PERCEPTIONS OF SUPERVISORY KNOWLEDGE, BEHAVIOR, AND SELF-EFFICACY: SUPERVISOR EFFECTIVENESS IN PERFORMING CLINICAL SUPERVISION AND DEVELOPING THE SUPERVISORY RELATIONSHIP

By

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ABSTRACT

PERCEPTIONS OF SUPERVISORY KNOWLEDGE, BEHAVIOR, AND SELF-EFFICACY: SUPERVISOR EFFECTIVENESS IN PERFORMING CLINICAL SUPERVISION AND DEVELOPING THE SUPERVISORY RELATIONSHIP

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Clinical supervision is a critical element of the pre-service training and development of rehabilitation counselors (Thielsen & Leahy, 2001). This evaluative, yet supportive relationship between counselor and supervisor has the intended response of improving counselor professional development, while maintaining a strong focus on the counselor-client relationship as its core element (Herbert, 2012). Past research efforts have explored the clinical supervision process in the state vocational rehabilitation system (English, Oberle, & Byrne, 1979; Herbert, 2004c; Herbert & Trusty, 2006; McCarthy, 2013; Schultz, Ososkie, Fried, Nelson, & Bