Rating Form (SERF) (Lanning, 1986). Lanning and Freeman (1994) proposed four areas of supervision emphasis: (1) processing (interaction between client and counselor (or supervisor/supervisee)); (2) personalization (attitudes, beliefs, and feelings of the counselor/supervisee); (3) conceptualization (ability to cognitively understand therapy/supervision processes), and (4) professional behaviors (attention to detail, timeliness, paperwork, administrative duties, etc.). In terms of conceptualizing supervision emphasis in an administrative or clinical sphere, the processing, personalization, and conceptualization areas are considered to be clinical concerns,

while the fourth area, professional behaviors, is considered to be administrative. The emphasis a supervisor selects can be a conscious choice that is based upon the needs of the clinician, the direction of supervision, and the presenting issues (Lanning, 1986)—but supervisory emphasis can also be impacted by external rules or regulations (e.g., the DMAS expectation that supervision focuses on professional behaviors). Importantly, the emphasis of supervision can also have an impact on a counselor’s self-efficacy (Wise, 2006), as well as the working relationship between the supervisor and supervisee.

This working relationship, referred to as the “working alliance,” was first defined as an aspect of the counselor-client relationship, but was later adapted to the supervisory relationship (Bernard & Goodyear, 2014; Bordin, 1983; Milne, 2006). Efstation, Patton, and Kardash (1990) defined the supervisory working alliance as a purposeful relationship whereby the supervisor guides the supervisee in professional development and clinical skills and techniques. When the clinician perceives the working alliance as strong, helpful, and supportive, client outcomes can increase (Castonguay, Constantino, & Holtforth, 2006). Among the models that explain the intricacies of the working alliance, Bordin’s (1983) is the most widely accepted. Bordin (1983) asserted that the working alliance should be comprised of goals, tasks, and bonds. Based on Bordin’s working alliance model, Horvath and Greenberg (1990) later created the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1990), which is an instrument for measuring the three subscales of the working alliance (tasks, goals, and bonds) and the overall strength of the alliance. Baker (1990) then revised the WAI for use in the supervisory relationship by replacing the words “therapist and client” with “supervisor and supervisee.”

The clinician’s perception of both the supervisory working alliance and what is emphasized during supervision can impact the conditions and outcomes of supervision. In turn,

supervision is an integral component of the success of the clinical relationship and therapeutic outcomes between clinician and client (Ellis & Ladany, 1997). As indicated earlier, both DMAS and DBHDS require an administrative focus in supervision that has been shown to negatively impact the supervisory working alliance (Chen & Bernstein, 2000). Although measuring the influence of the supervisory relationship on the outcome of clinical work is difficult due to the multiple factors that can impact this relationship, it is imperative to further explore the influence of the perception of supervision emphasis on the supervisory working alliance in order to support clients in their quest for improved mental health.

This section explains the context that supports this investigation—including the evolution of supervision in terms of the guidelines and expectations in private community-based agencies that may obfuscate or undermine the supervisor-supervisee relationship. The concepts of supervision emphasis, including the components of process skills, personalization skills, conceptualization skills, and professional behaviors, and the working alliance were introduced and will be further expounded upon in Chapter Two.

Statement of the Problem

Counseling and counselor education leaders have standardized and operationalized a definition for supervision that is widely accepted throughout the field (Association of Counselor Education and Supervision, 2011; Bernard & Goodyear, 2014). While this definition is accepted in the field of counseling, there is no evidence of a standardized definition or operational standards for private community-based mental health agencies that employ a large number of counselors. Creaner (2013) stated that it is difficult to define supervision because “...supervision may mean different things in different contexts, all of which may have a bearing on where emphasis is placed and how supervision is effected” (p.7). Supervision for these agencies is

defined by the regulations that govern reimbursement for services through DMAS (2014) and policies and protocols through DBHDS (2014). The definition of supervision utilized by private community health agencies leans more toward a task-oriented definition, which includes review of progress notes, case loads, and individualized service plans—in short, a more administrative approach toward supervision (Department of Behavioral Health and Developmental Services, 2014). Moreover, clinicians in private community-based mental health agencies are required to meet certain weekly billing standards, and as such, time is limited for supervision, meetings, etc. In short, the professional supervision clinicians need in order to support effective service delivery, skills building, and professional development can either be deficient in be clinical development and skills building and/or be in direct competition with administrative tasks. How clinicians and their supervisors are managing to address both exigencies in the field is underexplored.

Although the definition of supervision in the DBHDS guidelines and DMAS protocols do not stress the supervisory process and relationship, the research confirms that appropriate supervision is a powerful tool that can exert a lasting effect on supervisee self-efficacy (Freeman & Lanning, 1994; Lanning, 1986; Wise, 2006), as well as influences the outcome of mental health services provided by the supervisee (Ellis & Ladany, 1997). The working alliance described in the literature (e.g., Bernard & Goodyear, 2014; Bordin, 1983; Milne, 2006) may be impacted by how supervision is emphasized in private community-based mental health agencies.

The majority of research conducted on supervision emphasis and the supervisory working alliance has taken place in graduate schools (Bernard & Goodyear, 2014). In contrast, there is little available research that examines the supervision emphasis and the supervisory working alliance in private community-based mental health agencies. Therefore, this study will expand

upon current research by exploring clinicians' perceptions of supervision emphasis and its influence on the supervisory relationship in private mental health agencies in Virginia.

Purpose of Study and Research Questions

This study was designed to explore clinicians' perceptions of supervision emphasis and its influence on the supervisory relationship in private mental health agencies in Virginia. Also examined in this study is how mental health clinicians employed at private mental health agencies in Virginia described the emphases that their supervisors used in session. To reiterate, the four areas of emphasis from Lanning (1994) are process skills, personalization skills, conceptualization skills, and professional behaviors. Prior to examining clinicians' perceptions of the supervisory relationship, snowball sampling was used to connect with participants who met the criteria for the study. The following research questions guided this quantitative study:

1. How much variance in the supervision working alliance is explained by a clinician's perception of the supervision emphasis?
2. Do clinicians who are supervised by Licensed Professional Counselors (LPCs) describe the supervision working alliance differently than clinicians who are supervised by supervisors with other mental health credentials?
3. Do clinicians who are supervised by supervisors who are responsible for hiring/terminating departmental staff and/or conducting performance evaluations describe the supervision working alliance as differently than clinicians who are supervised by supervisors who are not responsible for hiring/terminating and/or conducting performance evaluations?

Definition of Terms

The following terms are germane to this investigation and are defined to improve clarity and understanding.

Supervision – “An intervention that is provided by a senior member of a profession to a junior member or members of that profession. This relationship is evaluative, extends over time, and has the simultaneous purpose of enhancing the professional functioning of the junior member(s), monitoring the quality of professional services offered to the client he, she, or they see(s), and serving as a gatekeeper for those who are to enter the particular profession” (Bernard & Goodyear, 1992, p.4).

Clinician – For this study, the term “clinician” is used to identify any mental health professional (QMHP-A, QMHP-C, QMHP-E, and LHMP) working in a direct service capacity or providing services under a DBHDS/DMAS program in a private community-based mental health agency.

Stakeholder – An organization or entity that has a vested interest in another organization.

Supervisee – Clinicians and counselors who have completed university-level education, are employed by a mental health agency, are using counseling skills in direct work with clients, and whose work is monitored by a senior-level clinician (Association for Counselor Education, 1993).

Supervisor – A mental health professional who is designated within an agency to directly oversee the professional, clinical, and administrative work of mental health clinicians and counselors. Supervisors serve many capacities in an agency, but

typically are responsible for administrative, clinical, and licensure supervision (Association for Counselor Education, 1993).

Supervision Emphasis – The area of focus for supervision that aids in the development of clinical skills and counseling ability. Supervision emphasis can be categorized into four distinct areas:

- 1) Process skills: Focus on the interaction between the client and clinician/counselor
- 2) Personalization skills: Focus on the clinician/counselor and his/her beliefs and feelings
- 3) Conceptualization skills: Focus on the cognitive patterns and thought processes that are required to be an effective clinician/counselor
- 4) Professional behaviors: Focus on established behavioral and practice standards in the profession (Lanning, 1986).

Qualified Mental Health Professional (QMHP) - A DBHDS qualification that categorizes mental health clinicians by their education and level of experience. At a minimum, a QMHP is required to hold a bachelor's degree. Three QMHP categories exist:

- 1) QMHP–E (Qualified Mental Health Professional–Eligible)
 - A clinician can be considered a QMHP–E with a minimum of either a bachelor's degree in a non-human services field and one year of experience in direct mental health care, or a bachelor's degree in a human services field with less than one year of experience.
- 2) QMHP–A (Qualified Mental Health Professional–Adult)

- A clinician is considered a QMHP–A when he or she has at least a bachelor’s degree and one year of experience in direct mental health care with clients over the age of 18.

3) QMHP–C (Qualified Mental Health Professional–Children)

- A clinician is considered a QMHP-C when he or she has at least a bachelor’s degree and one year of experience in direct mental health care with clients under the age of 18 (Department of Behavioral Health and Developmental Services, 2014).

Working Alliance – “The supervisory working alliance is that sector of the overall relationship between the participants in which supervisors act purposefully to influence trainees through their use of technical knowledge and skill and in which trainees act willingly to display their acquisition of that knowledge and skill” (Efstation et al., 1990, p. 323).

Overview of the Methodology

This quantitative investigation was designed to assess clinicians’ perceptions of supervision emphasis and its influence on the supervisory relationship in private mental health agencies in Virginia. Participants for this study included mental health clinicians at the bachelor’s, master’s, or doctoral level who had been employed during the prior five-year period by a private mental health agency. A snowball sampling technique was used to identify as many qualified clinicians as possible to take part in this study. Specifically, participants were recruited through professional networks (Virginia Counselors Association, Virginia Association of Community-Based Providers), private community-based mental health organizations (National Counseling Group), and educational institutions (Virginia Tech and Radford University). A

recruitment e-mail, which included the purpose of the study, informed consent, benefits/risks, procedure for the study, and confidentiality, was sent to prospective participants. Two follow-up e-mails were sent to possible research participants in order to increase participation. Prior to undertaking this investigation, approval was obtained from the Virginia Tech Institutional Review Board (IRB).

As detailed in Chapter 3, an online survey was utilized to gather data. The survey included three sections: (a) the Supervision Emphasis Rating Form – Revised (SERF-R) (Lanning & Freeman, 1994), (b) the Working Alliance Inventory – Revised (WAI-R) (Horvath & Greenberg, 1989; Baker, 1990) and (c) a demographic questionnaire designed to gather information about age, gender, ethnicity/race, education, licensure status, and frequency/duration/format of supervision. SPSS was used to analyze the quantitative data with descriptive and inferential statistics.

Document Organization

This chapter provided a rationale for investigating clinicians' perceptions of supervision emphasis and its influence on the supervisory relationship in private mental health agencies in Virginia. Chapter One included a brief overview of the context and purpose of the study, the research questions, a definition of terms, and an overview of the methodology used in this investigation. Chapter Two provides an in-depth review of the literature in the area of supervision (administrative and clinical), community mental health organizations, and the role of managed care in supervision. Chapter Three includes the methodology utilized in this investigation, including the data collection methods, instrument, and data analysis. The fourth chapter details the results obtained from this quantitative investigation. Finally, Chapter Five

offers a discussion of the results, key findings, implications of the research, and suggestions for future studies.

CHAPTER TWO: REVIEW OF THE LITERATURE

History of Community-based Mental Health Treatment

A heartbreaking series of tragedies perpetrated by someone with a diagnosed mental illness (e.g., Virginia Tech, Sandy Hook Elementary School, and Umpqua Community College in Roseburg, Oregon) have focused media attention on the prevalence of mental illness in the United States (Metzl & MacLeish, 2015; Smith, 2013). Although the true number of individuals dealing with some form of mental illness may be impossible to know for certain, The National Institute of Mental Health (2012) reported that 18.6% of the adult population and 13.1% of the child/adolescent population in the United States has been diagnosed with a mental illness.

The prevalence of mental illness in this country has resulted in a variety of treatment options that continue to evolve as more is known about mental illness. The history of mental health treatment in the U.S. dates back to the 1800s when mental health institutions (or asylums) were common fixtures in many states. During the late 1800s, state mental institutions were overcrowded and patients were warehoused (often against their will) in de-humanizing, unsanitary and unsafe conditions (Timeline, 2002). The public's growing awareness of the abysmal state of mental health treatment led to the formation of the National Committee for Mental Hygiene—which is today known as Mental Health America—to advocate for better living conditions and care for the mentally ill (Mental Health America, n.d.).

In the first important legislative action legitimizing the needs of those with mental illness, President Harry S. Truman passed the National Mental Health Act in 1946, which established the National Institute of Mental Health (NIMH). It was the NIHM that started to fund essential research on the interaction of mind, brain, and behavior—although changes to treatment options

were slow in coming. In fact, the 1950s marked the peak of the institutionalization of mental health patients in asylums. As a result, a counter movement developed that cited existing mental health treatment therapies as causing more harm than good (Timeline, 2002). For example, in 1951 almost 20,000 frontal lobotomies were performed in the U.S. with typically devastating results, including severe brain damage and even death. Once antipsychotic medications came on the scene in the mid-1950s, lobotomies all but disappeared (Kalat, 2007). In addition to the development of drug therapies, the focus of mental health treatment in the 1960s was on moving people from an institutional setting back into the community, controlling psychiatric symptoms, and increasing stability in everyday life through a variety of interventions (Drake, Green, & Mueser, 2003). As the move toward de-institutionalization gained momentum, mental health treatment was moved to community-based facilities that offered psychiatric care and counseling (Timeline, 2002).

The second major piece of legislation advocating for those with mental illness became law in October 1963 when President John F. Kennedy signed the Mental Retardation and Community Mental Health Centers Construction Act, also known as the Community Mental Health Act. This act allocated money for the construction of community-based mental health centers designed to connect mental health clients with care options in their own communities. This act was in direct support of the de-institutionalization of mental health clients and the development of holistic care, including psychiatric, counseling (mental health and addictions), and case management (National Council for Behavioral Health, n.d.). Indeed, the “modern” concept of community-based mental health treatment developed out of the need to provide comprehensive care to clients who were affected by the de-institutionalization of state-run mental health asylums.

The community-based mental health centers envisioned by President Kennedy are still in existence today—although the focus of treatment has moved from mere symptom management to multifaceted healing strategies that include medication interventions, counseling, self-help techniques, and increased independence (Drake et al., 2003). This type of “managed care” was introduced into mental health services in the late 1980s. Important for this investigation is that this diversification also included the ability for private community-based mental health providers to deliver services to mental health clients (National Council for Behavioral Health, n.d.). Managed care organizations also introduced several important resources into the management of mental health services, which include the ability to negotiate fees, incentives for organizations to participate, and information-management systems. In addition, more organizations were authorized to deliver mental health services with certain caveats, such as pre-authorization requirements, a regular review of services, and the establishment of a predetermined network of providers (Essock & Goldman, 1995). Compared to the early (and horrific) history of mental health treatment in this country, there have been “truly remarkable advances in mental health intervention of the past 40 years” (Drake et al., 2003, p. 3).

Defining Private Mental Health Agencies in Virginia

Approximately 1.5 million Virginia residents are living with a diagnosed mental illness, which is a mental disorder that appears in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). The DSM is the standard classification of mental disorders utilized by mental health professionals in the U.S. across all clinical settings and regardless of their theoretical orientations. Included in that number are 300,000 people who have been diagnosed with a serious mental illness, which is one that impairs everyday functioning (National Alliance on Mental Illness, 2011). For Virginia residents who seek mental health treatment, the

system is a complex network of inpatient psychiatric hospitals, and public and private community-based providers that includes non-profit and for-profit agencies.

The Department of Behavioral Health and Development Services (DBHDS) lists a total of 498 public and private community-based mental health agencies in the Commonwealth of Virginia. Of those 498 providers, 40 are public community services boards (CSBs) and 458 are private mental health providers (Virginia Department of Behavioral Health and Developmental Services, 2015). Because they are funded by the Department of Medical Assistance Services (DMAS) with federal and state monies, CSBs are contractually mandated to provide mental health, substance abuse, and intellectual disability services to anyone in need. The 2015 Overview of Community Services states:

CSBs function as the single points of entry into publicly funded mental health, developmental, and substance abuse services, defined in § 37.2-100 of the Code of Virginia. This includes access to state hospital and training center services through preadmission screening, case management, services coordination, and discharge planning.

- CSBs are service providers, directly and through contracts with other providers.
- CSBs serve as advocates for individuals who are receiving or are in need of services.
- CSBs act as community educators, organizers, and planners.
- CSBs function as advisors to the local governing bodies that established them.
- CSBs are the local focal points for programmatic and financial responsibility and accountability (p. 2).

In 2014, a total of 401,346 individuals received services from CSBs in Virginia: 182,424 received clinical mental health services, 45,001 received substance abuse services, 27,887

individuals participated in developmental services, and the remaining 146,034 individuals utilized emergency/ancillary services. In addition, CSBs brought in a total of 27% of the monies paid out by Medicaid in Virginia for mental health, developmental, and substance abuse services, which amounted to \$348,474,768 in 2014 (Virginia Department of Behavioral Health and Developmental Services, 2015).

In contrast, private mental health providers collected 73% (\$931,308,616) of Medicaid monies paid out for mental health services in Virginia. As such, private agencies represent a powerful force on the Virginia mental health scene. In fact, it was reported in the 2015 Overview of Community Services that "...private providers are vital partners and major resources in serving individuals with mental health or substance use disorders or intellectual disabilities. Besides serving many individuals through contracts with CSBs, private providers serve thousands of other individuals directly" (p. 19). Private providers differ from CSBs in that they are not funded by DBHDS/DMAS, are not required to provide mandated services such as emergency services and case management, and are subject to an application process by the DBHDS (Virginia Department of Behavioral Health and Developmental Services, 2015). Specifically, private community-based mental health providers in Virginia are licensed by DBHDS and are subject to an application process that involves an initial application, approval by the local Human Rights Committee, and an on-site review (Department of Behavioral Health and Developmental Services, 2014). Typically, private providers in Virginia are licensed to deliver mental health, substance abuse, intellectual disability, developmental disability, and/or brain injury services. In addition, DBHDS licenses private providers to deliver other specialized services including crisis stabilization, therapeutic day treatment, intensive in-home counseling, residential treatment, substance abuse treatment, and a variety of other services. DBHDS also

defines the qualifications of the staff, supervision required, and procedures for each service (Department of Behavioral Health and Developmental Services, 2011).

An example of a service provided by private community-based mental health providers under a DBHDS license and DMAS regulations is intensive in-home counseling. Such services would be available to children and adolescents who have been diagnosed with a serious mental illness or who have been determined, by assessment, to be at risk of developing mental illness. Intensive in-home counseling is provided to clients who are under the age of 21, at risk for out-of-home placement, or are transitioning back to home after a residential placement. The services provided under the umbrella of intensive in-home counseling include case management, family counseling, individual counseling, crisis management, and coordination of care. In order to qualify for services, clients must show “a clinical necessity for the service arising from a severe condition due to mental, behavioral, or emotional illness that results in significant functional impairments in major life activities” (Department of Medical Assistance Services, 2014, p. 8). Eligible clients demonstrate a clinical necessity for services by showing impairment in two of the following areas: difficulty establishing and maintaining relationships, consistent need for interventions by judicial services, mental health, or social services, and/or be unable to recognize “inappropriate social behavior” (p. 8) and potentially dangerous situations (Department of Medical Assistance Services, 2014).

In order for a child/adolescent client to qualify for intensive in-home counseling, a licensed mental health provider must conduct an independent clinical assessment that includes determining presenting issues, developmental history, drug/alcohol use, educational status, legal issues, mental health history, and medical history. Ultimately, a diagnosis is made using the DSM-5 (American Psychiatric Association, 2013). Once the clinical assessment has been

completed, the case is assigned to a clinician who is responsible for direct clinical care and all documentation. Intensive in-home services are conducted under the guidance of an individualized service plan, which details the goals, objectives, and interventions to be utilized during the service. Additionally, the client, clinician, and responsible family members are mandated to meet a minimum of three hours a week, but no more than ten hours per week. Intensive in-home services must take place in the client's residence unless it is deemed that the residence is unsafe; in such cases the services can take place in the community (Department of Medical Assistance Services, 2014).

Classification of Clinicians by DBHDS and DMAS

DBHDS and DMAS classify clinicians based upon their education and experience through the classification of Qualified Mental Health Professional (QMHP) and Licensed Mental Health Professional (LMHP). DBHDS defines a QMHP as "...a person in the human services field who is trained and experienced in providing psychiatric or mental health services to individuals who have a mental illness" (Department of Behavioral Health and Developmental Services, 2014, p. 20). Within the category of QMHP there are three separate classifications: Qualified Mental Health Professional–Adult (QMHP–A), Qualified Mental Health Professional–Child (QMHP–C) and Qualified Mental Health Professional–Eligible (QMHP–E). A clinician qualifies for QMHP status by having, at a minimum, a bachelor's degree in a human services field (psychology, sociology, education, or a related field) and one year of direct mental health experience. The difference in the designation between a QMHP–A and QMHP–C is whether the year of experience was with children/adolescents or adults. In addition, the QMHP–E designation is given to a clinician who has either, at a minimum, a bachelor's degree in a human services field—but does not have a full year of direct mental health experience with either

children or adults—or has a full year of experience with the designated population and has a bachelor’s degree in a non-human services field. A QMHP-E requires an extra hour of supervision per week with a licensed practitioner.

The designation of LMHP is a DBHDS and DMAS qualification that is utilized for a clinician who is certified by the appropriate regulatory board through the Virginia Department of Health Professions. LMHPs include a wide range of service providers: licensed professional counselors, licensed clinical social workers, licensed clinical psychologists, psychiatrists, medical doctors, psychiatric nurse practitioners, psychiatric registered nurses, or licensed marriage and family therapists. In addition, the designation of Licensed Mental Health Professional–Eligible (LMHP–E) is assigned to professionals who are registered with the appropriate regulatory board under the Department of Health Professions, and are under the supervision of an LMHP (Department of Behavioral Health and Developmental Services, 2014; Department of Medical Assistance Services, 2014).

The definition and classification of a clinician—not to mention the education and experience to qualify as such—varies considerably between professional counseling organizations, community-based mental health agencies (public and private), and licensing regulatory boards. DBHDS and DMAS created the qualification of QMHP and LMHP as a way to specify the professional credentials needed to provide certain services in Medicaid-funded programs in community-based mental health agencies (Department of Medical Assistance Services, 2014). The Virginia Board of Counseling, which is the entity responsible for licensing counselors in Virginia, states on its website that the term “license eligible” is not recognized (Virginia Board of Counseling, n.d.). Moreover, the lack of consistency in the definition and classification of the term “clinician” between entities involved in the regulation of mental health

services creates dissonance and confusion among stakeholders, clinicians, and clients.

History of Supervision

Supervision in mental health counseling is a complex concept that has differing definitions depending upon the educational or clinical delivery setting. The term also has specific connotations according to the agency defining it. Although DMAS, DBHDS, the Association of Counselor Education and Supervision (ACES), and the American Counseling Association (ACA) may denote differing characterizations as to the content, delivery, and focus of supervision, the history of the development of supervision in the mental health arena shares a common etymology. The meta-concept of “supervision” can be separated into two principal components: super and vision. Essentially, these components refer to a senior member of the profession with postgraduate training in supervision theory, process, and application. This person is committed to building a professional relationship with a supervisee, and is responsible for the oversight of that individual’s clinical work (Bradley, 1989; Leddick & Bernard, 1980).

The history of supervision in mental health counseling can be traced to major theorists, such as Freud and Jung, who trained their apprentice counselors according to burgeoning theories in the field. When an apprentice counselor began studying under a major theorist, he or she was responsible for sharing the intricacies of the particular theory and the mode of delivery for therapy. As supervision evolved during the early stages, supervisors worked without definitive models or guidelines that outlined the process of supervision (Leddick & Bernard, 1980). The process of supervision evolved in a parallel process to the development of therapeutic theories, models, and techniques. Carroll (2007) defined the history of supervision in three distinct eras: (a) psychotherapeutic techniques, (b) cognitive, behavioral and humanistic models, and finally, (c) as a modality separate from the clinical counseling process. According

to Bradley (1989), the psychotherapeutic model of supervision—the first model to be developed—had the largest clinical following (Bradley, 1989).

Contemporary supervision models can be traced back to the beginning stages of counseling and psychotherapy (Bradley, 1989); however, the definition, process, and expectations of the supervision process continue to evolve with the changing face of counseling and mental health treatment. In the modern era of supervision, different models—including the discrimination, systems approach, and Hawkins model—provide a foundation for understanding the process and purpose of supervision (Bernard & Goodyear, 2014). As our grasp of the etiology of mental health disorders and treatment protocols continue to evolve with the development of community-based mental health practices and the standardization of curriculum to train both counselors and counselor educators, the definition of supervision has been adapted by different educational, community, and mental health organizations.

Definition of Supervision

Supervision is an essential component for developing the counseling skills, competence, and professional identity of counselors and clinicians (Bernard & Goodyear, 2014). The problem is that it is difficult to define supervision due to the fact that “...supervision may mean different things in different contexts, all of which may have a bearing on where emphasis is placed and how supervision is effected” (Creaner, 2013, p. 7). With the history of supervision closely connected to the evolution of counseling theory, a developmental definition of supervision can be traced through a similar lineage (Creaner, 2013). Moreover, a working definition of supervision is confounded by the different types of supervision needed in field of mental health treatment: clinical, administrative, individual, group, and peer (Bernard & Goodyear, 2014; Creaner, 2013). In addition to the different types of supervision required in mental health

counseling and treatment settings, organizations are defining the practice of supervision differently depending on the specific thrust of each—be it counselor education, community-based mental health, private practice, Medicaid-serving agencies, as well as entities such as ACA and ACES.

As the fields of counseling and mental health services have evolved, so has an operational definition of supervision. For example, Boyd (1978) introduced a three-part definition of supervision: (a) it is conducted by a senior member of the profession who is trained in supervision, (b) supervision work focuses on both professional and personal aspects of counseling, and (c) the supervisor is responsible for oversight of practice by the supervisee. Since that time, the field of counseling supervision has evolved and grown in importance—and with those changes has come a more nuanced definition of supervision. In the field of counseling and counselor education, the following definition of supervision proposed by Bernard and Goodyear (1992) is now widely accepted (Bernard & Goodyear, 2014):

Supervision is an intervention provided by a more senior member of the profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession. This relationship

- is evaluative and hierarchical
- extends over time, and
- has the simultaneous purposes of enhancing the professional functioning of the more junior person(s): monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as a gatekeeper for the particular profession the supervisee seeks to enter. (p. 9)

Important in this definition is that Bernard and Goodyear (2014) expanded the concept of

supervision by including both the notion of continual gatekeeping throughout a supervisor's relationship with a supervisee, and that a professional outside the counseling field (e.g., social workers, psychologists, etc.) can and do provide skilled supervision.

Community-based mental health agencies in the Commonwealth of Virginia are responsible for following regulations and licensing standards set forth by the state licensing board, managed care organizations (Magellan/Medicaid), and state behavioral health organizations. Because the definition of supervision can vary between these organizations, it is the responsibility of the agency providing services to ensure that the supervision being delivered meets the accountability requirements for all entities. For example, DMAS is tasked with administering Virginia's Medicaid program and provides the regulations for reimbursement, treatment regulations, and program oversight for all providers, including private community-based mental health agencies (Department of Medical Assistance Services, 2014). Supervisory practices in DMAS community-based mental health agencies are not guided by an overarching, all-encompassing definition; rather, the concept of supervision is based upon the clinician's status as a qualified mental health professional (QMHP) and the specific programs offered at the facility (therapeutic day treatment, crisis intervention, intensive in-home counseling, etc.). An example of a task-oriented definition of supervision is linked to DMAS children's residential services:

Supervision is demonstrated by the QMHP by a review of the progress notes, the member's progress towards achieving ISP goals and objectives, and recommendations for change based upon members status. Supervision must occur and be documented monthly in the clinical record. (DMAS, 2014, pp. 9-10)

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) is

the entity in Virginia responsible for licensing private mental health providers. DBHDS (2013) issues licenses to mental health providers who "...offer services to individuals who have mental illness, mental retardation (intellectual disability), or substance abuse (substance use disorders); or have developmental disability" (p. 9). As such, all private mental health providers have to apply to DBHDS and go through a rigorous screening process before they are sanctioned to deliver mental health services. In addition, DBHDS sets standards for supervision for the different programs it licenses in Virginia, such as intensive in-home counseling, therapeutic day treatment, partial hospitalization, and addiction services. Similar to DMAS, DBHDS does not precisely define supervision; rather, it provides a outline for each service for the tasks required to meet licensure standards for supervision. Supervision tasks required by DBHDS include developing a supervision plan for each DBHDS program that outlines how staff will be supervised and how supervision will be documented. DBHDS also requires a review of client assessments, documentation, and individualized service plans. In addition, the DBHDS (2013) provider manual states the following:

Supervision of mental health, substance abuse, or co-occurring services that are of an acute or clinical nature such as outpatient, inpatient, intensive in-home, or day treatment shall be provided by a licensed mental health professional or a mental health professional who is license-eligible and registered with a board of the Department of Health Professions. (p. 26)

In addition to abiding by the regulations set forth by DMAS and DBHDS, private community-based mental health agencies who employ licensed or license-eligible clinicians also must abide by the Department of Health Professions (DHP) regulations. DHP is the entity responsible for issuing professional licenses in the Commonwealth of Virginia for doctors,

dentists, social workers, and counselors. The Virginia Board of Counseling (VBC) is housed under DHP and in addition to establishing laws and regulations, also has oversight over the licensed professional counselor endorsement. According to the VBC (2014), a professional counselor is a person who has received master's degree-level training in the theories and the application of techniques in order to counsel individuals, families, and groups toward the alleviation of mental, emotional, and behavioral issues. The Virginia Board of Counseling (2014) defines supervision as "the ongoing process, performed by a supervisor, of monitoring the performance of the person supervised and providing regular, documented individual or group consultation, guidance, and instruction with respect to the clinical skills and competencies of the person supervised" (p. 3). Supervision in this context is exemplified in private community-based mental health agencies when a resident in counseling (an individual who has applied to the Board of Counseling for residency and supervision), and is under a supervision contract, is employed by an agency (Virginia Board of Counseling, 2014). Thus, not only are the counseling supervisor, resident counselor, and agency responsible to licensing agencies, regulatory boards, and reimbursement sources, these entities also have an ethical responsibility to follow guidelines set forth by the American Counseling Association.

Although the ACA has no direct, legal oversight over private community-based mental health agencies, those who define themselves as counselors and are members of the organization are obligated to abide by the ethical codes set forth by the ACA. These codes serve to inform ethical decision making, support the practice of counseling, help with the decision-making process, and ensure ethical practice of counselors and counselors-in-training (American Counseling Association, 2014). The primary purpose of supervision, according to the ACA (2014), is to "...monitor client welfare and supervisee performance and professional

development” (p.12). In order to accomplish these tasks, the supervisor must meet with the supervisee regularly, provide feedback on work, and help the supervisee diversify skills to serve a wider range of clients. The ACA provides the following guidelines for supervision: the counseling supervisor must be trained in supervision methods and techniques, address multicultural issues during supervision, ensure supervisee competence with the ethical code and its application, and monitor the boundaries of the supervisory relationship (American Counseling Association, 2014).

The Association of Counselor Education and Supervision (ACES) is a division of the ACA; its primary purpose is to “advance counselor education and supervision in order to improve the provision of counseling services in all settings of society” (ACES, 2011, p. 1). In 2011 an ACES taskforce developed best practices for clinical supervision of counselors, which featured three distinct thrusts: administrative, clinical, and programmatic supervision. Administrative supervision focuses on “...those supervisory activities which increase the efficiency of the delivery of counseling services” (Association of Counselor Education, 2011, p.1). Clinical supervision is defined as “...the supportive and educative activities of the supervisor designed to improve the application of counseling theory and technique directly with clients” (Association of Counselor Education, 2011, p. 1). The third thrust, programmatic supervision, is defined as “...having a systems focus with program improvement and counselors' professional development as its purpose” (Association of Counselor Education, 2011, p. 1). This tri-part definition of supervision supports a more nuanced approach to the practice and can serve as a basis for a tasks, bonds, and process approach to counselor supervision.

Variations in Supervision: Administrative and Clinical

While DMAS and DBHDS provide a task-oriented, administrative definition for

supervision that includes a review of documentation and monitoring of client care, there is no direct reference to the need to develop and monitor a clinician's growing skills. The contemporary counseling literature has explored the differences between administrative and clinical tasks in the supervisory process (Bernard & Goodyear, 2014; Henderson, 2009; Tromski-Klingshirn & Davis, 2007). State regulatory boards (DBHDS and DMAS) play a crucial role in defining the meta concept of supervision for mental health agencies in terms of the experience and education of the supervisor, the amount of supervision required, and how supervision is to take place (Bernard & Goodyear, 2014). However, defining both clinical and administrative supervision is difficult due to the lack of intersection between the community mental health and contemporary counseling literature. Nonetheless, the literature assessments of these essential forms of supervision will be explored in order to further enrich and define the concepts of clinical and administrative supervision in counseling and mental health services.

Administrative Supervision

Defining administrative supervision is difficult due to the overlap in supervision processes with clinical supervision, as well as the fact that administrative supervision is mentioned in the counseling literature more in the form of practice than as a foundational concept (Henderson, 2009). Although DMAS and DBHDS do not directly identify supervision or supervisory tasks as either clinical or administrative, the tasks listed in regulations tend to be administrative in nature, such as reviewing progress notes, conducting assessments, and formulating individualized services plans during weekly supervision sessions (Department of Behavioral Health and Developmental Services, 2014; Department of Medical Assistance Services, 2014). Bernard and Goodyear (2014) stated that while the clinical supervisor may also have administrative functions, a true administrative supervisor is focused on "...matters such as

communication protocol, personnel concerns, and fiscal issues” (p. 132). Thus, the administrative supervisor in private community-based mental health agencies views the process of supervision from an agency point of view, wherein the primary focus is not on the intricacies of the counseling process (Bernard & Goodyear, 2014; Falvey, 1987; Tromski-Klingshirn, 2006). In fact, administrative supervisors are typically managers who are responsible for tasks such as those listed in the DBHDS and DMAS regulations. They are viewed as “the boss” (Tromski-Klingshirn & Davis, 2007, p. 295), administering regulations of the agency, supervising staff, and guiding the agency in day-to-day operations (Henderson, 2009). As reported by Kadushin (1992), the task of administrative supervision is concerned with the “correct, effective and appropriate implementation” (p. 20) of guidelines set forth by licensing boards, agencies, and other stakeholders. Administrative supervision tends to be task-focused and encompasses one or more of the following duties: reviewing progress notes, enforcing agency guidelines, carrying out fiscal responsibilities, recruiting/retaining staff and conducting performance evaluations, and ensuring that minimum care requirements are being met per stakeholder requirements (Tromski-Klingshirn & Davis, 2007).

In the most basic terms, the role of an administrative supervisor can be thought of as “ensuring adherence to policy and procedure” (Kadushin, 1992, p. 14). Along with balancing the protocols set forth by the agency and meeting clinician needs, the administrative supervisor must also be familiar with the guiding principles of the agency to ensure compliance with the agency mission. The goals of administrative supervision are derived directly from the role definition and include supporting clinicians in providing the best care possible to a diverse caseload of clients—but all the while complying with agency guidelines and policies and adhering to administrative protocols (Henderson, 2009).

As indicated above, one of the key components of effective administrative supervision is balancing agency requirements with the supervision of clinicians. Henderson (2009) described the juggling act in the following way:

Effective administrative supervision entails balancing the interests of clients, professional counselors and other staff members, and their agencies; balancing the priorities of performance quality with the expectations for quantity of services; and balancing effectiveness of services with delivery system efficiency. (p. 3)

First and foremost, administrative supervision in private mental health agencies fulfills a necessary role by ensuring agency-wide compliance with DBHDS and DMAS policies and procedures in the form of reviewing progress notes, ensuring compliance with standards, and overseeing service delivery.

Clinical Supervision

Clinical supervision has been clearly distinguished from the practice of counseling and the process of administrative supervision. In fact, the recognition of clinical supervision as a distinct focus through the Standards for Counseling Supervision (1990) and the Supervision Best Practice Guidelines (2011) has enabled the fields of counseling and counselor education to further advance our understanding of clinical supervision. In general, the focus of clinical supervision includes professional development, increasing counseling skills, promoting interpersonal processes, and defining case conceptualization. As such, clinical supervision serves as the foundation for developing clinical skills, ensuring best practice with client care, and supporting clinicians in their professional development. In addition, proper clinical supervision has been shown to increase clinician self-efficacy (Falender & Shafranske, 2004), which is then likely to have a direct impact of the quality of care that clients receive (Barnett, Cornish,

Goodyear, & Lichtenberg, 2007; Ladany, Walker, & Melincoff, 2001). Clinical supervision is evidenced in practice in similar ways across the fields of psychology, social work, and counseling (Bernard & Goodyear, 2014), and which generally engages clinicians in a process that generates new skills, ideas, and functions—sometimes by creating uncertainty to necessitate change (Shulman, 2005). Indeed, clinical supervision has been described as the single most important mechanism for the dissemination of technique, theory, and skills in the counseling profession (Shulman, 2005).

Both administrative and clinical supervision share the characteristics of being evaluative, having a power component to the relationship, not being time-limited, and featuring a responsibility for reviewing clinical documentation. In contrast, clinical supervision is differentiated from administrative supervision in that the supervisor's focus may be on the clinician's interpersonal process in working with clients and how clients may bring up issues in counseling (Falender & Shafranske, 2004). In addition, clinical supervisors can change the focus of supervision by alternating the roles they undertake—including teacher, counselor, and consultant (Bernard & Goodyear, 2014; Borders et al., 2014). Falender and Shafranske (2004) stated that clinical supervision has the tasks of "...observation, evaluation, feedback, facilitation of supervisee self-assessment and acquisition of knowledge and skills by instruction, modeling, and mutual problem solving" (p. 3). Similarly, Tromski-Klingshirn and Davis (2007) reported that the goal of clinical supervision is focusing on the professional development of the clinician by increasing his or her knowledge base, helping the supervisee develop a theoretical orientation and applicable techniques, and overseeing the safety of all clients with whom the clinician interacts. According to Bernard and Goodyear (2014), the purpose of clinical supervision is twofold: to increase a clinician's sense of professional identity and sense of professional self

through increasing autonomy, and ensuring the safety and clinical welfare of all clients.

The Association of Counselor Education and Supervision published the Best Practices in Clinical Supervision in 2011 to support the further distinction of clinical supervision as a separate practice. The best practices document provides “minimally acceptable” (p. 29) guidelines for the delivery of clinical supervision, as well as establishes education and research protocols in the area of supervision (Borders et al., 2014). Specific criteria are given for cultivating the supervisory relationship by developing supervision goals and evaluation strategies, providing feedback, promoting ethical practices and ensuring diversity, and by documenting the supervisory relationship in answerable ways. In addition, the best practice document supports Bernard & Goodyear’s (2014) assertion that the supervisor role is best supported by the functions of teacher, counselor and consultant.

The Administrative/Clinical Supervision Overlap

Despite the fact that the counseling literature is increasingly distinguishing the two facets of supervision, administrative and clinical, in most private community-based mental health agencies there is often no differentiation between the two outside of licensure supervision. Indeed, regulations for private community-based mental health agencies do not separate the concept of supervision into administrative and clinical tasks. In general, supervision as practiced in these settings provides the foundation from which adherence to protocols and agency policies can be monitored, as well as facilitates professional development opportunities for clinicians. In wearing their two hats, supervisors are responsible for reviewing progress notes, creating individualized service plans, monitoring client welfare, helping to develop the clinical skills of their supervisees and ensuring their professional development, as well as adhering to DMAS and DBHDS standards. Therefore, given this lack of differentiation between administrative and

clinical supervisors in the private agency setting, the term “supervisor” will be used herein to reflect both the administrative duties mandated by DBHDS and DMAS, as well as the clinical supervision component comprising skills/professional development. Analogously, the term “clinical supervision” will be used to define the all-inclusive supervision taking place in private community-based mental health agencies in Virginia.

Implications for Dual Roles in Supervision

As noted earlier, the division of supervision into two distinct components has been readily explored in the available literature. Interestingly, however, there is a common thread in the literature that it is difficult to entirely separate administrative and clinical supervision into two distinct components—but that problems can arise by *not* distinguishing the two. As Bernard and Goodyear (2014) stated, “There is a strong and necessary component to clinical supervision that is managerial in nature, thus requiring organizational skills that are similar to those used by administrative supervisors.” The Association of Counselor Education and Supervision (1993) supports educating the supervisee about the dual role of the supervisor with the following statement:

Supervisors who have multiple roles (e.g., teacher, clinical supervisor, administrative supervisor, etc.) with supervisees should minimize potential conflicts. Where possible, the roles should be divided among several supervisors. Where this is not possible, careful explanation should be conveyed to the supervis[e]es as to the expectations and responsibilities associated with each supervisory role. (Guideline 2.09)

While the literature does not directly address the separation of clinical and administrative supervision into two distinct entities in private community-based mental health agencies, researchers have explored counselor perceptions of the dual roles of supervision, counselor

views of negative supervision and its influence on the supervisory relationship, and how administrative and clinical supervision are defined in counseling.

Issues arise when supervisors are required to assume the role of both administrative and clinical supervisor (Kadushin, 1992; Kadushin, 1992(b); Tomski-Klingshirn, 2007). Separating the two supervision realms will facilitate greater autonomy in the supervision roles, lessen the power differential between supervisor and supervisee, and allow the supervisor more freedom to function in the selected supervision role (Kadushin, 1992). In addition, the dual role of a single supervisor serving as both the administrative and clinical supervisor brings to the forefront a “potential ethical challenge,” which has the potential to negatively impact client welfare and supervisee development (Tomski-Klingshirn & Davis, 2007, p. 294). In a quantitative study conducted by Tomski-Klingshirn and Davis (2007) with counselor residents (counselors registered with a state regulatory board and under supervision for licensure), it was found that 49% of the counseling residents had supervisors who functioned as both clinical and administrative supervisors. Among the counseling residents who were supervised by a dual-role supervisor, 82% reported the duality as being a non-issue. When questioned as to why it didn’t present a problem, one participant stated the following: “Management is simple. The supervisor makes the rules, and we follow—simple” (p. 301). Although this simplistic interpretation might have been accurate, it does show a lack of understanding for the complexity of the duality. For respondents who did note the dual supervision issue as problematic, the following reasons were given: fear of professional retaliation, use of supervisory power for negative purposes, and conflict between administrative and clinical duties (Tomski-Klingshirn & Davis, 2007).

The ethical issues that dual-role supervisors face can negatively impact the relationship that they build with their supervisees. In order for a clinical supervisor to fully function in the

role, a relationship built upon non-judgment and with full clinical disclosure must be established. In contrast, a supervisor who works in a dual role may have limited access to the full scope of a supervisee's work due to the latter's hesitancy to fully disclose due to the power differential in the administrative role. Although the supervision role already has inherent power, when both clinical and administrative roles are combined that power differential becomes more pronounced (Tromski-Klingshirn, 2006). Tromski-Klingshirn (2006) acknowledged the ethical dilemma of wearing two supervisory hats: "In terms of counselor supervision practice it seems there is an inherent dilemma: the ethics appear to be in conflict with current practice reality, in that nearly half of the clinical supervisors are also administrative supervisors" (p. 61). This study highlights the difficulty that may be present in private community-based mental health agencies due to combining administrative and clinical supervision tasks, such as ethical dilemmas, clinicians who are hesitant to readily disclose, and unbalanced supervisory relationships.

The issue of the dual supervisory role is not unique to the counseling profession. Kadushin (1992) explored both the positive and negative aspects of the supervisor role in a qualitative study involving social work supervisors and supervisees. Participants were asked to complete a questionnaire regarding the strengths and weaknesses in the functions and structures of supervision. Supervisor responses about the shortcomings of the supervision process were most often related to the administrative duties required in supervision (review of paperwork, staff management, etc.). Negative comments include the following: "My disdain for bookkeeping, quality assurance, red tape is one of my principal shortcomings" (p. 12), and "I hate having to reprimand and discipline a supervisee" (p. 11). The latter statement could be especially problematic in that Kadushin (1992) asserted: "Strong supervisors are perceived as competent in implementing the instrumental and expressive requirements of supervision, manifesting practice

expertise and relationship skills” (p. 18). The strongest supervisors are those seen as capable of handling both the administrative and clinical duties with equal competence in the supervisory relationship. In private community-based mental health agencies, supervisors are often responsible for hiring and firing, evaluating clinicians, and facilitating professional and clinical development. The above-mentioned study highlights the difficulty supervisors may have with dual supervisory roles that require mastery of all supervisory tasks.

In a qualitative study conducted by Magnuson (2000), the experiences of 11 counselors and counselor educators were examined to understand the outcomes of “counterproductive” (p. 1) (i.e., lousy) supervision. One of the themes that emerged from the study indicated that supervision tended to be too highly focused on one area and was “unbalanced”: “We’re overbalanced or over functioning in that one area, but we don’t have a good, balanced way of thinking about what’s going on” (p. 2). Another theme that emerged in connection with lousy supervision was understanding the development of supervisees and how the needs in supervision may change. Supervision is a “dynamic process” (p. 3) where the content changes based upon the needs of the supervisee, client, and supervisory relationship. Lousy supervision can occur when the supervisor fails to allow the supervision session to change based upon the needs of the supervisee, and/or the same content is covered in supervision in a repetitive process (Magnuson, 2000). DMAS regulations for supervision indicate that the same tasks should be accomplished in supervision on a weekly basis and be centered on a review of clinical documentation. Private community-based mental health agencies are bound by these regulations, which unfortunately allow little room for balanced supervision to occur in adapting to the needs of clinicians.

In summary, DMAS and DBHDS regulate supervision for mental health programs at private community-based agencies with guidelines that speak to the credentials of the supervisor,

the frequency of supervision, and the tasks to be accomplished during supervision. The tasks mentioned in the regulations include review of progress notes, development of individualized service plans, and assessment of client progress (Department of Behavioral Health and Developmental Services, 2014; Department of Medical Assistance Services, 2014). No additional guidance as to the content or process of supervision is provided. In contrast, the professions of counseling, social work, and psychology define supervision with much greater breadth—and importantly, focuses primarily on the development of the supervisee. While some licensure regulations stress that the focus of supervision should be on supervisee development, DMAS and DBHDS accentuate a task-focus for supervision. Important for this investigation is that little is known about how supervisors in private community-based mental health agencies determine the focus for supervision, how clinicians experience that focus, and how the focus of supervision affects the working alliance.

Supervision Standards in Private Community-based Mental Health Agencies

Supervision regulations in private community-based mental health organizations are determined by DBHDS, DMAS, as well as by the individual organization. The standards set forth by DBHDS and DMAS are the minimum standards that community-based mental health organizations must meet for providing supervision for clinicians in order to meet licensure and Medicaid requirements. DBHDS supervision standards are general and address supervision in either acute or support programs. DMAS supervision standards differ from program to program, as do the credentials required for the counselor providing the supervision (Department of Behavioral Health and Developmental Services, 2014; Department of Medical Assistance Services, 2014). In contrast, the focus of supervision and external review of documentation is not mentioned. In addition, individual organizations can develop stricter supervision standards

to coincide with the requirements set forth by managed care organizations and licensing entities.

DMAS provides both general supervision guidelines as well as program specific guidelines for all covered services. If a community-based mental health agency is providing services and is being reimbursed for services by a DMAS managed care organization, then the agency is required to document in the clinical record the supervision of clinicians working in licensed programs. Moreover, the supervision record is required to include a review of documentation including progress notes, individualized service plans, and goals/objectives. Regulations state that individual supervision is to occur on a monthly basis and no duration for supervision is designated. If a clinician is working as a QMHP-E, they are required to have an additional one hour a week of individual supervision and participate in on-site supervision where the designated supervisor directly observes the clinician at work. In addition, the clinician is required to have a total of one hour of additional training per month on topics relevant to the program (Department of Medical Assistance Services, 2014).

DMAS also defines the supervision guidelines for specific programs in community-based mental health agencies. These guidelines can vary based on whether the program is acute or supportive in nature, and the intensity and duration of the service. An example of a DMAS program is intensive in-home counseling (IIH), which is an acute program that requires supervision by a LMHP or LMHP-E. The supervisor is mandated to supervise no more than ten QMHP-C clinicians, and of those ten, only one clinician may be under supervision as a QMHP-E. Each clinician is required to have weekly individual supervision of an undetermined length, and the supervision session must be documented in the clinical record. In addition, the supervisor is required to keep detailed supervision notes in a separate clinician file. The DMAS regulations align with the supervisor's professional affiliation (e.g., American Counseling

Association, National Association of Social Workers, and the American Association for Marriage and Family Therapy) in that the supervisor is to practice within the scope of competence and follow the ethical standards of their identified association (Department of Medical Assistance Services, 2014).

In addition to the requirements set forth by DMAS, private community-based mental health agencies with programs licensed by DBHDS are required to abide by the guidelines set forth in DBHDS regulations. DBHDS provides a broad set of guidelines for private community-based mental health agencies (in contrast, DMAS provides more specific requirements for each program). The broad regulations include a description of how the agency will provide supervision, such as ensuring that the assigned supervisor has experience working with the population they are supervising, approving assessments, creating individualized service plans and other documentation, and documenting supervision in the clinical record. In addition, if the supervisor is working in a clinical service—including outpatient counseling, crisis stabilization, or intensive in-home counseling—then the supervisor must be an LMHP or LMHP-E (Department of Behavioral Health Services, 2014).

The Impact of Supervision on the Outcome of Therapy

Assessing the therapeutic outcomes of clients has been referred to as the “acid test” for measuring the effectiveness of clinical supervision (Ellis & Ladany, 1997, p. 485). In order to truly understand the effects of clinical supervision on client outcomes, methodically-sound research with diverse client populations needs to take place. However, Bernard and Goodyear (2014) reported that conducting such investigations may be difficult due to the lack of instruments and the shortage of prior research on the topic. In addition, measuring the effect of supervision on client outcomes is difficult due to the multiple factors that influence the

supervisory relationship, the counseling relationship, and eventual outcomes. These factors include the culture and gender of both the counselor and supervisor, the focus of supervision, the supervisor's style and modality, the personalities of all parties, and the interventions and case conceptualization ability of the counselor (Bernard & Goodyear, 2014). Despite the admitted difficulty of conducting research in this area, it is becoming increasingly important to understand the influence of supervision on client outcomes due to the pressure for evidence-based practice and data-driven interventions and modalities (Watkins, 2011).

Over the last 30 years, 18 separate studies representing a variety of fields (e.g., counseling, social work, and nursing) have examined the effectiveness of clinical supervision in relation to client outcomes,(Alpher, 1991; Bambling, King, Raue, Schweitzer, & Lambert, 2006; Bradshaw, Butterworth & Mairs, 2007; Couchon & Bernard, 1984; Dodenhoff, 1981; Friedlander, Siegel, & Brenock, 1989; Harkness, 1995; Harkness, 1997; Harkness & Hensley, 1991; Iberg, 1991; Kivlighan, Angelone, & Swafford, 1991; Mallinckrodt & Nelson, 1991; Milne, Pilkington, Gracie & James, 2003; Sandell, 1985; Steinhelber, Patterson, Cliffe, & LeGoullon, 1984; Triantafillou, 1997; Vallance, 2004; White & Winstanley, 2010; and Watkins, 2011). Although the studies do not directly test supervision, Watkins (2011), who explored all 18 studies in a meta-analysis, grouped them according to those with a direct connection to supervision, and those with implications for the study of supervision. Six studies are not actually supervision-outcome studies and/or feature poor methodology: Alpher (1991); Friedlander et al., (1989); Iberg (1991); Kivlighan et al., (1991); Mallinckrodt & Nelson (1991); Milne et al., (2003); Sandell (1985); Vallance (2004). These studies, which represent 40% of the available literature on the influence of supervision on client outcomes, have been misidentified due to methodical error or misunderstanding (Watkins, 2011). Therefore, they will not be described

herein. Of the remaining studies included in the Watkins (2011) meta-analysis, the research conducted by Bambling et al., (2006) has been identified as the hallmark study for soundness of methodology and providing a clear path for future research (Bernard & Goodyear, 2014).

Bambling et al. (2006) studied the effects of supervision on the working alliance in terms of a reduction of depressive symptoms as reported by patient-participants. The participants included 127 mental health patients, 127 therapists with a graduate degree and one year of experience, and 40 supervisors with a graduate degree and two years experience as supervisors. The therapists and supervisors were trained in the selected therapeutic and supervision techniques (problem-solving therapy), and the patients were provided eight sessions of therapy. The therapists were assigned to one of the following three supervision conditions: no supervision, alliance process focus (interpersonal skills), or alliance skills focus (behavioral focus). The researchers hypothesized that the clients assigned to the supervised therapists would report a reduction in symptoms and a higher working alliance. And indeed, the researchers found that the patients who were seen by therapists receiving supervision experienced a reduction in depressive symptoms and reported a stronger working alliance in comparison to non-supervised patients. In addition, there was a connection between supervision and client retention, in that clients who were working with supervised therapists were more likely to return for therapy. This study's methodology was sound because it used valid and reliable instruments—specifically, the Beck Depression Inventory and Working Alliance Inventory. In summary, this study supports a linkage between focusing on the working alliance during supervision and positive client outcomes (Bambling et al., 2006; Watkins, 2011).

Watkins (2011) also analyzed another significant study conducted by Bradshaw et al. (2007), which he described as “solidly constructed and conducted” (Watkins, 2011, p. 249).

Bradshaw et al. (2007) designed a study that involved nursing supervisors, psychiatric nurses, and patients diagnosed with schizophrenia. The purpose of the study was to further understand the effect of supervision on client outcomes (psychotic symptoms and social functioning). Nursing supervisors were provided with training in supervision while the psychiatric nurses received training in the selected intervention. After receiving training the psychiatric nurses were separated into two groups—with one group receiving supervision from the nursing supervisors and the other group receiving no supervision. The results of the study show that both groups of nurses showed an increased knowledge of case management skills; in comparison, the group under supervision increased their knowledge of the condition of their patients, as well as the appropriate skills and interventions to serve them. In addition, the patients who were assigned to the nurses in the group receiving supervision showed a greater decrease in psychiatric symptoms. Three limitations of this study must be noted: (a) it was a non-randomized sample, (b) the nurses in the group receiving supervision had more experience, and (c) the supervision training provided was only for two days (Watkins, 2011). However, even with the described limitations, this study still provides a credible example of the importance of supervision to client outcomes.

Included in Watkins (2011) meta-analysis were eight other studies that examined the effects of supervision on client outcomes. Couchon and Bernard (1984) investigated the effects of the timing of supervision on clients' satisfaction with therapy. Specifically, counselors in the study received supervision four hours, one day, or two days prior to the next session. The authors reported that timing did not have an effect on client satisfaction with therapy. However, what did emerge was the trend that when counselors received supervision four hours prior to the next session, the supervisor was more apt to work from the consultant role. A major limitation

of this study was the fact that researchers designed the instrument that was used. A second study included in the meta-analysis was conducted by Dodenhoff (1981) and examined the influence of counselor attraction to the supervisor on client outcomes. The results of the study indicated that the higher counselor attraction to the supervisor, the more likely the supervisor is to rate the counselor highly effective and rate patient outcomes as high. This study was limited in that assignments were purposeful and not random, and patient outcomes were only measured one time. The next group of studies by Harkness and Hensley (1991) and Harkness (1997) explored different variables using the same dataset. Harkness & Hensley (1991) investigated the effects of client-focused (clinical) supervision versus mixed-focused (administrative) supervision on client outcomes. The results of the study showed that clients who were seeing counselors receiving client-focused supervision made considerable gains and rated the counseling relationship higher in comparison to the mixed-focused group. Limitations of this study included the lack of data collected and the difference in how the mixed-focused and client-focused supervisions were conducted (i.e., group versus individual). Six years later Harkness (1997) used the same dataset to identify the presence of causal relationships amongst different supervisory variables (skills, outcomes and relationships). The results were unexpected and showed that empathy expressed by the supervisor had a negative effect on a counselor's perception of the supervisory relationship and helpfulness. While the results were surprising, there were several limitations that limited the generalizability of this study—such as the lack of control for type I/type II errors and lack of reporting psychometric properties of instruments. That same year, Triantafillou (1997) investigated the effectiveness of clinical versus administrative supervision with management staff and direct care workers in a mental health care facility. The management staff was trained in supervision techniques and the direct care staff

participated in supervision. Serious incidents and medication compliance for clients from the mental health care facility-trained supervisors were compared with a facility with no trained supervisors. The results of this study show a reduction in serious incidents and an increase in medication compliance at the facility with trained supervisors. Despite the positive association between supervision and a reduction in serious incidents, one cannot directly attribute improved clinical outcomes to supervision training due to the lack of measures for supervision.

Steinhelber et al. (1984) designed a study to examine the effect of theoretical congruence and the amount of supervision on client outcomes. The results indicated that the amount of supervision did not result in greater client gains. However, theoretical congruence between supervisor and counselor was shown to result in greater client gains. This study was limited by the lack of similarity in the counselors' backgrounds, as well as by the lack of control over frequency and duration of supervision (Freitas, 2002; Watkins, 2011). The final study included in Watkins (2011) meta-analysis was conducted by White & Winstanley (2010), who examined if supervision training had any effect on the stress and coping mechanisms of mental health care nurses. Nursing supervisors were provided clinical supervision training and then conducted a year-long supervision of nurses. Qualitative data in the form of journal entries about supervision from the supervisor's perspective, and quantitative data in the form of assessments, were collected. Results from this study indicated that the nursing supervisors who received training scored higher on the supervision scales, while there were no gains in patient satisfaction (Watkins, 2011).

Despite the known importance of examining the effects of supervision on client outcomes due to the need for evidence-based practice (Watkins, 2011), as well as the fact that it is mandated by managed-care organizations, the literature is still sparse. With only 18 available

studies over the last three decades—and very few of those identified as sound in measure and outcome—the need for more research in this area is necessary (Bernard & Goodyear, 2014; Freitas, 2002; Watkins, 2011). The most recent literature provides some methodologically-sound insights substantiating that supervision has positive effects on clients, clinicians, and counselors (e.g., Bambling et al., 2006; Bradshaw et al., 2007; White & Winstanley, 2010). However, more research is needed to fully document the effects of clinical supervision on client outcomes. Moreover, for private community-based mental health agencies it is imperative to understand the influence certain factors have on clinical supervision in order to support positive outcomes. Two factors that influence clinical supervision—namely, supervision emphasis and the working alliance—will be explored in order to further understand clinical supervision in private community-based mental health agencies.

Supervision Emphasis

As Lanning (1986) noted, “...the purpose of supervision is to produce effective counselors, there are certain skills or areas of focus that need to be addressed to develop the skills necessary to be an effective counselor” (p. 192). The basis for conceptualizing supervision in terms of areas of focus or emphasis is grounded in Bernard’s (1979, 1997) discrimination model. Supervision emphasis, as described by Bernard (1979, 1997) and Lanning (1986), encompasses four areas of focus that support the development of effective clinicians: personalization skills, process skills, conceptualization skills, and professional behaviors. While supervision emphasis was originally described in the counseling literature and research in terms of training protocols, the concept is applicable to private community-based mental health agencies because the training of clinicians does not stop when a formal training programs ends. Indeed, private community-based mental health agencies serve a training ground for young

clinicians with various levels of preparation (bachelor's, master's, etc.) who require supervision across all areas of practice. Therefore, the next section will explore the discrimination model as the basis for supervision emphasis, the concept of supervision emphasis as presented by Lanning (1986), and the research behind both concepts.

Discrimination Model

One of the most widely tested models of clinical supervision is Bernard's (1979, 1997) discrimination model (Bernard & Goodyear, 2014). Bernard (1979, 1997) created this model after recognizing the need for a framework for supervision for both clinicians and supervisors that would allow for further evaluation of the supervision process. The model breaks down supervision into roles a supervisor can fulfill and areas of focus for clinicians during a supervision session—the overarching goal of which is to help develop counselors who have a stronger skills set (Bernard, 1979, 1997).

Bernard (1979, 1997) identified three areas of focus for supervision: process skills, case conceptualization skills, and personalization skills. Process skills can best be identified as easily-observed clinical skills, typically learned at the beginning point of a clinical program, which a clinician uses during session to work through material with a client (Bernard & Goodyear, 2014). Such behaviors included under the category of process skills include how a clinician opens a session, basic processing skills (reflection, summarizing, etc.), methods to help a client share deeper meaning, and the use of non-verbal skills (Bernard, 1979, 1997). Bernard and Goodyear (2014) summarized process skills as “interventions” (p. 52) used during a session. The second area of focus is case conceptualization skills, which include behaviors that are not necessarily readily observed in session. An example of a case conceptualization skill is a clinician spending time in understanding the client's presentation through the use of verbal, non-

verbal, and contextual approaches. Clinician behaviors in the focus area of conceptualization skills include understanding themes, identifying appropriate objectives, acknowledging client progress, and an increased aptitude in selecting appropriate interventions. Finally, the third area of focus is personalization skills, which can be summarized as behaviors or approaches that may not be readily apparent, but nonetheless impact the efficacy of the session. Consider, for example, how a clinician's personal background, values, and biases influence a session. Clinician behaviors in the area of personalization skills included an ability to understand and accept the power that comes with being a clinician, appropriately challenging clients, accepting constructive criticism from supervisors/clients/peers, and continuing to work to understand the role of the clinician's personal experiences and background in how he or she approaches counseling (Bernard 1979, 1997).

In addition to the areas of focus for a clinician, Bernard (1979, 1997) included three basic roles a supervisor can fulfill in the discrimination model: as teacher, counselor, and consultant. The role(s) a supervisor fulfills is typically a conscious choice, which is based upon the training level of the clinician, current presenting issues, and the need for supervision. The role of a supervisor differs from a consultant, teacher, or counselor in the control and power present in the relationship, the evaluative nature, and how information is delivered (Bernard & Goodyear, 2014). The teacher role is utilized when direct teaching needs to occur and the focus of the supervision session is the transfer of information. This role is most often used with beginning clinicians who require a greater amount of direction and didactic instruction (Bernard 1979, 1997). The counselor role is utilized when the clinician needs greater focus on their own processes and the influence this may have on a session. In the counselor role, the supervisor moves into a more supportive role and encourages the clinician to focus on themselves, their

experience, and what is happening for them in the session (Bernard & Goodyear, 2014). The last role that a supervisor may utilize is that of a consultant. In the role of a consultant the focus is brought back to the relationship between the clinician and supervisor; in this mode the supervisor moves into the role of colleague. As a consultant, the supervisor encourages clinicians to think more independently, develop deeper intuition about their work, and begin the process of supervising their own work (Bernard, 1979, 1997; Bernard & Goodyear, 2014).

Of the supervision models currently in use, Bernard's discrimination model (1979,1997) has been widely researched and used as a training model since it enables the supervisor to analyze the needs of his or her supervisee and meet them accordingly (Bernard & Goodyear, 2014). Studies utilizing the discrimination model include Luke, Ellis, & Bernard (2011), Lazousky & Shimoni (2007), Glidden & Tracey (1992), Ellis, Dell, & Good (1988), Ellis & Dell (1986), Goodyear, Abadie, & Efros (1984), and Goodyear & Robyak (1982). Of particular interest to this investigation is Lazousky and Shimoni's (2007) study of the applicability of the discrimination model in mentoring of counseling interns in Israel. The researchers specifically noted that they employed the discrimination model because it clearly defines the supervisor's role in supervision and has been widely studied. Participants in the qualitative study included 158 counseling mentors and 171 school counseling interns who were asked to describe how mentors and interns view the performance of actual mentors versus the ideal mentor. In addition to providing demographic information, participants were asked to describe "the ideal onsite mentor," and complete a 29-item questionnaire utilizing the four supervisor roles (teacher, counselor, consultant, and sponsor) depicted in the discrimination model and another model specific to counseling mentorship. Study results indicated that the most important role was that of teacher, which greatly overshadowed the counselor, sponsor, and consultant roles. The

researchers noted, however, that this trend is often seen with beginning counseling interns who expect more didactic instruction. In addition, when describing the ideal mentor both participant groups emphasized the importance of mentoring relationships, personal/professional traits, and how the mentor views their role (Lazousky & Shimoni, 2007). This study is applicable to the current study in that it emphasizes the preference of beginning clinicians for a more didactic approach to supervision. Because private community-based mental health agencies often serve as a training ground for clinicians with limited experience, it is important to recognize the increased didactic role a supervisor is likely to play in this setting.

A significant body of research conducted in the 1980s and 1990s with the discrimination model serves as the foundation for ongoing studies in the field of mental health care supervision (Ellis et al., 1988; Ellis & Dell, 1986; Glidden & Tracey, 1992; Goodyear et al., 1984; and Goodyear & Robyak, 1982). Ellis and Dell (1986) tested different models of supervision with clinical and counseling psychologists—including Bernard’s (1979, 1997) discrimination model—in order to understand the dimensionality of supervision in psychology. The authors reported support for the model due to the fact that the supervision dimensions identified by the psychologists relate to the roles and focus dimensions in the discrimination model (Ellis & Dell, 1986). Goodyear and Robyak (1982) conducted a quantitative a study incorporating the three focus areas of the supervision dimension of the discrimination model. Specifically, the authors compared theoretical orientation, years of experience in supervision, and percentage weight for the three areas of focus in evaluating supervisees. The results of the study indicated that the differing theoretical orientations only differed in their emphasis on the supervision focus area of clinical skills (Goodyear & Robyak, 1982). Two years later, Goodyear et al. (1984) published a study in which the supervision of four experienced psychologists was ranked using the

supervision focus areas of the discrimination model. The researchers videotaped the four psychologists and 58 counseling center supervisors, who ranked the psychologists on their use of the different focus areas. The discrimination model was effective in helping to understand the results of the study, which indicated a differing supervision focus based upon theoretical orientation of the supervisor (Goodyear et al., 1984). Glidden and Tracey (1992) examined the three dimensions of supervision with respect to if and how these dimensions varied with the experience level of the trainee, as well as whether the supervisors were cognizant of the dimensions during supervision. The authors reported that the supervisors in this study tended to use a more controlling, authoritarian teaching style rather than a collaborative approach to supervision. Indeed, control emerged as an important topic in this study, with the indication that further study was needed to understand the role control plays in the dimensions of supervision (Glidden & Tracey, 1992).

One of the most recent investigations to utilize the discrimination model is a study conducted by Luke et al., (2011), which compared school counselors' view of the discrimination model against the findings from Ellis and Dell (1986) with mental health counselors. The authors surveyed 38 school counselors with prior supervision experience and used Bernard's (1979,1997) discrimination model in the conceptualization of the study. The authors also utilized the original instrument from the Ellis and Dell (1986) study in order to compare the role of the supervisor against the focus of supervision for any dissimilarities. Luke et al. (2011) hypothesized that school counselors view supervision differently than their counterparts in the mental health care arena. Their findings showed that school counselors generally viewed supervision from three dimensions: a) dimension one – behavioral intervention vs. conceptualization; b) dimension two – role of consultant vs. role of teacher and counselor, and c)

dimension three – emotional vs. cognitive focus—in short, much the same as mental health counselors. However, the difference with school counselors showed in the third dimension, which was viewed as least important for school counseling supervision (Luke et al., 2011). This study reinforces the importance of the discrimination model in modern counseling research by highlighting the applicability of the model to today’s counseling supervisors. In addition, this study supports the fact that clinicians across different mental health specialties tend to view of the focus of supervision in similar ways.

The most applicable study to the current investigation in the area of supervision emphasis utilizing the discrimination model is the study by Ellis et al. (1988). Using a two-phase approach, the researchers explored supervision dimensions from the point of view of counseling supervisor trainees utilizing a questionnaire. Only the first phase of the study will be reported herein because it is the most applicable to the current investigation in that it utilized Bernard’s (1979) discrimination model. As a basis for their study, Ellis et al. (1988) reported that prior research indicated that supervisors and supervisees view supervision differently and conceptualize supervision along different dimensions. To test this association, they surveyed 15 doctoral-level counselor trainees about their perceptions of supervision using stimuli presented in a paired comparison format with a Likert scale. The participants also ranked each of the nine stimuli on ten attributes, after which the researchers used multidimensional scaling to understand the dissimilarity of the rankings of the stimuli. The dimensions of supervision were further interpreted using correlation and subjective interpretation. The results of the study confirmed that trainees viewed supervision along three dimensions: process vs. conceptualization, directive vs. non-directive, and cognitive behavioral vs. supportive emotional. The results of the first and second study support Bernard’s (1979, 1997) dimensions of role and function and suggest that

both supervisors and trainees (regardless of level of training) work from the same concept of supervision (Ellis et al., 1988). This study is applicable to the current investigation because (a) clinicians with various level of training were surveyed, and (b) the prior research supports the view that clinicians view supervision similarly across three dimensions regardless of training.

Lanning (1986) expanded upon Bernard's (1979, 1997) discrimination model by examining supervision emphasis with the goal of developing an instrument that would measure the areas of focus in supervision. First, Lanning (1986) employed Bernard's (1979) discrimination model as a basis for understanding the areas of emphasis a supervisor can choose from in supervision (Bernard & Goodyear, 2014). Lanning (1986) then conceptualized supervisor emphasis in counseling supervision using the Supervisor Emphasis Rating Form (SERF) (Lanning, 1986), based upon Bernard's (1979, 1997) areas of focus for supervision (processing, personalization, and conceptualization). After completing a factor analysis on the original SERF and finding that supervisors overinflated their ratings on the subscales, Lanning (1986) reported that "...supervisors at each level of training were reluctant to reveal their lack of superhuman skills in being able to emphasize everything" (p. 250). To counter the overemphasizing of skills, Lanning and Freeman (1994) worked to revise the form by adding professional behaviors (professional writing, punctuality, etc.) as an additional area of focus for supervision and changing the format from a Likert scale to ipsative. Lanning (1986) developed a list of behaviors that corresponded to the areas of focus and submitted the list to a group of doctoral-level supervision students, practicing supervisors, and counselor educators. The researcher reached a consensus as to what behaviors should be included on the instrument by ensuring an 80% agreement rating between the raters. Lanning (1986) utilized the areas of conceptualization skills, process skills, personalization skills, and added a fourth dimension of

professional behaviors. The purpose in developing the form was to measure areas of focus that supervisors typically emphasize during counseling supervision. Two studies utilizing the Supervisor Emphasis Rating Form-Revised (SERF-R) (Lanning & Freeman, 1994) will be reviewed to highlight the need for further exploration of supervisor emphasis in counseling.

Davis-Gage (2005) investigated the supervision style and emphasis of site supervisors in a mental health counseling training program. In addition, the author sought to understand the relationship between the number of years of professional counseling and supervision experience with supervisory style and emphasis. The Supervisory Styles Inventory (SSI) (Friedlander & Ward, 1984) and SERF-R (Lanning & Freeman, 1994) were used to survey 43 site supervisors from CACREP counseling programs, who collectively had an average of 17 years counseling experience. Each had served as a site supervisor within three years prior to the study and were social workers, clinical psychologists, and mental health counselors. The independent variables for the study were years experience as a counselor, years experience as a supervisor, and the amount of training in supervision. The dependent variables for the study were the SSI subscales (attractive, interpersonally sensitive, and task oriented) and the SERF-R subscales (conceptualization, personalization, process, professional). In order to analyze the data that emerged from the mailed questionnaires, the researchers used descriptive statistics (research questions 1 and 2) and multiple regression and correlation (question 3). Findings indicated that site supervisors most readily used the attractive style of supervision with a focus on personalization. In addition, results showed that supervisors placed the greatest emphasis on personalization skills, then process skills, conceptualization skills, and finally professional behaviors. In addition, there was a positive correlation between the number of years of counseling experience, hours of supervision training, and the preference for the task style of

supervision. This study is applicable to the current investigation because site supervisors for CACREP clinical counseling programs are based offsite, usually at agencies or other community-based mental health facilities, and are responsible for interns and clinicians. This study provides a basis for further research about how clinicians view supervision emphasis in private community-based mental health agencies.

Finally, Usher and Borders (1993) examined the preference of supervision style and emphasis with counselors working in the mental health and school counseling fields. The researchers noted that prior research had shown that counselors' preference for supervision was correlated with their level of experience. Moreover, beginning counselors tended to prefer a supervisor who focused on teaching; intermediate counselors preferred a focus on building and sustaining relationships and self-awareness; and advanced counselors preferred a supervisor who served as more of a consultant. In their study, 274 National Certified Counselors (106 school counselors and 168 community mental health counselors) participated in a two-part survey. The SERF-R (Lanning, 1986) and SSI-R (Friedlander & Ward, 1984) were used as instruments to further understand supervisor style and supervision emphasis with practicing counselors. The research participants were classified by degree level, counseling experience, and supervision experience. The dependent variables for this study were supervisory style (attractive, interpersonally sensitive, and task focused) and supervision emphasis (professional behaviors, conceptualization skills, process skills, personalization skills). Participants were asked to respond to the following questions: (a) What are practicing counselors' preference for supervisory style and does this differ between mental health and school counselors? (b) What are practicing counselors' preference for supervision emphasis and does this vary between mental health and school counselors? (c) Does the preference for supervisory style for both mental health and

school counselors vary by the three measures of experience? And (d) Does the preference for supervision emphasis for both mental health and school counselors vary by the three measures of experience? Data analysis for this study included descriptive statistics and intercorrelations for both the SSI-R and the SERF-R, and multivariate analysis for the research questions.

Descriptive statistics were provided for the subscales of the SERF-R and the mean and the standard deviation for each subscale were as follows: professional behaviors ($M = 45.04$, $SD = 6.37$), process skills ($M = 38.39$, $SD = 5.26$), personalization skills ($M = 33.72$, $SD = 6.72$), conceptualization skills ($M = 32.85$, $SD = 6.71$). It should be noted that the lower the mean score, the stronger the preference for that emphasis. The results of the study indicated that school and community counselors alike emphasized conceptual skills over personalization and process skills. In addition, the more experience a community-based counselor had, the more they wanted the focus of supervision to change to personalization and community counselors, with less supervision preferring a focus on professional behaviors. Both school and professional counselors preferred to have supervision that was not task-oriented and a supervisor who was supportive and focused on building a solid relationship. Differences amongst school and community settings included a preference for supervisor emphasis and focus of supervision (Usher & Borders, 1993). The SERF-R provided the foundation for conceptualizing the supervisor emphasis in both the school and community settings.

Supervision emphasis provides a foundation for the work happening in supervision with a focus on personalization, process, conceptualization, or professional behaviors. Bernard's (1979, 1997) discrimination model serves as the benchmark for understanding supervision emphasis with Lanning and Freeman's (1994) work extending this research. The SERF-R (Lanning & Freeman, 1994) allows one to measure supervision emphasis—both from the supervisor and

supervisee viewpoint. Two significant studies have highlighted the importance of supervision emphasis in mental health counseling. The results show that emphasis in supervision varies based upon setting, years of experience, and training in supervision. However, both studies support conceptualization skills and personalization skills as the most important supervisory emphasis. To extend our understanding of supervision emphasis, further research is needed to understand how this factor plays out in private community-based mental health care settings from the point of view of clinicians.

The Working Alliance

The working alliance, which is a theoretical extension of the counseling relationship, serves as a foundation for the supervisory relationship (Bernard & Goodyear, 2014; Bordin, 1983; Milne, 2006). Similarities between counseling and supervision include setting goals based upon identified needs, using identified needs to select mechanisms for change, and eliciting feedback (Milne, 2006). Bordin (1983) defined a working alliance as “a collaboration for change” (p. 35), wherein all parties collaboratively define and agree upon goals, the role and purpose each party will play in the alliance, and the necessary “bond” (p. 35) for the relationship to persist. Efstation et al. (1990) expanded upon the definition of the working alliance by stating:

By definition, the supervisory working alliance is that sector of the overall relationship between the participants in which supervisors act purposefully to influence trainees through their use of technical knowledge and skill and in which trainees act willingly to display their acquisition of that knowledge and skill. (p. 323)

Given that a strong therapeutic working alliance is correlated with positive client outcomes, it is an important factor to be explored in supervision. A number of therapist attributes are correlated with a strong working, such as empathy, compassion, and an ability to work with whatever is

brought to session (Castonguay et al., 2006). As such, the same attributes and positive outcomes can be expected for a supervisory relationship with a strong working alliance.

A number of supervision theories with either a developmental, process, or psychotherapy focus have been described in contemporary literature (Bernard & Goodyear, 2014). A unique theory that supports the alliance between therapist and client is Bordin's (1979) model for the working alliance. This model transcends the therapeutic relationship and traditional counseling theories (Wood, 2005) and is applicable outside the traditional therapeutic relationship. Bordin's (1983) working alliance model focuses on three areas: goals (identified by client and therapist), tasks (the work required to achieve the goals), and bonds in the therapeutic relationship. Bordin (1983) further expanded the working alliance by examining it from a supervisory perspective. He asserted that the same three areas (goals, tasks, and bonds) were applicable to the supervisory working alliance, while further expanding on the goals of supervision. Included in the goals are increasing competence with basic counseling skills, broadening case conceptualization abilities, understanding the role of self as therapist/supervisee, identifying personal issues preventing momentum in session, and connecting with professional development resources to continue broadening scope of practice. The bonds in the supervisory working alliance differ from those of the therapeutic relationship in that the supervisor functions between the role of teacher and counselor, while the supervisee works from a student/client perspective (Bernard & Goodyear, 2014; Bordin, 1983).

The Working Alliance Inventory

The Working Alliance Inventory or WAI (Horvath & Greenberg, 1990), which is based upon Bordin's (1979) conceptualization of the working alliance, was developed to assess the counseling relationship. The three subscales developed for the WAI include tasks (counselor

behaviors that occur during the session), goals (focused on the outcomes of therapy), and bonds (personal attachments present in the therapeutic alliance). Horvath and Greenberg (1990) asserted that to accurately measure the working alliance the instrument has to function independently of the theoretical orientation and have a clear definition of the working alliance. Three studies are cited in support of the WAI, with the first examining the working alliance between counselors and clients involved in short-term counseling. The WAI and Relationship Inventory (RI) (Barrett-Lennard, 1962) were administered to the counselor/client dyads, with results indicating a relationship between the working alliance and client satisfaction and change (Horvath, 1981). A second study examined the working alliance between therapists and adult clients in Gestalt therapy (Greenberg & Webster, 1982). The RI, WAI (task subscale), and social influence variables were used to predict the treatment outcomes of clients. The study's findings indicate a positive relationship between the task subscale of the WAI and the outcome of therapy. The third study examined the therapeutic relationship between counselors and clients who were engaged in therapy using a variety of theoretical orientations; findings support prior results that the working alliance is positively correlated to advantageous therapeutic outcomes (Moseley, 1983).

Subsequent researchers have revised Horvath and Greenberg's (1986) Working Alliance Inventory to examine the supervisory relationship in other settings. For example, Baker (1990) assessed the experiences of 66 supervisors and 71 psychology interns using both the WAI-R (Horvath, 1981) and the Narcissistic Personality Inventory (NPI) (Raskin & Hall, 1979) to investigate the impact of supervisor/supervisee narcissism, gender, and theoretical orientation on the supervisory working alliance. For this study, Baker (1990) adapted the WAI for the supervisory relationship and by replacing the original words of "therapist," "client," and

reference to the “therapeutic relationship” with “supervisor,” “supervisee,” and reference to the “supervision relationship.” Baker’s (1990) revision of the WAI was utilized in the current investigation to measure the supervisory working alliance. Given the importance of the working alliance as a foundation for both the therapeutic and supervisory relationship, the influence of both the supervisor and supervisee will be further explored in the following sections.

Supervisor and Supervisee Influence on the Working Alliance

Bernard and Goodyear (2014) provided a framework that outlines the different factors that influence the supervisory working alliance from the supervisor and supervisee perspective. Specifically, the authors identified five components that can have a direct influence on the supervisor’s view of the supervisory working alliance: (a) supervisory style, (b) use of expert and referent power, (c) use of self-disclosure, (d) attachment style/emotional intelligence, and (e) unethical behavior. In addition, three aspects impact the supervisees’ view of the working alliance: (a) attachment style and emotional intelligence, (b) experience of negative supervision, and (c) stress and coping (Bernard & Goodyear, 2014).

A supervisor’s style has been defined as “an interactional process between supervisor and supervisee” (Fernando & Hulse-Killacky, 2005, p. 293). Supervisors can adopt different styles in supervision sessions that directly correlate with Bernard’s (1979,1997) Discrimination Model and the roles supervisors fulfill. The first style is known as “attractive,” which corresponds to the supervisor role of consultant, refers to when a supervisor displays warmth, compassion, and receptivity. The second style, “interpersonally sensitive,” corresponds to the supervisor role of counselor, has the attributes of being insightful, working from a therapeutic stance, and being invested in the relationship. The third supervisor style is “task oriented,” which corresponds to

the teacher role, and has the attributes of being didactic and focused on goals (Ladany et al., 2001).

Three studies highlight the effect of supervisory style on the working alliance via the use of the Supervisory Styles Inventory or the SSI (Friedlander & Ward, 1984). Ladany et al. (2001) carried out a fundamental study to determine the extent to which the alliance between supervisor and supervisee impacts the supervisory working alliance. The researchers examined the relationship between how supervisors interpret their supervising style and the different facets (including the working alliance) of the supervision process. Participants included 137 supervisors who were supervising 137 beginning-level trainees. Each supervisor was surveyed with the SSI (Friedlander & Ward, 1984), the Working Alliance Inventory-Supervisor (WAI-S) (Baker, 1990), the Supervisor Self Disclosure Inventory (SSDI) (Ladany & Lehrman-Waterman, 1999), and a demographic survey. The authors' first hypothesis examined the influence of supervisory style on the working alliance with a multivariate multiple regression analysis, with results indicating a significant variance among the subscales of the working alliance (tasks, goals, and bonds) when combined with the supervisory styles index. In addition, the perception of the bond was significantly related to the perception of an attractive style ($F = 17.46$); the perception of the interpersonally sensitive style were significantly related to the perception of task in the working alliance ($F = 6.62$); and the task supervisory style contributed significantly to tasks component of the working alliance ($F = 4.11$). Ladany et al. (2001) summarized their findings: "The more attractive the supervisors perceived themselves to be, the greater their perception that there was a stronger emotional bond and more agreements on the goals and tasks of supervision" (p. 270). Thus, their results confirm a relationship between a supervisor's style, the process in supervision, and the outcomes.

When looking at individual supervisory styles evidenced in this study, supervisors who viewed their supervision style as interpersonally sensitive believed they aligned more with supervisees on tasks. And supervisors who viewed their supervision style as task-oriented would attend to tasks in session, which may have negatively effected the working alliance and reinforced the hierarchy of the supervision dyad (Ladany et al., 2001). In considering the task-oriented approach that regulatory boards recommend for private community-based mental health agencies, it may seem that power differential would be reinforced in such circumstances—thereby negatively impacting the working alliance. However, the working alliance in supervision is influenced by multiple factors including the way supervisors view themselves, their style, and the tasks, bonds, and goals of supervision. Ladany et al. (2001) stressed that the key to building a strong working alliance is flexibility, moving fluidly, and attending to supervisee needs.

Chen and Bernstein (2000) investigated the supervisory working alliance through a research informed case study with ten supervision dyads comprised of a doctoral-level supervisor trainee and a master's-level counselor trainee. Process and outcome data were collected from each dyad prior to supervision and after every third session. The researchers utilized the following data-collection instruments: a demographic questionnaire, the SSI (Friedlander & Ward, 1984), the Critical Incidents Questionnaire or CIQ (Heppner & Roehlke, 1984), Supervisory Working Alliance Inventory (SWAI) (Patton, Brossart, Gehlert, Gold & Jackson, 1992), and the Session Evaluation Questionnaire from Stiles and Snow (1984). To analyze the data, the researchers examined the scores of all participating dyads and identified the dyads with the highest and lowest working alliance outcomes. The scores of the SWAI for supervisees ranged from 198 to 251, and for supervisors the range was 92 to 134. The score for the SSI for supervisees ranged from 6.71 to 5.43 on the attractiveness scale, 6.75 to 4.75 on the interpersonal

sensitivity scale, and 4.30 to 3.30 on the task oriented scale. For supervisors, the SSI scores ranged from 6.86 to 5.14 on the attractiveness scale, 6.63 to 4.38 on the interpersonal sensitivity scale, and 4.00 to 4.60 on the task oriented scale. The researchers found that supervision dyads with a low working alliance rated personal issues, competence, and emotional awareness as the most important factors to address in supervision. The dyads with a low working alliance were found to be highly task oriented and evidence a low attractive supervisory style. In addition, the supervision styles of interpersonally sensitive and attractive were found to be good predictors for the nature of the supervision working alliance (Chen & Bernstein, 2000). Chen and Bernstein (2000) highlighted the need for supervisors to be flexible in their use of styles and adapt to the needs of the supervisee.

A third study investigating the effect of supervisory style on the working alliance focused on predicting role conflict and ambiguity with supervisees. Specifically, Spelliscy (2007) examined the working alliance as a predictor of the relationship between supervisee attachment, anxiety, supervisor style, and role conflict and ambiguity. Of particular interest to the current investigation is Spelliscy's (2007) overarching research question: Can a supervisor's style predict the supervisory working alliance? Participants in this study were 200 counseling psychology doctoral students enrolled in American Psychological Association (APA) approved programs. One aspect of this study examined whether a supervisor's style had any influence over the development of the working alliance. Results from this study, which used a path analytic method, showed that the attractive and interpersonally sensitive styles were a positive predictor for the working alliance. In addition, the working alliance can be influenced by how a supervisee interprets the intent of supervision (e.g., if a supervisor is perceived by a supervisee to be attractive, rapport in the relationship may be increased) (Spelliscy, 2007).

The supervisory working alliance is akin to a chess game with many moving pieces and opportunities for alliances, bold moves, and checkmates. The working alliance can be affected by many variables (style, attachment, unethical behavior, etc.)—and due to the nature of human beings, these variables can change at a moment's notice. The supervisor is required to wear many different hats in establishing and maintaining a working alliance; as such, he or she has to be in tune with the emotional cues of supervisees. The working alliance is a complicated concept that requires considerable attention in order to ensure a positive relationship with outcomes that benefit supervisor, supervisee, and clients.

All three of the above studies that utilized the SSI evidenced a link between supervisory style and the working alliance. The supervisory styles of attractive and interpersonally sensitive are positively correlated with the supervisory working alliance (Fernando & Hulse-Killacky, 2005; Ladany et al., 2001). Although the task-oriented supervisory style was evidenced, it tended to dominate supervision, thereby creating a power differential and weakening the working alliance. Bernard and Goodyear (2014) stated that the teaching style of supervision is generally not supportive of a collaborative working alliance. Thus, it is essential that supervisors work to understand the different influences on the working alliance so they can adapt their supervision style, focus strategies, and increase flexibility (Ladany et al., 2001). The key to supporting the supervision working alliance is moving fluidly between supervision styles as the needs of the supervisee change (Chen & Bernstein, 2000; Hulse-Killacky, 2005; Ladany et al., 2001). For private community-based mental health agencies that have a responsibility to follow regulatory boards guidelines and definitions for supervision, a highly task-oriented focus may negatively affect the working alliance, thus disrupting the outcomes of therapy for clients. In fact, Chen and Bernstein (2000) reported that supervision dyads with a low working alliance were found to be

highly task oriented and emphasized the administrative tasks of supervision.

Lanning and Freeman (1994) identified four areas of supervision emphasis: professional behaviors, process skills, personalization skills, and conceptualization skills. The current investigation categorized professional behaviors as administrative, while process skills, personalization skills, and conceptualization skills were considered as emphasizing the clinical realm. As noted earlier, DMAS and DBHDS licensure regulations stress an administrative supervisory focus for community-based mental health agencies. In other words, they are required to focus on professional behaviors and review progress notes, assessments, and client progress (Department of Behavioral Health and Developmental Services, 2014; Department of Medical Assistance Services, 2014). Because of the task-oriented focus of supervision in private community-based mental health agencies, the supervisory working alliance may be negatively affected.

The emphasis of supervision and the supervision working alliance are known to influence the supervisory relationship, the therapist-client relationship, and ultimately the outcomes of therapy (Chen and Bernstein, 2000; Ladany et al., 2001; Spelliscy, 2007). The supervisory relationship guides the supervisee in his or her interactions and therapeutic interventions with clients. Although these prior studies indicate that the supervisory working alliance is influenced by supervisory style, I suggest that other forces—including supervision emphasis—also influence the supervisory working alliance. Indeed, given its importance, it is interesting that the choice of emphasis in supervision (professional behaviors, process skills, personalization skills, and conceptualization skills) has not yet been fully explored in conjunction with the goals, tasks, and bonds of the supervisory working alliance. Moreover, with supervision in community-based mental health agencies required to be task oriented, it would be beneficial to study the influence

of the emphasis of supervision on the supervisory working alliance in order to ensure the best possible outcomes in client care.

There are no studies in the available literature that examine a clinician's view of the emphasis on the facets of supervision in private mental health agencies. In addition, there are no studies that examine how a clinician's perception of the emphasis of supervision affects the supervisory working relationship. Therefore, this study was designed to examine clinicians' perceptions of supervision emphasis and its influence on the supervisory relationship in private mental health agencies in Virginia.

Summary

This literature review synthesized available studies on supervision, with an emphasis on the types (clinical versus administrative) and the factors that influence how supervision is conducted. In particular, this review examined supervision emphasis and how that impacts the supervisor-supervisee working alliance. The impact of supervision on therapy outcomes was also discussed. A synthesis of major studies in the area confirms that the supervisory working alliance is impacted by both supervisory style and the emphasis of supervision. With little known about these factors in private community-based mental health agencies, this study was designed to fill this scholarly gap. Thus, Chapter Three presents the methodology and instruments for this investigation of clinicians' perceptions of supervision emphasis and its influence on the supervisory relationship in private mental health agencies in Virginia.

CHAPTER THREE.

METHODOLOGY

Introduction and Research Questions

The purpose of this study was to explore clinicians' perceptions of supervision emphasis and its influence on the supervisory relationship in private community-based mental health agencies in Virginia. According to Lanning (1994), the four areas of emphasis are process skills, personalization skills, conceptualization skills, and professional behaviors. Data were obtained by examining how a select group of mental health clinicians employed in private mental health agencies in Virginia described the emphasis that their supervisors used in session. In addition to determining the clinicians' perceptions of the supervisory relationship, this study also investigated the influence of the emphasis of supervision on the supervisory relationship. Snowball sampling was used to identify participants who met the criteria for the study. The following research questions guided this quantitative study:

1. How much variance in the supervision working alliance is explained by a clinician's perception of the supervision emphasis?
2. Do clinicians who are supervised by Licensed Professional Counselors (LPCs) describe the supervision working alliance differently than clinicians who are supervised by supervisors with other mental health credentials?
3. Do clinicians who are supervised by supervisors who are responsible for hiring/terminating departmental staff and/or conducting performance evaluations describe the supervision working alliance as differently than clinicians who are supervised by supervisors who are not responsible for hiring/terminating and/or conducting performance evaluations?

Research Design

A cross-sectional quantitative research design was utilized for this study. Creswell (1994) reported that quantitative research designs are appropriate for studies where the researcher wishes to understand the relationship between two variables through the use of instruments, measurements, and analysis. Thus, a quantitative approach was appropriate in that the researcher intended to explore the relationship between two variables: clinicians' perceptions of supervisory emphasis, and how that impacts the working alliance. The study was designed to be cross-sectional in nature because the information gathered herein is representative of one period in time and compares different variables from that point in time. A demographic survey and two instruments were utilized to collect data for subsequent analysis of whether a relationship exists between the variables in the selected population (Coughlan, Cronin, & Ryan, 2009).

Participants

The population for this study was comprised of mental health clinicians who were currently or formerly (within the last five years) employed by private community-based mental health agencies in the Commonwealth of Virginia. The mental health clinicians who took part in this investigation were all either qualified mental health practitioners (QMHP-A, QMHP-C, QMHP-E), or licensed practitioners (licensed professional counselors, licensed clinical social workers, licensed clinical psychologists, etc.). Therefore, for the purpose of comparison across the independent variables, participants were grouped into two main categories: (a) licensed professional counselors, or (b) clinicians who were not licensed professional counselors.

The researcher located participants for this study through private community mental health agency contacts (National Counseling Group, EHS Support Services, Intercept Youth

Services, and Family Preservation Services), professional organizations, and educational institutions (Radford University and Virginia Tech). Snowball sampling was utilized due to the difficulty locating a rare sample in a large geographic area (Chromey, 2008). Identifying clinicians who were working (or had worked) for private community-based mental health agencies was challenging because there was no single list of individuals who met all the criteria for inclusion in the study. Nonetheless, because clinicians often maintain relationships with colleagues even after leaving an organization, snowball sampling provided the best probability of yielding a sufficiently large sample size. A recruitment e-mail (Appendix C) was sent to potential participants directly inviting them to participate in the survey—but the email also asked them to suggest others who might be interested in taking part in this investigation based on known inclusion criteria.

Survey Procedures

The demographic survey and two instruments were converted to a web-based survey via Qualtrics. A web-based survey was chosen because all the participants had access to a computer and internet to complete the instruments. Tourangeau, Conrad, and Couper (2013) stated that so much of day-to-day life is conducted on the computer and over the Internet, that web-based surveys are a natural evolution of survey-based research. Additionally, web-based surveys are more practical in comparison to mailed surveys because of the low cost to administer them and their ability to reach a wider audience of participants (Tourangeau et al., 2013). Web-based surveys also allow for an easier presentation of material, provide flexibility in timing, and provide a quick turn-around of data (Alvarez, Sherman, & VanBeselaere, 2003; Dillman, 2000). Cook et al. (2000) reported that utilizing online surveys decreases the economic impact and increases the response rate of participants due to the decreased time commitment to complete the

survey. The researchers also noted the design of the survey, the use of incentives, and the length of the survey as important factors for increasing a survey's response rate.

A recruitment e-mail was used to solicit survey participants. The recruitment e-mail included the purpose of the study, an informed consent for participation in the research, benefits and risks, procedures for participation, assurance of confidentiality, procedures to withdraw, and a link to the survey. Prior to soliciting survey participants, approval was granted from the Virginia Tech Institutional Review Board (IRB). Appendix A contains the informed consent, Appendix B contains the approval from the Virginia Tech IRB, and Appendix C contains the recruitment e-mail. As noted earlier, prospective participants were asked to forward the recruitment e-mail to other clinicians who might meet the recruitment criteria. Studies suggest that follow up e-mails are useful for increasing response rates to online surveys (Sanchez-Fernandez et al, 2012; Cook et al., 2010). Thus, the first follow-up e-mail (Appendix D) was sent three days after the initial recruitment e-mail to all research participants and contained a link to the survey. In addition, a final follow up e-mail (Appendix E) was sent five days after the initial e-mail and included a link to the survey.

In general, research indicates that response rates of Internet-based surveys are approximately 11% lower than other modalities, which negatively impacts a researcher's ability to properly measure the variables of interest (Fan & Yan, 2010; Sanchez-Fernandez, Munoz-Leiva, & Montoro-Rios, 2012). To offset this deficit, the authors recommend personalizing emails, adding incentives, and increasing the number of contacts with research participants as ways to increase the rate and quality of responses (Fan & Yan, 2010; Sanchez-Fernandez et al., 2012). For this study, an incentive was offered, which was philanthropic in nature and allowed the participants to select an organization to which they would like to donate \$50. The

organizations for the research participants to choose from included the National Alliance on Mental Illness – Virginia, Mental Health America of Virginia, Substance Abuse and Addiction Recovery Alliance of Virginia, or The Campaign for Children’s Mental Health. A humanitarian donation was selected in lieu of directly awarding a participant a gift card to ensure the anonymity of the research pool and avoid any conflicts of interest.

Instruments

Three instruments were utilized to gather data for this study of clinicians’ perceptions of supervision emphasis and its influence on the supervisory working alliance: a demographic questionnaire, the Supervisory Emphasis Rating Form-Revised (SERF-R) (Lanning & Freeman, 1994), and the Working Alliance Inventory-Revised (WAI-R) (Horvath & Greenberg, 1989).

Demographic Questionnaire

The demographic questionnaire (Appendix H) was developed by the researcher in order to collect information that would fully describe the sample. Specifically, participants were required to indicate their gender, age, ethnicity/race, and education (bachelor’s, master’s, PhD/EdD). Additional questions were included in order to determine professional licensure status (LPC, LCSW, LCP, LMFT, and unlicensed), qualified mental health professional (QMHP-A, QMHP-C, QMHP-E), number of years in the field, and employment status (full time, part time, contract). In addition, information was gathered about the most recent supervision experience, including frequency of supervision, duration of supervision, and supervisory roles (hiring/firing and/or performance evaluations).

Supervisor Emphasis Rating Form – Revised

The Supervisor Emphasis Rating Form was originally developed by Lanning (1986), but was revised (SERF-R) (Lanning & Freeman, 1994). The revised form is an ipsative instrument

that has the goal of assessing areas of emphasis (professional behaviors, process skills, personalization skills, and conceptualization skills) in the supervisory relationship. Lanning and Freeman (1994) stated that an ipsative format was selected for the revised version because it prevents respondents from indicating that all choices are of equal importance. The revised instrument contains 15 sets of 4 items and the respondent rank orders the items in each set from 1 to 4 (1 = area of most emphasis in supervision, 4 = area of least emphasis in supervision). The instrument sets can then be summed using the scoring key to determine the level of emphasis for each subscale (Lanning & Freeman, 1994).

Lanning and Freeman (1994) confirmed that the validity and reliability of information from the original SEFRF is applicable to the SERF-R because "...the items used in the SERF-R were identical to those used in the SERF, the validity information presented with the SERF applies also to the revision" (p. 5). In order to determine the reliability of the SERF, a Cronbach alpha reliability analysis was computed for each subscale, as well as the entire instrument. The SERF showed good internal consistency on the subscales (process = .89, personalization = .94, conceptual = .92, and behavior = .93) and overall excellent internal consistency for the entire instrument ($r = .97$). Intercorrelations were also computed for the subscales of the SERF with r values ranging from .64 (behavior/process) to .78 (behavioral/personal). Both the intercorrelations of the subscales and the high internal consistency of the scales solidify the reliability of the SERF (Lanning, 1986).

In establishing reliability for the SERF-R, the psychometrics from the original instrument can be considered, along with internal consistency reliability and split-half reliability for each subscale. The Cronbach's alpha for the trainee form for professional behaviors was .776, process skills was .753, personalization skills was .736, and conceptualization skills was .698.

Based upon the reported Cronbach's alpha scores, there is high internal consistency among the subscales of the SERF-R. The split-half reliability scores for the SERF-R ranged from .65 to .73, which supports the results from the Cronbach's alpha and suggests good internal consistency. The scores on the presented measures support the reliability of the SERF-R as an instrument to examine supervision emphasis (Lanning & Freeman, 1994).

McHenry (1993) explored the construct validity of the SERF-R using a multi-trait multi-method construct. The author developed five research questions that compared different versions (supervisor and trainee) of the SERF-R with the SSI (Friedlander & Ward, 1984) and the SWAI (Efstation et al., 1990). The sample for the study was comprised of supervisor and supervisee dyads from a counseling training clinic. The dyads taped one counseling supervision session and then completed the SERF-R, SSI, and SWAI. Correlational procedures were used to analyze the data, with results indicating that there was limited support for the validity of the SERF-R.

Working Alliance Inventory – Revised

The Working Alliance Inventory or WAI (Horvath & Greenberg, 1989) is described as an "...efficacious early predictor of successful counseling outcome" (p. 231). The WAI is a self-report form with 36 items, containing both counselor and client forms, which utilizes a 7-point Likert scale (1 = never to 7 = always). The instrument is based on Bordin's (1979) theory of the working alliance in which counselor and client influence the working alliance through agreement on goals, tasks, and the bonds of the relationship. When Horvath and Greenberg (1989) first conceived of the WAI, it was intended for use during the initial sessions of a therapeutic relationship; since that time the inventory has been utilized in many other settings (case management, supervision, etc.). To score the WAI, the researcher sums the subscales of goal,

task, and bond using the scoring key (note that several items are reverse scored). After the sums of the subscales are reached, the total for each subscale is determined by dividing the sum by 12. In order to determine the composite score for the WAI, the three subscales are totaled.

Two studies were conducted to examine the scale interdependence of the subscales (tasks, bonds, and goals). Horvath (1981) reported the intercorrelation between the subscale of bond and goal as .69, bond and task as .78, goal and bond as .84, goal and task as .92, task and bond as .79, and task and goal as .88. The high intercorrelation scores suggest that the subscales are intertwined, making it difficult to delineate the effects of each. In order to balance out this effect, the subscales were revised and the goal and bond scale were further delineated. Horvath and Greenberg (1989) report, "...the evidence appears to suggest that we might be dealing with some highly related but functionally distinguishable components" (p. 229).

Mosley (1983) reported that the WAI is internally consistent and has an overall total scale reliability of .93. In addition, the reliability estimate for the goal subscale was .89 and both bond and task were .92 (Mosley, 1983). Horvath & Greenberg (1989) reported the reliability for the WAI as "adequate" (p. 229), noting that the alpha score for the client version was .93 and the reliability score for the counselor version was .87. The authors also reported significant correlations between the instrument and client satisfaction with therapy ($r = .66$) and change made in therapy ($r = .38$). When examining the WAI's validity, Horvath and Greenberg (1989) reported evidence to support the convergent and discriminant validity of the subscales.

For the purposes of this study, the Working Alliance Inventory-Revised-Supervisee (Baker, 1990) was utilized to assess the working alliance in supervision. The revised version of the WAI removes any reference to therapist/client and the working alliance, and replaces it with supervisor/therapist and the supervision working alliance. In addition, in order to better align

with the commonly-accepted language of Medicaid funded private community-based mental health agencies in Virginia, the term “therapist” will be replaced with “clinician” to match the vernacular of the protocols and guidelines. Prior to utilizing the revised scale, Baker (1990) performed an item analysis to ensure its reliability and validity. For the supervisee form, the reliability score on the goal subscale was .836, task was .892, bond was .862, and the overall instrument reliability was .948.

Data Analysis

The methods for analyzing data in relation to the three research questions are described in this section.

Research Question 1: How much variance in the supervision working alliance is explained by a clinician’s perception of the supervision emphasis?

Since multiple regression enables a researcher to explore the relationship between independent and dependent variables (Howell, 2013), it was used to determine how much variance in the supervision working alliance could be explained by a clinician’s perception of the supervision emphasis. Wampold and Freund (1987) stated that multiple regression allows for the exploration of “the separate and collective contributions” (p. 372) of multiple independent variables on one dependent variable. The dependent variable for this research question was the supervision working alliance as reflected in the three subscales of tasks, bonds, and goals. The independent variable was the perception of supervision emphasis as reflected in the four subscales: professional behaviors, conceptualization skills, personalization skills, and processing skills.

Research Question 2: Do clinicians who are supervised by Licensed Professional Counselors (LPCs) describe the supervision working alliance differently than clinicians who are supervised by supervisors with other mental health credentials?

To explore how clinician's who are supervised by LPCs view the supervisory working alliance in comparison to clinician's who are supervised by supervisors with different professional credentials, an independent sample t-test was used. An independent t-test is useful when the researcher wants to identify a difference between two population means with the same continuous dependent variable (Scott, 2010). Thus, utilizing an independent sample t-test was effective in determining if the mean of the sample group (clinicians supervised by LPCs) differed in the way they described the supervisory working alliance in comparison to clinicians who were supervised by those with other professional credentials. The dependent variable for this research question was the supervision working alliance, and the independent variables were (a) a supervisor with an LPC designation, or (b) a supervisor with professional credentialing other than an LPC.

Research Question 3: Do clinicians who are supervised by supervisors who are responsible for hiring/terminating departmental staff and/or conducting performance evaluations describe the supervision working alliance as differently than clinicians who are supervised by supervisors who are not responsible for hiring/terminating and/or conducting performance evaluations?

To understand the influence of the supervisory tasks of hiring/terminating and completing performance evaluations on the supervisory working alliance, an analysis of variance (ANOVA) was utilized. An ANOVA allows the researcher to explore differences among sample means, while also exploring different levels of an independent variable at the same time (Howell, 2010). The independent variables for Research Question Three were hiring/terminating and conducting

performance evaluations. To further explore this research question, there were three levels to the independent variables: (a) “yes” to hiring/terminating AND performance evaluations, (b) “yes” to hiring/terminating OR performance evaluations, and (c) “no” to hiring/terminating and performance evaluations. The dependent variable for Research Question Three was the mean score on the WAI (Horvath & Greenberg, 1989).

Summary

This quantitative research study focused on understanding clinicians’ perceptions of supervision emphasis and its influence on the supervisory relationship in private community-based mental health agencies in Virginia. The three research questions addressed (a) the clinicians’ perceptions of supervision emphasis (conceptualization, professional behaviors, process, and personalization skills), (b) clinicians’ perceptions of the working alliance in supervision (task, bonds, and goals), (c) the influence of their perceptions of supervision emphasis on the supervision working alliance, (d) the relationship between a supervisor’s licensure status (LPC versus other designations) and the influence on the supervisory working alliance, and (e) the influence of supervisor responsibilities of hiring/terminating and conducting performance evaluations on the working alliance. Instruments used in this study included a demographic questionnaire, the SERF-R (Lanning & Freeman, 1994) and the WAI (Horvath & Greenberg, 1989; Baker, 1990). Data analysis used for this study included measures of multiple regression, T-tests, and analysis of variance (ANOVA). Results will be presented in Chapter Four along with explanation of the implications for community mental health and counselor education.

CHAPTER FOUR.

RESULTS

This cross-sectional qualitative study was designed to explore mental health clinicians' perceptions of supervision emphasis and its influence on the supervisory relationship in private mental health agencies in Virginia. Results from this investigation are expected to increase our understanding of how the various facets of supervision—primarily in terms of its administrative or clinical focus—impact the supervisor-supervisee relationship, which ultimately has important implications for patient care. The following questions guided this investigation:

1. How much variance in the supervision working alliance is explained by a clinician's perception of the supervision emphasis?
2. Do clinicians who are supervised by Licensed Professional Counselors (LPCs) describe the supervision working alliance differently than clinicians who are supervised by supervisors with other mental health credentials?
3. Do clinicians who are supervised by supervisors who are responsible for hiring/terminating departmental staff and/or conducting performance evaluations describe the supervision working alliance as differently than clinicians who are supervised by supervisors who are not responsible for hiring/terminating and/or conducting performance evaluations?

This chapter contains a demographic description of the participants who took part in this study. Analysis and results of the research questions are also presented. The final section of this chapter contains an in-depth analysis and synthesis of interviews that emerged in three themes for each of the three research questions.

Participants

Snowball sampling, which is a useful technique for identifying participants in difficult-to-access populations, was utilized for this investigation. Given the limited number of clinicians who had worked within the five years prior to this study or were currently working in private community-based mental health agencies in Virginia—coupled with the fact that no single list existed for those who met the inclusion criteria—snowball sampling was identified as the most appropriate method for identifying potential participations. The researcher recruited participants through private community-based mental health agency contacts (National Counseling Group, EHS Support Services, Intercept Youth Services, and Family Preservation Services), through contacts at professional organizations, and through experts at educational institutions (Radford University and Virginia Tech).

A total of 170 clinicians responded to the invitation to participate in the survey (Appendix C), with 111 completed surveys, 56 refusals, and 3 partially completed surveys. According to the American Association for Public Opinion Research (2015), a partial completion is defined as a respondent completing 80% of the survey questions, and a refusal is defined as completing less than 50% of the survey questions. Prior to undertaking data analysis of the three research questions, the data was cleaned and analyzed for any missing items, which resulted in a final sample of $n = 114$.

The responses for the survey were examined for inconsistent responses; however, due to the fact that most questions required participants to state their opinions, inconsistencies could not be detected. In addition, the responses were examined for missing values and some were found. The questionnaire item with the most missing responses was Set #10 on the SERF-R, which contained four items: “You recognized when a client needed help in continuing to cope,” “You

took advantage of opportunities for additional writing,” “You were able to identify and manage personal feelings that were generated in counseling,” and “You maintained a receptive and appropriate posture during session.” This set contained a total of 13 missing responses (11.5%). It should also be noted that this instrument used a rank order scale—meaning that if a participant did not answer one item, it resulted in all four items having no response. The other possibility could be that participants looked at the order presented and felt that it was an accurate representation of their experiences and therefore did not rank order the responses. Thus, these missing values were due to either purposefully or accidentally skipping the question. Participants with a large number of missing scores, which for this study constituted a refusal, were deleted. When possible, pairwise deletion was used to control for the amount of lost data and to maximize the amount of data available (Peugh & Enders, 2004). Although no pattern of missing responses was found within the instruments, it should be noted that within the first instrument there was a variance in the number of sets answered. From observing the data, there appeared to be no identifiable pattern, although there was a slight decline in participation in the first portion of the survey—namely the SERF-R.

Evidence of Reliability

Supervision Emphasis Rating Form – Revised

For the SERF-R, the internal consistency for the subscales in this sample ($n = 114$) is reported as follows: professional behaviors = .621, process skills = .639, case conceptualization skills = .588, and personalization skills = .647. These four scores were determined to confirm reliability, since Nunnally (1967) indicated that scores of .50 and .60 could be considered adequate for demonstrating reliability. In a subsequent study, Nunnally (1978) suggested that .70 to .80 should be considered a standard score for meeting internal consistency. While the

subscales of the SERF-R do not meet the standard of .70 to .80, the obtained scores are considered adequate for the purposes of this study. This statement is supported by the original internal consistency values found by Lanning and Freeman (1994), which consisted of the following results: professional behaviors = .776, process skills = .753, personalization skills = .736, and conceptualization skills = .698.

Working Alliance Inventory – Revised

For the WAI-R, the internal consistency for the subscales in this sample ($n = 114$) was as follows: bond = .930, task = .942, goal = .867. These internal consistency scores are analogous to the values obtained by Baker (1990): goal = .836, bond = .862, and task = .892. Internal consistency and reliability scores in excess of .80 are considered to show excellent reliability (Nunnally, 1978).

Data Cleaning

As noted, this study utilized two instruments for data collection—the SERF-R and the WAI-R; the subscale scores from the former, and the subscale and total scores from the latter, were used to analyze findings from the three research questions. As detailed in this section, data cleaning procedures yielded a final sample of 114 participants. To support rigor and quality in the analyses of the research questions, participants who answered less than 80% of the survey questions were eliminated from the data pool and counted as a refusal, which is in accordance with guidelines established by the American Association for Public Opinion Research (2015). There were a total of 70 participants who did not meet the completion requirement of 80% on both instruments and were therefore counted as refusals and were deleted from the results, resulting in the final participant count of $n = 114$.

A pair wise t-test was performed on both the SERF-R and WAI-R to support the decision to either include or exclude the use of mean imputation, which is a method employed to replace a missing value with the mean value from the corresponding units (Howell, 2008). The benefits of using mean imputation include not having to exclude variables from the research, and having a complete dataset from which to draw findings (Acock, 2005). In contrast, the pitfalls of using mean imputation include skewing the dataset—and therefore risking altering the study’s results (de Waal, Pannekoek, & Scholtus, 2011). As noted by Mittag (2013), “If the mechanism is ignorable, efficiency has to be an important issue and strong arguments regarding the benefits of the incomplete cases have to be made to justify imputation.” Thus, due to the low occurrence of missing data, the use of mean imputation was not necessary in this study.

Pair wise t-tests were performed for both the SERF-R and the WAI-R; results indicated no statistically significant difference with the use of mean imputation. The statistical software chosen for this investigation, SPSS, defaults to listwise deletion. Whenever possible, pairwise deletion was utilized in the analysis in order to preserve the maximum number of participants. Therefore, mean imputation was not used for this study because overall there was only one missing response on the mean.

The SERF-R and WAI-R were both checked for skewness and kurtosis using both histograms and numerical scoring. Skewness is defined as the symmetry (or lack thereof) of a dataset; while kurtosis is defined as “...the relative concentration of scores in the center, the upper and lower ends (tails), and the shoulders (between the center and the tails) of a distribution (Howell, 2010, p. 29). Items in the SERF-R were examined for skewness and kurtosis; roughly half of the items from the SERF-R were found to exhibit some degree of kurtosis. The item with the highest score for kurtosis was “You actively participated in professional organizations,” with

a score of 11.66. The SERF-R was examined for skewness and the item with the highest score was “You actively participated in professional organizations,” with a score of -3.287. Items in the WAI were also examined for skewness and kurtosis, with four items exhibiting kurtosis and three items exhibiting skewness. The item with the highest kurtosis was, “I have the feeling that if I say or do the wrong things, my supervisor will stop supervising me,” with a score of 7.971. Furthermore, the items on the WAI were examined for skewness; the item with the highest skew was, “I have the feeling that if I say or do the wrong things, my supervisor will stop supervising me,” with a score of -2.553.

Scatter plots were run on the mean score of the subscales for both the SERF-R and the WAI-R in order to determine the presence of any linear relationships. By visually examining the scatter plots, a linear relationship was observed between the WAI mean score and the SERF-R professional behaviors mean score ($n = 114$) with a correlation of .130. No other linear relationships were identified. Moreover, no curvilinear relationships were found between any of the subscale means for the SERF-R or the WAI-R.

Additional data screening was completed prior to multiple regression analysis. There are four assumptions associated with multiple regression analysis: normal distribution of variables, a linear relationship between independent and dependent variables, reliability of variables, and the assumption of homoscedasticity (Keith, 2006; Williams, Gomez Grajales, & Krukiewicz, 2015). All data were examined for the above four assumptions, which is discussed earlier in this chapter. Additionally, Cook’s D, and leverage values were also examined. Cook’s D measures influential observations, which higher values indicating a more substantial influence. Leverage refers to the amount of pull a variable has on the overall mean score; therefore, the higher the

leverage the more substantial the influence (Howell, 2008). All data were examined for high values for Cook's D and leverage, with no high values identified.

Description of the Sample

The demographic questionnaire was designed to gather information about length and duration of supervision, credentials and education of both supervisor and clinician, responsibility of supervisor for yearly performance evaluations and hiring/terminating employees, QMHP status, age, gender, and ethnicity.

The ages of participants ranged from 23 to 65 years of age, with an average age of 35 years ($n = 113$, $sd = 10.53$); one survey participant did not answer this item. In terms of gender, 20 of the survey participants were male (17.5%), 89 were female (78.1%), 2 identified as female to male transgender (1.8%), 2 did not wish to disclose gender (1.8%), and 1 participant omitted the question.

Participants were able to select as many ethnicities as they wished from the options and were also able to select "other." If participants selected multiple ethnicities, they were identified as biracial or multiethnic. Out of the 114 completed and partial surveys, 113 participants (99.1%) responded to this question: 26 individuals (22.81%) identified their ethnicity as Black/African American; 75 individuals (65.79%) identified as White; 5 individuals (4.39%) identified as Hispanic; 1 individual (0.88%) identified as American Indian or Alaska Native; 1 respondent (0.88%) identified as Asian, and no one identified as Native Hawaiian or other Pacific Islander. In total, 11 individuals (7.89%) identified as biracial or multiethnic, and 2 people (1.75%) identified as "other." Finally, 5 individuals selected multiple ethnicities. Table 1 provides a summary of participant ethnicity represented in this study.

Table 1.

Clinician Race/Ethnicity

Ethnicity	<i>n</i> (%)
Black/African American	26 (22.81)
White	75 (65.79)
Hispanic	5 (4.39)
American Indian or Alaska Native	1 (0.88)
Asian	1 (0.88)
Native Hawaiian or other Pacific Islander	0 (0.00)
Biracial or multiethnic	9 (7.89)
Other	2 (1.75)

The survey participants also provided information about education, licensure status, QMHP status, and current employment (full time, part time, or formerly employed) in the demographic questionnaire. Of the sample, 99 (89.8%) of the clinicians reported working full time for a private community-based mental health agency, 9 reported working part time (7.9%), 5 (4.4%) reported being formerly employed, and 1 respondent did not answer the question. In terms of educational background, 43 (37.7%) of the participants reported earning a bachelor's degree, 68 (59.6%) had a master's degree, 2 (1.8%) had earned a doctorate, and 1 participant did not respond. As far as licensure status, 8 (7.0%) of participants reported their licensure status as Licensed Professional Counselors, 2 (1.8%) as Licensed Clinical Social Workers, 20 (17.5%) had completed their residency toward a professional license, 1 (.9%) was a Registered Nurse, 9 (7.9%) reported having earned another license, 73 (64%) were unlicensed, and 1 participant did not respond. With respect to professional status, 52 (45.6%) of participants described their

Qualified Mental Health Professional (QMHP) status as a combined QMHP-C and QMHP-A. 43 (37.7%) of the participants identified as QMHP-C, 7 (6.1%) identified as QMHP-A, 8 (7.0%) identified as QMHP-E, 3 (2.6%) were unsure of their QMHP status, and 1 participant did not respond. Table 2 summarizes information about clinicians' QMHP status:

Table 2.

Clinicians' QMHP Status

Clinicians' QMHP Status	<i>n</i> (%)
QMHP-A	7 (6.1)
QMHP-C	43 (37.7)
QMHP-A/QMHP-C	52 (45.6)
QMHP-E	8 (7.0)
Unknown	3 (2.6)

In addition, information was gathered about the supervisors' education, licensure status, and responsibility for performance evaluation and hiring/terminating departmental staff. The responding clinicians reported that 4 (3.5%) of their supervisors had earned bachelors degrees, 101 (88.6%) earned master's degrees, 7 (6.1%) earned doctorates, one (0.9%) was unsure, and 1 (0.9%) did not respond. As for licensure status, the participating clinicians reported that 45 (39.5%) of their supervisors were Licensed Professional Counselors, 25 (21.9%) were Licensed Clinical Social Workers, 15 (13.2%) were residents working toward licensure, 3 (2.6%) had another mental health-related licensure, 25 (21.9%) were not licensed, and 1 (0.9%) did not respond. Tables 3 and 4 summarize the educational status and the licensure status for both clinicians and supervisors.

Table 3.

Supervisor and Clinician Education Status

Educational Level	Clinicians: <i>n</i> (%)	Supervisors: <i>n</i> (%)
Bachelors	43 (37.7)	4 (3.5)
Masters	68 (59.6)	5 (3.5)
Doctorate	2 (1.8)	6 (3.5)
Unknown	0	7 (3.5)
No response	1 (0.9)	8 (3.5)

Table 4.

Supervisor and Clinician Licensure Status

Licensure status	Clinicians: <i>n</i> (%)	Supervisors: <i>n</i> (%)
LPC	8 (7.0)	45 (39.5)
LCSW	2 (1.8)	25 (21.9)
RN	1 (0.9)	0
Completing residency	20 (17.5)	15 (13.2)
Other license	9 (7.9)	3 (2.6)
Not licensed	73 (64)	25 (21.9)
No response	1 (0.9)	1 (0.9)

Data were also obtained for supervisors' responsibility for yearly performance evaluations and/or hiring/terminating employees (Table 5). Of the total, 92 (80.7%) participants reported that their supervisors were responsible for yearly performance evaluations; 10 (8.8%)

responded that their supervisors were not responsible for evaluations; 11 (9.6%) were unsure; and 1 (0.9%) did not respond. Finally, 47 (41.2%) participants reported that their supervisors was responsible for hiring and terminating departmental employees, 46 (40.4%) responded that their supervisor did not have these responsibilities, 20 (17.5%) were unsure, and 1 (0.9%) participant did not respond.

Table 5.

Supervisors' Responsibility for Performance Evaluations and/or Hiring/Terminating Employees

Response	Performance Evaluations: <i>n</i> (%)	Hiring/terminating: <i>n</i> (%)
Yes	92 (80.7)	47 (41.2)
No	10 (8.8)	46 (40.4)
Unknown	11 (9.6)	20 (17.5)
No response	1 (0.9)	1 (0.9)

Additional information was gathered about the frequency and duration of supervision for clinicians in private mental health agencies. In total, 72 (63.2%) participants reported that on average they met with their supervisors one time per week; 27 participants (23.7%) reported meeting one time every other week; 7 participants (6.1%) reported meeting more than once per week; 7 participants (6.1%) reported meeting once per month; and 1 (0.9%) participant did not respond. In addition, 84 (73.7%) of the participants reported that supervision lasted 60 minutes; 14 (12.3%) reported that supervision lasted 30 minutes; 13 (11.4%) reported that supervision lasted 90 minutes; 1 (0.9%) participant reported supervision lasted 120 minutes; and 1 participant did not respond.

Findings

As noted, the findings for this investigation are based on demographic data, as well as data obtained from the SERF-R and the WAI-R. The SERF-R instrument contains 15 sets of 4 items and the respondent rank orders the items in each set from 1 to 4 (1 = area of most emphasis in supervision, 4 = area of least emphasis in supervision). The instrument sets can then be summed using the scoring key to determine the level of emphasis for each subscale (Lanning & Freeman, 1994). For the SERF-R, although the mean was calculated for the subscales, there was no overall mean score. For the WAI-R, the means were calculated for the subscales and overall mean. To score the WAI, the researcher summed the subscales of goal, task, and bond using the scoring key (note that several items are reverse scored). After the sums of the subscales were calculated, the total for each subscale was identified by dividing each sum by 12. In order to determine the composite score for the WAI-R, the three subscales were totaled. Mean scores and descriptive statistics for each instrument are presented in Tables 6 and 7.

Table 6.

Clinicians' SERF-R Scores, including Process, Conceptualization, Personalization Skills, and Professional Behaviors Subscales

SERF-R Subscale	n	M (SD)	Min	Max
Process	114	2.46 (.379)	1.33	3.63
Conceptualization	114	2.34 (.364)	1.36	3.00
Personalization	114	2.84 (.413)	1.57	3.57
Professional Behaviors	114	2.59 (.377)	1.33	3.63

Table 7.

Clinicians' WAI-R Scores, including Bond, Task, and Goal Subscales

WAI-R Subscales	<i>n</i>	<i>M (SD)</i>	Min	Max
WAI – Total	113	5.08 (1.06)	2.54	6.83
Bond	113	5.34 (1.15)	2.00	7.00
Task	113	5.10 (1.18)	1.92	7.00
Goal	113	4.80 (0.98)	2.67	6.5

Findings for Research Question 1

Research Question 1: How much variance in the supervision working alliance is explained by a clinician’s perception of the supervision emphasis?

To measure how much variance in the supervision working alliance could be explained by a clinician’s perception of the supervision emphasis, a regression analysis was run. The mean of the WAI was used as the dependent variable and the SERF-R subscales (conceptualization skills, personalization skills, process skills, and professional behaviors) served as the independent variables. Eigen values and condition index were examined and indicated multicollinearity. Condition index scores greater than 30 were found, which indicated a problem with multicollinearity. Therefore, z scores were computed, since this is the recommended course of action for addressing multicollinearity (IBM, 2012). The regression model was re-run with z scores and the Eigen values and condition index vastly improved in relation to the original model.

Multiple regression analysis was used to test if the SERF-R subscales (conceptualization, process, personalization skills, and professional behaviors) significantly predicted variance in the supervision working alliance. The results of the regression indicated that one predictor—

namely, professional behaviors—explained 13% of the variance ($R^2 = .130$, $F(1, 111) = 16.524$, $p < .001$). Thus, the professional behaviors subscale of the SERF-R was found to be a significant predictor of the supervision working alliance ($\beta = .360$, $p < .001$).

Multiple regression analysis was also utilized for the other SERF-R subscales: conceptualization skills, personalization skills, and process skills. The results of the regression indicated that conceptualization skills ($R^2 = .024$, $F(1,111) = 2.782$, $p > .05$), process skills ($R^2 = .023$, $F(1,111) = 2.641$, $p > .05$), and personalization skills ($R^2 = .025$, $F(1,111) = 2.853$, $p > .05$), only explain approximately 2% each of the variance each and thus are not significant and cannot be said to be significant predictors of variance in the supervision working alliance. Table 8 provides a summary of the regression analysis results.

Table 8.

Regression Analysis of SERF-R subscales and WAI-R

Model	R	R Square	Adjusted R Square
Professional Behaviors Mean	0.36	0.13	0.122
Personalization Mean	0.158	0.025	0.016
Conceptualization Mean	0.156	0.024	0.016
Process Mean	0.152	0.023	0.014

Dependent Variable: WAI-R Mean

Findings for Research Question 2

Research Question 2: Do clinicians who are supervised by Licensed Professional Counselors (LPCs) describe the supervision working alliance differently than clinicians who are supervised by supervisors with other mental health credentials?

An independent samples t-test was undertaken to compare the mean score of the WAI to the licensure status of the clinicians' supervisors. The licensure status of the supervisor was recoded in order to compare LPCs ($n = 45$) to non-LPCs (LPC = 1, all other licensure status = 2) ($n = 69$). A significant difference in the mean scores was found, with LPCs having a higher mean score. The groups were unequal and the mean difference was .44315, which is significant. The independent samples t-test comparing the mean scores of the LPCs and other licensure status professionals (Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Licensed Clinical Psychologist, Registered Nurse, completing residency toward license, other mental health licensed, and those not licensed) identified a significant difference between the means of the two groups ($t(111) = 2.223, p < .05$). The WAI was scored using a Likert scale ranging from 1 to 7, with 1 = never and 7 = always. The mean of the LPC group was significantly higher ($M = 5.3483, sd = .99145$) than the mean of the group with another licensure status ($M = 4.9051, sd = 1.06620$). Table 9 provides a summary of the data described herein:

Table 9.

Independent Samples T-Test Results

		Levene's Test for Equality of Variances		T-test for Equality of Means				
		F	Sig.	t	Sig. (2- tailed)	Std. Error Difference	95% Confidence Interval of the Difference Lower Upper	
WAI Mean	Equal variances assumed	1.154	0.285	2.223	0.028	0.19932	0.04819	0.83812
	Equal variances not assumed			2.257	0.026	0.19637	0.05351	0.83279

Findings for Research Question 3

Research Question 3: Do clinicians who are supervised by supervisors who are responsible for hiring/terminating departmental staff and/or conducting performance evaluations describe the supervision working alliance as differently than clinicians who are supervised by supervisors who are not responsible for hiring/terminating and/or conducting performance evaluations?

The mean of the WAI-R scores from participants who had supervisors with different responsibilities (hiring/terminating and performance evaluations) were compared using a one-way ANOVA. No significant difference was found ($F(3, 98) = 2.40, p > .05$). Thus, the working alliance did not seem to differ based upon supervisor responsibilities. Participants whose supervisors were responsible for hiring/terminating staff *and* conducting performance

evaluations ($n = 35$) had a mean score of 5.38 ($sd = .839$). Participants whose supervisors were responsible for either hiring/terminating staff *or* for conducting performance evaluations ($n = 40$) had a mean score of 5.19 ($sd = .999$). Participants whose supervisors were not responsible for either function ($n = 2$) had a mean score of 4.79 ($sd = 1.44$). It must be noted that due to the low number of survey participants who indicated that their supervisor did not serve in some administrative function, the validity of the results is compromised. However, it should also be noted that all but two of the participants indicated that their supervisor had some responsibility for either hiring/terminating staff and/or for conducting performance evaluation in private community-based mental health agencies.

Table 10.

ANOVA of Working Alliance Mean Scores

Category	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	6.954	3	2.318	2.145	0.099
Within Groups	117.78	109	1.081		
Total	124.734	112			

Summary

Three key findings emerged from this study of clinician perceptions of supervision emphasis and its influence on the supervisory relationship in private mental health agencies in Virginia. The first key finding is that multiple regression results showed that 13% of the variance in the WAI can be explained by the professional behaviors mean score in the SERF-R. Professional behaviors are associated with attention to detail, timeliness, paperwork, administrative duties, etc. The other subscales for the SERF-R (conceptualization skills,

personalization skills, and process skills) could only account for 2% each of the variance and were not statistically significant.

The second key finding from this investigation is that supervisees with supervisors who were credentialed LPCs perceived the working alliance as stronger in comparison to those whose supervisors had other licensure credentials. In fact, results indicate that the working alliance that LPCs established with their supervisees in this study was higher in goals, bonds, and tasks in comparison to all other professional licensure categories combined (LCSW, LCP, LMFT, RN, under residency for licensure, other mental health license and unknown).

Finally, the last key finding is that there is no significant difference in the working alliance between clinicians whose supervisor was responsible for conducting performance evaluations and/or hiring/terminating staff in comparison to those whose supervisors did not have those responsibilities.

In Chapter Five, the implications of the results are described as they pertain to the field of mental health services and supervision practices in private community-based mental health agencies. This chapter also describes the limitations of this investigation, as well as provides suggestions for continued research in the areas of supervision practices in community-based mental health agencies.

CHAPTER FIVE:

DISCUSSION

This chapter discusses the results of this study on clinicians' perceptions of supervision emphasis and its influence on the supervisory working alliance in private community-based mental health agencies in Virginia. This chapter begins with an overview of the study and the rationale for undertaking this investigation. Next, the research questions are presented with accompanying discussion of the findings for each. The implications for private community-based mental health agencies and administrators are explored, along with implications for counselor education. Finally, the limitations of the study are explored, along with suggestions for further research.

Overview of the Study

Private community-based mental health agencies fill a vital need in the provision of mental health services in Virginia. In order to operate, these private agencies must abide by regulations set forth by the Virginia Department of Behavioral Health and Development Services (DBHDS) and the Department of Medical Assistance Services (DMAS). Given the sometimes-competing definition of supervision utilized by private community health agencies—which leans more toward a task-oriented, administrative definition of supervision (e.g., reviewing progress notes, assigning case loads, and creating individualized service plans) instead of a clinical approach designed more toward the professional development of the supervisee—this quantitative study was designed to better understand a clinician's perception of the emphasis of supervision in the private setting. Specifically, the three research questions developed for this study attempted to elucidate (a) the influence of clinicians' perceptions of supervision emphasis

on the supervision working alliance, (b) the relationship between a supervisor's licensure status (LPC versus other designations) and the supervisory working alliance, and (c) the influence of supervisor responsibilities of hiring/terminating and/or conducting performance evaluations on the supervisory working alliance.

The emphasis of supervision can best be defined as the focus a supervisor chooses to stress in his or her supervisory relationships with supervisees. The areas of emphasis from Lanning (1994) include process skills, personalization skills, conceptualization skills, and professional behavior skills. Another important term for this investigation is the working alliance, which is described as a purposeful relationship where the supervisor works to guide the supervisee in professional development, techniques, and skills building (Efstation et al., 1990). Thus, the purpose of this quantitative study was order to determine how mental health clinicians employed (or formerly employed) in private mental health agencies in Virginia described their supervisory relationships and how the emphasis of supervision impacted the working alliance.

Participants for this study included clinicians currently or formerly employed (within the last five years) by private community-based mental health agencies in Virginia. For the purposes of this study, a clinician was defined as a mental health professional (QMHP-A, QMHP-C, QMHP-E, and LHMP), working in a direct service capacity, providing services under a DBHDS/DMAS program in a private community-based mental health agency. Snowball sampling was used to recruit the final participant total of 114 clinicians, each of who completed the three instruments used to collect data: the demographic questionnaire, the Supervision Emphasis Rating Form-Revised (Lanning & Freeman, 1994), and Working Alliance Inventory-Revised (Horvath & Greenberg, 1989; Baker, 1990).

Analysis of Findings

Frequency and Duration of Supervision

Information was gathered about the frequency and duration of supervision for clinicians working in private mental health agencies. The majority of survey respondents reported meeting with their supervisors once per week for 60 minutes. This frequency is in line with both DBHDS and DMAS requirements. In addition, DMAS regulations for supervision indicate that supervision should occur on a weekly basis and be centered on the review of clinical documentation and client progress. Private community-based mental health agencies are bound by these regulations, which allow little room for flexibility and adaptability of supervision to the needs of clinicians and clients.

In order to fully understand the frequency and duration of supervision in private agencies, it is helpful to understand what modes and mechanisms are used as supervision. The fact that 37% of participant respondents reported not receiving the minimum required one hour per week of supervision, as required by DBHDS and DMAS in acute care programs, begs the question of whether there is a knowledge gap between how supervisors and clinicians define supervision. For example, it is unclear if supervisors are counting time spent in staff meetings or other formal staff gatherings as supervision, in lieu of the one hour of individual supervision per week. Part of fully understanding the concept of supervision in private community-based mental health agencies is devising a definition of supervision outside of the basic standards set by DBHDS and DMAS. In my view, community-based mental health should look toward counselor education for guidance due to the fact that it clearly separates supervision into both clinical and administrative functions; in contrast, neither DMAS nor DBHDS has distinguished the two realms of supervision as having distinct features and goals.

Indeed, clinicians are best supported by a two-pronged approach that builds both their administrative and clinical skills. If both functions are addressed during supervision, the supervisor is more likely to support his or her clinician-supervisee, which ultimately leads to clients receiving the best services possible. Further defining supervision into a globally-understood definition in private mental health agencies will ensure that clinicians and supervisors alike have an understanding of the function and purpose of supervision. In addition, promulgating an unambiguous understanding of what is expected of supervisors will help ensure that DBHDS and DMAS regulations will be met and that clinical development is a requirement of supervision.

Supervisor Education and Licensure Status

Clinicians responding to the survey reported that the majority of their supervisors held master's degrees and were licensed as either Licensed Professional Counselors or Licensed Clinical Social Workers. These results are in line with the DBHDS and DMAS requirements. In addition, DMAS regulations for supervision indicate that supervisors for acute programs (outpatient, inpatient, intensive in-home, or therapeutic day treatment) must be licensed in the state in which they are working. The finding that supervisors with master's degrees and clinical licenses are supervising the majority of survey respondents adds support for supervision to include not only the required DMAS and DBHDS components, but also a clinical development focus. As noted earlier, DBHDS and DMAS both require a task-oriented view of supervision that includes a review of progress notes, treatment plans, and client outcomes. However, with the majority of supervisors holding a master's degree and accepted licensure, this indicates that supervisors have adequate clinical training such that they would be capable of incorporating clinical skills training into their weekly supervisory sessions. In order to understand if basic

clinical skills are being incorporated into weekly supervision, a more concrete definition of supervision in private community-based mental health agencies needs to be devised. It is imperative to understand the content of supervision sessions because prior research has shown that supervision has a direct impact on the outcome of therapy. As noted by Ellis & Ladany (1997), monitoring the outcomes of clients in therapy has been referred to as the “acid test” of examining the effectiveness of clinical supervision.

Emphasis in Supervision

This investigation utilized the SERF-R to measure supervision emphasis (Lanning & Freeman, 1994). The subscale means from the SERF-F indicated that conceptualization skills, which consist of the ability to cognitively understand supervision processes, present information about cases, and develop plans to support client progress, were most emphasized in supervision. The subscale that was ranked second in emphasis was processing skills, which includes interactions between supervisor and clinician. The professional behaviors subscale, which encompasses attention to detail, timeliness, paperwork, and administrative duties, was ranked third in emphasis. Finally, the least-emphasized subscale was personalization skills, which include the attitudes, beliefs, and feelings of the supervisee/clinician.

The finding that conceptualization skills—which include a clinician’s ability to provide information about a client, suggest interventions, and follow outcomes—were most emphasized in the supervisory relationship corresponds to current DMAS and DBHDS protocols. In fact, DBHDS requires that during weekly supervision in acute care program (crisis intervention, therapeutic day treatment, intensive in-home counseling) that client progress, treatment plans (including goals, objectives, and interventions), as well as progress notes are reviewed. In contrast, the fact that professional behaviors was ranked third in supervision emphasis points to a

lack of emphasis on these skills in supervision, which is surprising considering the importance of professional behaviors in DMAS and DBHDS standards.

The results of the current study were compared to those obtained by Davis-Gage (2005), who examined supervision style and the emphasis of site supervisors in a mental health counseling training program. Davis-Gage (2005) showed that the greatest emphasis was placed on personalization skills, with professional behaviors receiving the least amount of emphasis. Similar to the present study, the means for SERF-R subscale items were found to be similar to one another. However, unlike the Davis-Gage (2005) study where personalization skills had the lowest mean score and were therefore the most emphasized in supervision, results from this investigation indicated that conceptualization skills had the lowest mean score and were the most emphasized in supervision. Davis-Gage's (2005) findings contrast with the results reported herein, which may be due in part to this study's participant cohort and setting. In other words, supervision in mental health training programs differs greatly from the supervision present in private community-based mental health agencies in content, structure, and expectations. Therefore, clinicians may perceive the emphasis of supervision as more focused on conceptualization skills, rather than on professional behaviors—i.e., completing paperwork and other administrative duties.

Working Alliance In Supervision

As noted earlier, the working alliance in community-based mental health agencies is best defined by as a collaborative relationship that changes over time, but focuses on building supervisory bonds—in part through goal agreement and task alignment (Horvath & Greenberg, 1986). As indicated by the overall mean on the WAI, the population in this investigation reported

a fairly high working alliance with their supervisors, which suggests that clinicians and supervisors experienced relatively high alignment in the tasks, goals, and bonds of supervision.

The WAI subscale of bond, which consists of trust, acceptance, and confidence in the supervisory relationship (Bordin, 1979, 1983; Horvath & Greenberg, 1986), had the highest alignment between supervisor and clinician. Items included on this subscale included the following statements: “My supervisor and I understand each other,” and “I am confident in my supervisor’s ability to help me.” The mean score of 5.34 indicates a fairly high level of trust, confidence, and acceptance between clinician and supervisor. The second-highest subscale item was task. Items in this subscale include “I feel the things I do in supervision will help me to improve as a clinician,” and “We agree on what is important for me to work on.” The mean score of 5.10 indicates a relatively high level of concentration on clinicians in session behaviors with clients, including verbal and non-verbal behaviors. The subscale with the lowest alignment was goals with a mean score of 4.80. This subscale focuses on the alignment between clinician and supervisor regarding objectives and interventions in the therapeutic process. Items in this subscale include “My supervisor does not understand what I am trying to accomplish in supervision,” and “My supervisor and I are working towards mutually agreed-upon goals.” The mean score indicates that there is a moderately high focus on goals for this population.

This investigation’s mean scores for the subscales of task, goal, bond, and the total mean score were compared to those obtained by Baker (1990), who examined the supervisory working alliance amongst supervisors and doctoral-level psychology interns. This comparison showed that the mean scores for the subscales were similar to the current investigation. Baker (1990) reported the alignment of the subscales as follows: task had the highest reported alignment, bond had the second-highest reported alignment, and goal was ranked last in alignment between

supervisor and intern. The means for the subscales in the Baker (1990) study differed only by .11, compared to the current study with a difference of .53. The difference in the overall means in the two studies may be due to the standardization of supervision in American Psychological Association-approved doctoral-level psychology programs. In contrast, although supervision guidelines are provided by DBHDS and DMAS for private community-based mental health agencies, these guidelines are interpreted and implemented by each agency on a case-by-case basis.

Additionally, the present investigation ranked the subscales in order of alignment between clinician and supervisor—with bond having the highest level of alignment, followed by task, and goal with the lowest level of alignment. The Baker (1990) study differed slightly in that the task subscale had the highest level of alignment, followed by bond, and goal with the lowest level of alignment. In other words, although both studies concurred that the goal subscale had the lowest level of alignment between clinician and supervisor, the studies differed in the subscale with the highest level of alignment—which proved to be the bond subscale for this investigation, and the task subscale for the Baker (1990) study. Once again, this divergence may be due in part to the standardization of supervision practices in mental health training programs. In addition, doctoral-level psychology programs are taught from a medical model, which may lend themselves to being more task-oriented—hence, the higher level of alignment in tasks between supervisor and clinician.

A final study by Ladany et al. (2001), which examined different aspects influencing the interpretation of the working alliance, is also compared to this study's findings. The researchers stressed that the relationship between supervisor and supervisee is a fundamental component of supervision and is influenced by the supervisory working alliance. Similarly, the present study

found that the majority of clinicians reported a moderately high bond with their supervisor, thereby indicating a high working alliance. These findings support Ladany et al. (2001) in that the bond between supervisor and clinician directly influenced the working alliance.

Variance in the Supervision Working Alliance as Explained by Supervision Emphasis

The results of the current study indicate that variance in the supervisory working alliance can be predicted by the professional behaviors subscale of the SERF-R. Supervision working alliance was measured using the WAI-R, while clinician perceptions of supervision emphasis was measured with the SERF-R (Freeman & Lanning, 1994). The mean score of the WAI was used as the dependent variable and the SERF-R subscales (conceptualization skills, personalization skills, process skills, and professional behaviors) were used as the independent variables. The variance in the working alliance was most influenced by the emphasis on professional behaviors such as attention to detail, timeliness, paperwork, and administrative duties.

The regression model showed that about one-seventh of the variance in the WAI can be explained by the professional behaviors mean subscale of the SERF-R, which as noted earlier pertains to complying with professional practice and behavioral standards (Lanning, 1986). None of the other three subscales for the SERF-R showed statistically-significant variance with the overall mean of the WAI. Overall, 19.4% of the variance in the WAI was explained by all of the SERF-R subscales combined. Therefore, 80.6% of variance in the WAI was explained by outside factors not included in the SERF-R. These factors could possibly include the culture of the organization, personal factors pertaining to both clinician and supervisor—and, of course, DBHDS and DMAS regulations.

Results from this study also showed a moderately-positive relationship between the mean score for the professional behaviors subscale on the SERF-R and the overall mean for the WAI-R. In other words, as the professional behaviors mean increased, so did the overall working alliance mean. This finding is in line with prior research indicating a correlation between increases in the professional behaviors subscale mean and (1) a decreased emphasis on professional behaviors skills such as complying with standards in the profession in regards to practice, guidelines, and ethical behavior, and (2) improvements in the supervision working alliance. In essence, supervisees prefer that their supervisors spend time on clinical skills improvements rather than focusing on purely administrative duties. Supervision that is unbalanced and overly focused on one area (e.g., professional behavior skills) can create a divide between the supervisor and clinician, thus affecting the working alliance (Magnuson, 2000). Despite this known association, DMAS regulations for supervision indicate that the same tasks should be accomplished in supervision on a weekly basis, which are centered on the review of clinical documentation and client progress. Private community-based mental health agencies are bound by these regulations, thus allowing little room for balanced supervision, which is a fluid process that ideally should adapt to the needs of the clinician and client.

Supervisor's Licensure Status and the Working Alliance

From this study it is evident that clinicians who are supervised by supervisors with LPC credentials reported a stronger working alliance. This finding is important to the current research because a stronger working alliance has been directly correlated with positive outcomes in the therapeutic relationship between clinician and client (Bambling et al., 2006). Private community-based mental health agencies are required to report client outcomes on a quarterly basis through updates to treatment plans and quarterly reports. These outcomes determine if a

client has completed goals for service and/or is eligible to be re-authorized for continuing care. A strong working alliance between supervisor and clinician can help support the client in achieving therapeutic goals, shortening the duration of treatment, and increasing the availability and access to treatment for a variety of clients. Because many private community-based mental health agencies rely on funding from Medicaid to operate, it is imperative that a strong working alliance be maintained to support client outcomes.

In addition, supervisors who are credentialed LPCs must adhere to the American Counseling Association ethical code subsection on guidelines for supervision. These guidelines demand that counseling supervisor be trained in supervision methods and techniques, address multicultural issues during supervision, ensure supervisee competence with all ethical codes and their application, and monitor the boundaries of the supervisory relationship (American Counseling Association, 2014). The most recent guidelines established by the Virginia Board of Counseling require LPCs to have at minimum 200 hours of supervision to qualify for licensure. Guidelines established by the ACA and the Virginia Board of Counseling support having well-trained supervisors who can build strong working alliances with clinicians. In addition, supervisors who are LPCs are able to address the multifaceted nature of supervision through attention to professional behaviors, conceptualization, personalization, and process skills during supervision with clinicians.

The finding that supervisors with the credential of LPC evidenced a higher working alliance with their supervisees supports the need for mandated supervisor training by private community-based mental health agencies. Currently, there are stated requirements for the training of supervisors in DBHDS and DMAS programs. While some programs (i.e., acute care programs) require supervisors to be licensed (LPC, LCSW, LCP, etc.), there are also programs

that can be supervised by supervisors without a license. Given this gray area of supervisor training, the unfortunate outcome is that certain programs (and the counselors who serve them) are being managed by supervisors who do not have an understanding of supervision as a separate entity from counseling. The training that LPCs receive in Virginia in order to qualify as supervisors can serve as a template for the training of supervisors in community-based mental health agencies.

Supervisors Responsibility for Hiring/Terminating and/or Conducting Performance

Evaluations and the Working Alliance

The means for WAI scores of participants who had supervisors with different responsibilities pertaining to hiring/terminating and conducting performance evaluations were compared using a one-way ANOVA. In the demographic portion of the survey, participants were asked if their supervisors were responsible for hiring/terminating and conducting performance evaluations. No significant difference was found between the three groups: (a) yes to performance evaluation and hiring/terminating; (b) yes or no to performance evaluations and hiring/terminating; and (c) no to both performance evaluations and hiring/terminating. In other words, the working alliance appeared to be unaffected by whether or not supervisors had those duties. However, based upon the number of respondents for each group, there is insufficient evidence to either support or refute a strong correlation. In other words, because only two survey respondents indicated that their supervisors were not responsible for either hiring/terminating or conducting performance evaluations, it cannot be stated for certain that no correlation exists. What is important, however, is the fact that only 2 respondents of the 114 people who took part in this study indicated that their supervisors had no such administrative duties—meaning that in

the setting of interest, hiring/firing and performance evaluations are routinely mandated in supervision.

Previous research has shown that issues arise when supervisors are required to assume the role of both administrative and clinical supervisor. The issues include a clinician being unwilling to fully disclose, an exponential power dynamic due to the combined supervision duties, and ethical challenges (Kadushin, 1992; Kadushin, 1992 (b); Tomski-Klingshirn, 2007). Kadushin (1992) asserted that the two supervision duties should be separated to promote greater autonomy in the supervision roles, lessen the power differential between supervisor and supervisee, and allow the supervisor more freedom to function in the selected supervision role. In addition, in their quantitative study of counselor residents (counselors registered with a state regulatory board and under supervision for licensure), Tromski-Klingshirn and Davis (2007) found that 49% of the counseling residents had supervisors who functioned as both clinical and administrative supervisors. This reported percentage is much lower than the current study in which essentially 98% of respondents (112 of 114) indicated that their supervisors were responsible for either/both hiring/firing and conducting performance evaluations. It must be noted, however, that the Tromski-Klingshirn and Davis (2007) study supported the commonality of dual supervisor roles in both private community-based mental health settings and mental health trainings clinics.

In summary, due to the limited validity of this factor in the current study, this researcher cannot correlate a strong working alliance with either the presence of absence of the supervisory duties of hiring/terminating staff and/or conducting performance evaluations. This finding is likely associated with the normalization of these supervisor responsibilities in private community-based mental health agencies. To further explore the impact of dual supervisor roles

on the working alliance in private mental health agencies, an instrument would need to be developed that explicitly delineated the categorical differences between administrative tasks (hiring/terminating and performance evaluations) and clinical tasks (development of bond, goals, etc.). Additionally, a qualitative study could be used to further explore a clinician's understanding of supervisor roles and how these roles impact the working alliance.

Implications

This quantitative research study was designed to elucidate clinicians' perceptions of supervision emphasis and its influence on the supervisory relationship in private mental health agencies in Virginia. Research questions addressed the influence of clinicians' perceptions of supervision emphasis on the supervision working alliance, the relationship between a supervisor's licensure status (LPC versus other professional designations) and the influence on the supervisory working alliance, and the influence of supervisory responsibilities of hiring/terminating and/or performance evaluations on the working alliance.

Counselor Educators

The current research indicates that the primary emphasis in supervision in private community-based mental health agencies is on case conceptualization skills. This finding is in line with the requirements set forth by DBHDS and DMAS for acute care programs in Virginia. However, this finding is in opposition to the supervisory emphasis in mental health training programs that emphasize professional development and skills enhancement. In order to adequately prepare counseling students for the reality of the working world and equip them to better serve their clientele, it is imperative that information about the nature of community-based mental health agencies be clarified. Private community-based mental health agencies dominate the number of mental health service providers in Virginia. Therefore, it is necessary that the

unique nature of these agencies, their supervisory protocols, and services offered be introduced to counseling students during their graduate education.

Research has shown that more experience a clinician has, the more he or she prefers a supervisory emphasis on professional behaviors (Usher & Borders, 1993). However, this correlation contrasts with findings from the current investigation that the emphasis of supervision in private community-based mental health agencies is on conceptualization skills—with professional behaviors ranked third in emphasis. In order to prepare counseling students for the reality of supervision in private mental health agencies, there needs to be an open dialogue about the difference in supervision as promulgated in training programs versus supervision as practiced in community-based mental healthcare settings. As counseling students begin to transition from training programs that stress the development of clinical skills to professional positions, the emphasis of supervision transitions as well. Thus, it is important that counseling students be encouraged to seek supervision from multiple sources if they find that their supervision needs are not being met. Moreover, it is imperative that counseling students be educated in the basics of supervision, supervision emphasis, the working alliance, and resources for supervision. Through this education, counseling students will be empowered to seek supervision that addresses all areas (professional behaviors, conceptualization, process, and personalization skills) and supports the development of a strong working alliance between clinician and supervisor.

Private Community-based Mental Health Agencies

The first finding of this study that impacts private community-based mental health agencies is that clinicians perceive the emphasis of supervision to be on conceptualization skills (i.e., the clinician's ability to comprehend clients' presenting issues, plan a course of treatment and identify support systems, and formulate plans for discharge) (Lanning & Freeman, 1994).

This finding is in line with current DBHDS and DMAS standards that require a focus on client progress and treatment planning during supervision sessions. While it is all but impossible for a supervisor to equally balance all four areas of emphasis (process, conceptualization, professional behaviors, and personalization skills) during every supervision session, it is essential that a supervisor be knowledgeable of the different areas of emphasis. By so doing, the supervisor can provide a well-rounded supervision experience to support the wellbeing of the client and the professional growth of the clinician. In order to fully support the inclusion of multiple areas of emphasis in the supervision process, it is also important to educate supervisors about these areas of emphasis and what they entail, develop techniques for incorporating them, and determine how to monitor for clinician compliance and client well being while diversifying supervision.

Equally important is that clinicians are exposed to a supervisory experience that stresses the development of conceptualization skills, personalization skills, and processing skills. This goal can be accomplished by offering professional development opportunities, engaging in group supervision, or diversifying the current supervision to include these three important elements.

A second finding in this study that impacts private community-based mental health agencies is the difference in the working alliance with LPC-credentialed supervisors in comparison to the working alliance with supervisors with different professional credentials. In the current study, clinicians who were supervised by LPCs reported a stronger working alliance than those clinicians supervised by supervisors with other credentials. This finding may be due in part to the fact that there has been much work done in the past decade to define, operationalize, and standardize supervision in the counseling profession. This trend is evidenced in supervision requirements set forth by ACES and requirements for the licensing of LPCs as promulgated by the Virginia Board of Counseling. In the Commonwealth of Virginia, current

requirements for serving as a supervisor require postgraduate education in supervision and two years post-licensure experience. In addition, students enrolled in CACREP master's level counseling programs are exposed to supervision techniques during their program by way of CACREP standards. Although these standards exist for master's-level counseling students and LPCs, similar standards are not yet in place for supervisors in private community-based mental health agencies. Therefore, these agencies have much work to do in the development of a concept of supervision that supports not only gains in revenue, but clinician development as well.

Despite the fact that LPCs are exposed to the concept, definition, and operationalization of supervision from the onset of their graduate education, the work of clinicians in private agencies is still very much governed by supervision standards established by DBHDS and DMAS. For example, private agencies are bound to Medicaid standards and supervision standards are often formulated to meet these standards. In order to increase the working alliance—and ultimately positive client outcomes—it is necessary for private community-based mental health agencies to align and standardize a definition of supervision regardless of licensure designation. And, in fact, these agencies have an excellent template in the work done by ACA, ACES, and the Virginia Board of Counseling in the conceptualization, definition, and operationalization of supervision. To support more than merely meeting the standards of DBHDS and DMAS, it is becoming increasingly important that consensus occurs among private community-based mental health agencies as to how enhance both client outcomes and clinician growth via supervision. In addition, standardization of a definition of supervision will support the development of supervision standards for private community-based mental health agencies that ensure compliance with all areas of emphasis.

Limitations

Several limitations must be noted in this study, which include the lack of random sampling, the fact that this study was limited to one geographic location, the exclusion of Community Services Boards (CSBs), the use of an online survey format, the influence of social desirability, and the lack of a variety of instrumentation to measure supervision emphasis and the supervision working alliance.

Of the limitations noted above, the single limitation that may have had the most impact was the use of snowball sampling. Snowball sampling was utilized because of the difficulty locating a rare sample in a large geographic area (Chromey, 2008). However, this approach was dependent on prospective participants forwarding the survey to others in order to gather a large enough cohort of participants. In contrast, the preferred method for accessing participants for this study would have been random sampling. This approach would have enabled every clinician in the Commonwealth of Virginia (or at least those currently or formerly employed by a private mental health agency) to have any equal chance of being selected (Howell, 2008). However, due to the lack of a professional organization representing private community-based mental health agencies (which may have provided a list of e-mail addresses of clinicians), there was no way to conduct a study based on random sampling. Therefore, snowball sampling may not have resulted in a sample that accurately represented all clinicians employed by private mental health agencies in the Commonwealth of Virginia. In addition, snowball sampling does not provide a mechanism for calculating sampling error, which means that no reliable inferences about the population can be made (Faugier & Sargeant, 1997)

An additional limitation that must be discussed was the potential effect of social desirability bias on the results of the survey. With the increased media attention on mental

health treatment and outcomes in the United States, the potential for reporting socially-desirable responses can occur. The increased attention on treatment options and outcomes in mental healthcare settings can leave clinicians feeling vulnerable and protective of their agencies, colleagues, and supervisors. Furr (2010) reported that social desirability is a very complex factor to assess, which can affect measurement validity and the validity of scores. In order to overcome the potential limitation of social desirability in this investigation, it was important to use questions that avoided bias in phrasing. Both the SERF-R and the WAI-R were noted to have many items that may have been affected by social desirability. For example, SERF-R statements such as “You recognized personal limitations and strengths,” and “You were aware of socio-economic and/or cultural factors that may influence the counseling session,” may have caused a clinicians desire to answer in a socially-expected way. In addition, WAI-R statements such as “I believe my supervisor likes me,” and “I am confident in my supervisor’s ability to help me,” may have garnered a similar response. In order to control for the influence of social desirability, future studies could utilize the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960), which would allow for additional analyses to be run on collected data, thereby minimizing this limitation.

An additional limitation that may have affected the findings of this study is the administrative structure of private community-based mental health agencies—specifically, the fact that clinicians in these settings may be supervised by more than one supervisor. The number of supervisors responsible for the oversight of a clinician’s work will be dependent upon QMHP status and licensure eligibility. In addition, a clinician may report to one supervisor for administrative supervision and a second supervisor for clinical supervision (if offered).

Therefore, the multiple supervisors present in one clinician's supervision experience may have muddied the accuracy of recall about supervision emphasis and the working alliance.

A final limitation of note in the current study was the reliability and validity of the SERF-R. Recall that the internal consistency values for the subscales in the current study were as follows: professional behaviors = .621, process skills = .639, case conceptualization skills = .588, and personalization skills = .647. Correspondingly, Lanning and Freeman (1994) reported their internal consistency subscale scores as follows: professional behaviors = .776, process skills = .753, conceptualization skills = .698, and personalization skills = .736. Also recall that Nunnally (1967) indicated that scores of .50 and .60 could be considered adequate for demonstrating reliability. In a subsequent study, Nunnally (1978) suggested that .70 to .80 should be considered a standard score for meeting internal consistency. Given that this study's SERF-R internal consistency values do not reach Nunnally's (1978) suggested levels, the use of this instrument must be viewed as a potential limitation that ultimately may negatively impact the usefulness of this study's findings. Therefore, in order to support further investigations into supervision emphasis and the effect of the working alliance in private mental health agencies, it would be best to develop or seek out an instrument with stronger internal consistency scores to support the validity of the results. Indeed, Bernard and Goodyear (2014) recently reported that conducting research about clinical supervision is difficult due to the lack of instruments. In addition, a mixed-methods study utilizing open-ended questions about supervision emphasis would support clinicians being able to fully share their experience with supervision in a qualitative format.

Suggestions for Future Research

Future research in the area of the effects of supervision emphasis on the supervisory working alliance should concentrate on understanding the role of Medicaid regulations on how

supervisors structure supervision. It is imperative to understand if supervisors structure supervision solely based on mandated policies and procedures—or if supervision stressing more clinical development is also routinely included. Recall that the professional behaviors subscale can predict 13% of the variance in the working alliance. This finding supports the need for further investigation into the influence of supervision emphasis on the supervision working alliance. This recommendation is especially important in order to support positive outcomes in the clinician/client relationship, which ultimately will improve clinical outcomes for the client.

In addition, future research is needed that will address the impact of including administrative duties on the working alliance and client outcomes in private community-based mental health agencies. Perhaps the most interesting finding in the current research is that only two participants indicated that their supervisors were not responsible for some form of administrative supervision (hiring/terminating and/or performance evaluation). If this finding is indicative of the supervisory structure of most present-day mental health agencies, research should be conducted to further explore how to best balance administrative duties such as hiring/terminating staff and conducting and performance evaluations and clinical supervision that stresses the professional development of the clinician. And because prior research has shown that the nature of supervisory working alliance has a direct impact on client outcomes, further research will support meeting clients needs. Finally, additional studies could also incorporate other variables of interest, such as years of experience in the field, the role of clinical experience with administrative staff, and the structure of performance evaluations.

Conclusion

This study investigated clinicians' perceptions of supervision emphasis and its influence on the supervisory relationship in private mental health agencies in Virginia. The major findings

that emerged from this study are the following: (a) conceptualization skills are most often emphasized in supervision in private community-based mental health agencies in Virginia, (b) the majority of surveyed clinicians reported a moderately-strong working alliance with their supervisors, (c) an emphasis on professional behavior skills was the greatest predictor of the strength of the supervision working alliance, and (d) clinicians with supervisors with the credential of Licensed Professional Counselor reported a higher working alliance than clinicians with supervisors with other credentials. Finally, it was found that the only two of the surveyed respondents reported that their supervisors were not responsible for some sort of administrative task (hiring/terminating staff and/or conducting performance evaluations).

The findings from this study support the need for further work in the development of a working definition of the concept of supervision in private community-based mental health agencies in Virginia, as well as accompanying policies, procedures, and protocols that support supervision for the betterment of the supervisee, supervisor and the agency. Although counselor education programs have well defined and operationalized the notion of supervision to include both administrative and clinical aspects, this holistic approach has yet to trickle down to private agencies. Indeed, while DMAS and DBHDS have set standards for supervision, these requirements should be viewed as the bare minimum because they do not address clinician development. In order to support the needs of the client, the development of clinicians, and healthy business practices, it is imperative that the concept of supervision in community-based agencies be expanded beyond reviewing paperwork and documenting client progress. This goal can be achieved by transferring the focus away from revenue-generating and business practices toward the support of clients via the development of a clinician's clinical skills through quality supervision practices.

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Appendix A. Informed Consent

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Consent to Act as a Human Participant

Your participation is requested for a study of clinician's perception of supervision.

Your participation is requested in this study because you are a clinician who currently or formerly (within the last five years) works for a private community mental health agency in the Commonwealth of Virginia. Your impressions are essential to understanding this important topic. No identifying information about yourself, your agency, or your supervisor will be collected.

This study will take approximately 15 - 20 minutes to complete and includes demographic information and questions about the supervision you received. There are no known risks to participation in this study. We are utilizing this web-based survey to protect your digital data. As an added protection, we have not asked questions that would identify you in any way. The results of this study will be used to fulfill dissertation requirements and for possible publication in journals.

Benefits of participation in this study include having the opportunity to have your important opinions included in this study. This information has the potential to improve supervision practices. If you choose to participate in this study, there is the opportunity to select an organization you would like to receive a \$50 donation. The organization with the most votes at the end of the study will receive the donation.

Participation in this research study is voluntary and your responses will not be linked to you in any way. You can withdraw from this study at any point by exiting the survey or closing the browser window.

By selecting the button below, you consent to participate in this research study about your perceptions of supervision. In addition, by selecting the button below, you are indicating that you are at least 18 years of age and that you are currently or formerly (within the last five years) employed by a private community-based mental health agency in Virginia.

If you have any questions about the research study or protocol please contact:

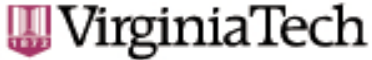
Jennifer Keith, LPC, NCC
(540) 797 – 5703
jkeith@vt.edu

If you have any questions about the protection of human subjects in this research study please contact:

Dr. David Moore, Chair
Virginia Tech Institutional review Board for the Protection of Human Subjects
(540) 231 – 4991
moored@vt.edu

_____ I acknowledge that I have read and understood the above informed consent and am giving my consent to participate in the study. Take me to the survey now.

Appendix B. IRB Approval Letter



Office of Research Compliance
Institutional Review Board
North End Center, Suite 4120, Virginia Tech
300 Turner Street NW
Blacksburg, Virginia 24061
540/231-4606 Fax 540/231-0959
email irb@vt.edu
website <http://www.irb.vt.edu>

MEMORANDUM

DATE: October 6, 2015
TO: Laura Everhart Welfare, Jennifer Lynn Keith
FROM: Virginia Tech Institutional Review Board (FWA00000572, expires July 29, 2020)
PROTOCOL TITLE: Clinician Perception of Supervision Emphasis and the Influence on the Supervisory Relationship in Private Mental Health Agencies in Virginia
IRB NUMBER: 15-786

Effective October 6, 2015, the Virginia Tech Institutional Review Board (IRB) Chair, David M Moore, approved the New Application request for the above-mentioned research protocol.

This approval provides permission to begin the human subject activities outlined in the IRB-approved protocol and supporting documents.

Plans to deviate from the approved protocol and/or supporting documents must be submitted to the IRB as an amendment request and approved by the IRB prior to the implementation of any changes, regardless of how minor, except where necessary to eliminate apparent immediate hazards to the subjects. Report within 5 business days to the IRB any injuries or other unanticipated or adverse events involving risks or harms to human research subjects or others.

All investigators (listed above) are required to comply with the researcher requirements outlined at:

<http://www.irb.vt.edu/pages/responsibilities.htm>

(Please review responsibilities before the commencement of your research.)

PROTOCOL INFORMATION:

Approved As: **Exempt, under 45 CFR 46.110 category(ies) 2,4**
Protocol Approval Date: **October 6, 2015**
Protocol Expiration Date: **N/A**
Continuing Review Due Date*: **N/A**

*Date a Continuing Review application is due to the IRB office if human subject activities covered under this protocol, including data analysis, are to continue beyond the Protocol Expiration Date.

FEDERALLY FUNDED RESEARCH REQUIREMENTS:

Per federal regulations, 45 CFR 46.103(f), the IRB is required to compare all federally funded grant proposals/work statements to the IRB protocol(s) which cover the human research activities included in the proposal / work statement before funds are released. Note that this requirement does not apply to Exempt and Interim IRB protocols, or grants for which VT is not the primary awardee.

The table on the following page indicates whether grant proposals are related to this IRB protocol, and which of the listed proposals, if any, have been compared to this IRB protocol, if required.

Appendix C. Recruitment E-mail

Dear Potential Research Participant,

I am studying clinicians' perceptions of supervision in private mental health agencies in Virginia. You are being asked to participate because you are currently or formerly (within the last five years) employed by a private mental health agency in Virginia and you received supervision while employed by this agency. Your opinions are important to me as you are a practicing clinician providing important services to clients in Virginia. The brief survey will take approximately 15 - 20 minutes to complete and is anonymous.

If you choose to participate in this research project, you will have the opportunity at the end of the survey to vote for a mental health advocacy organization that you would like to receive \$50.00. The organizations to choose from include: National Alliance on Mental Illness - Virginia, Mental Health America of Virginia, Substance Abuse and Addiction Recovery Alliance of Virginia, or The Campaign for Children's Mental Health. Once all survey results have been received, the organization with the most votes will receive the donation.

Before deciding to participate in the study please read the informed consent to gather more information.

https://virginiatech.qualtrics.com/SE/?SID=SV_6Kz7Uwc6Fdvp8ih

After you finish the survey, please consider forwarding this e-mail to other clinicians you may know who are currently or formerly employed by private community-based mental health agencies in Virginia.

If you have any questions or concerns before, or during, the process of taking the survey you can contact me at jekeith@vt.edu (540) 797 - 5703 or my advisor, Dr. Laura Welfare, at welfare@vt.edu (540) 231 - 8194

Thank you for considering participating in this research.

Jennifer Keith, LPC, NCC

PhD Candidate

Counselor Education and Supervision

Virginia Tech

Appendix D. First Follow-up E-Mail

Dear Potential Research Participant:

It has been three days since I first contacted you about participating in a study of clinicians' perceptions of supervision in private mental health agencies in Virginia. Your anonymous input is vital to understanding this topic and I am writing to request your participation in this study. Due to the anonymous nature of this study, this reminder e-mail is being sent to all initially identified potential research participants. If you have already participated in this study, please dis-regard this follow up e-mail. This brief survey will take 15 – 20 minutes to complete.

Before deciding to participate in the study you may read the informed consent to gather more information.

https://virginiatech.qualtrics.com/SE/?SID=SV_6Kz7Uwc6Fdvp8ih

After you finish the survey, please consider forwarding this e-mail to other clinicians you may know who are currently or formerly employed by private community-based mental health agencies in Virginia.

If you have any questions or concerns before, or during, the process of taking the survey you can contact me at jekeith@vt.edu (540) 797 - 5703 or my advisor, Dr. Laura Welfare, at welfare@vt.edu (540) 231 – 8194.

Jennifer Keith, LPC, NCC

PhD Candidate

Counselor Education and Supervision

Virginia Tech

Appendix E. Second Follow-up E-mail

The second follow up e-mail will be sent out five days after the request for participation e-mail.

Dear Potential Research Participant:

It has been five days since I first contacted you about participating in a study of clinicians' perceptions of supervision in private mental health agencies in Virginia. Your anonymous input is vital to understanding this topic and I am writing to request your participation in this study. Due to the anonymous nature of this study, this reminder e-mail is being sent to all initially identified potential research participants. If you have already participated in this study, please dis-regard this follow up e-mail. This brief survey will take 15 – 20 minutes to complete.

Before deciding to participate in the study you may read the informed consent to gather more information.

https://virginiatech.qualtrics.com/SE/?SID=SV_6Kz7Uwc6Fdvp8ih

After you finish the survey, please consider forwarding this e-mail to other clinicians you may know who are currently or formerly employed by private community-based mental health agencies in Virginia.

If you have any questions or concerns before, or during, the process of taking the survey you can contact me at jekeith@vt.edu (540) 797 - 5703 or my advisor, Dr. Laura Welfare, at welfare@vt.edu (540) 231 – 8194.

Jennifer Keith, LPC, NCC

PhD Candidate

Counselor Education and Supervision

Virginia Tech

Appendix F. Demographic Questionnaire

Supervision

Directions: Take a moment to think about the person at your private mental health agency who is your primary supervisor for individual supervision. Answer the following questions based on your experiences over the last month or your most recent month of employment with the private mental health agency.

1) On average, how often did you meet with your supervisor for individual supervision?

More than 1 time per week

1 time per week

1 time every other week

1 time per month

Less than 1 time per month

2) On average, how long was each supervision session?

120 minutes

90 minutes

60 minutes

30 minutes

15 minutes

Less than 15 minutes

3) What is/was your supervisor's highest level of completed education?

Bachelor's Degree

Master's Degree

Doctoral Degree

Unknown

4) What is/was your supervisor's licensure status (check all that apply)?

Licensed Professional Counselor

Licensed Clinical Psychologist

Licensed Clinical Social Worker

Licensed Marriage and Family Therapist

Completing residency for professional license

Registered Nurse

Other License

Not licensed

5) Is/Was your supervisor responsible for your yearly performance evaluations?

Yes

No

Unknown

6) Is/Was your supervisor responsible for hiring and termination of employees in your department of the agency?

- Yes
- No
- Unknown

Professional

7) Please indicate the highest level of education you have *completed*

- Associate's Degree
- Bachelor's Degree
- Master's Degree
- Doctoral Degree

8) Which of the following best describes your Qualified Mental Health Professional status?

- QMHP-E
- QMHP-A
- QMHP-C
- QMHP-A and QMHP-C
- unknown

9) Which of the following best describes your professional licensure status (check all that apply)?

- Licensed Professional Counselor
- Licensed Clinical Psychologist
- Licensed Clinical Social Worker
- Licensed Marriage and Family Therapist
- Completing residency for professional license
- Registered Nurse
- Other License
- Not licensed

10) Which of the following best describes your employment at the private mental health agency?

- Full time
- Part time
- Formerly employed

Demographics

11) Age:

18	56	94
19	57	95
20	58	96
21	59	97
22	60	98
23	61	99
24	62	100
25	63	101
26	64	102
27	65	103
28	66	104
29	67	105
30	68	106
31	69	107
32	70	108
33	71	109
34	72	110
35	73	111
36	74	112
37	75	113
38	76	114
39	77	115
40	78	
41	79	
42	80	
43	81	
44	82	
45	83	
46	84	
47	85	
48	86	
49	87	
50	88	
51	89	
52	90	
53	91	
54	92	
55	93	

12) Gender

Female

Male

Female to Male Transgender

Male to Female Transgender

Other gender identity

Prefer not to respond

13) Race/Ethnicity

Black/African American

White

Hispanic

American Indian or Alaska Native

Asian

Native Hawaiian or other Pacific Islander

Biracial or multiethnic

Other

Appendix G. Supervision Emphasis Rating Form-Revised

The complete instrument is available from the author.

Appendix H. Working Alliance Inventory (Revised)

Supervision Research Questionnaire (Supervisee Form-Revised)

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her supervisor.

Above the statements there is a scale:

Never Rarely Occasionally Sometimes Often Very Often Always

If the statement describes the way you always feel (or think), select always; if it never applies to you, select the never. Use the statements in between to describe the variations between these extremes.

Work fast; your first impressions are the ones we would like to see.

1. I feel uncomfortable with my supervisor.

Never Rarely Occasionally Sometimes Often Very Often Always

2. My supervisor and I agree about the things I will need to do in therapy to help improve my abilities as a clinician.

Never Rarely Occasionally Sometimes Often Very Often Always

3. I am worried about the outcome of these sessions.

Never Rarely Occasionally Sometimes Often Very Often Always

4. What I am doing in supervision gives me new ways of looking at how I approach my work as a clinician.

Never Rarely Occasionally Sometimes Often Very Often Always

5. My supervisor and I understand each other.

Never Rarely Occasionally Sometimes Often Very Often Always

6. My supervisor perceives accurately what my goals are.

Never Rarely Occasionally Sometimes Often Very Often Always

7. I find what I am doing in supervision confusing.

Never Rarely Occasionally Sometimes Often Very Often Always

8. I believe my supervisor likes me.

Never Rarely Occasionally Sometimes Often Very Often Always

9. I wish my supervisor and I could clarify the purpose of our sessions.

Never Rarely Occasionally Sometimes Often Very Often Always

10. I disagree with my supervisor about what I ought to get out of supervision.

Never Rarely Occasionally Sometimes Often Very Often Always

11. I believe the time my supervisor and I are spending together is not spent efficiently.

Never Rarely Occasionally Sometimes Often Very Often Always

12. My supervisor does not understand what I am trying to accomplish in supervision.

Never Rarely Occasionally Sometimes Often Very Often Always

13. I am clear on what my responsibilities are in supervision.

Never Rarely Occasionally Sometimes Often Very Often Always

14. The goals of these sessions are important to me.

Never Rarely Occasionally Sometimes Often Very Often Always

15. I find what my supervisor and I are doing in supervision is unrelated to my concerns.

Never Rarely Occasionally Sometimes Often Very Often Always

16. I feel the things I do in supervision will help me to improve as a clinician.

Never Rarely Occasionally Sometimes Often Very Often Always

17. I believe my supervisor is genuinely concerned for my welfare.

Never Rarely Occasionally Sometimes Often Very Often Always

18. I am clear as to what my supervisor wants me to do in these sessions.

Never Rarely Occasionally Sometimes Often Very Often Always

19. My supervisor and I respect each other.

Never Rarely Occasionally Sometimes Often Very Often Always

20. I feel that my supervisor is not totally honest about his/her feelings toward me.

Never Rarely Occasionally Sometimes Often Very Often Always

21. I am confident in my supervisor's ability to help me.

Never Rarely Occasionally Sometimes Often Very Often Always

22. My supervisor and I are working towards mutually agreed upon goals.

Never Rarely Occasionally Sometimes Often Very Often Always

23. I feel that my supervisor appreciates me.

Never Rarely Occasionally Sometimes Often Very Often Always

24. We agree on what is important for me to work on.

Never Rarely Occasionally Sometimes Often Very Often Always

25. As a result of these sessions, I am clearer as to how I might be able to improve my work as a clinician.

Never Rarely Occasionally Sometimes Often Very Often Always

26. My supervisor and I trust one another.

Never Rarely Occasionally Sometimes Often Very Often Always

27. My supervisor and I have different ideas on what my difficulties are.

Never Rarely Occasionally Sometimes Often Very Often Always

28. My relationship with my supervisor is very important to me.

Never Rarely Occasionally Sometimes Often Very Often Always

29. I have the feeling that if I say or do the wrong things, my supervisor will stop supervising me.

Never Rarely Occasionally Sometimes Often Very Often Always

30. My supervisor and I collaborate on setting goals for my supervision.

Never Rarely Occasionally Sometimes Often Very Often Always

31. I am frustrated by the things I am doing in supervision.

Never Rarely Occasionally Sometimes Often Very Often Always

32. We have established a good understanding of the kind of changes that would be good for my work as a clinician.

Never Rarely Occasionally Sometimes Often Very Often Always

33. The things that my supervisor is asking me to do don't make sense to me.

Never Rarely Occasionally Sometimes Often Very Often Always

34. I don't know what to expect as the result of my supervision.

Never Rarely Occasionally Sometimes Often Very Often Always

35. I believe the way we are working in supervision is correct.

Never Rarely Occasionally Sometimes Often Very Often Always

36. I feel my supervisor cares about me even when I do things that he/she does not approve of.

Never Rarely Occasionally Sometimes Often Very Often Always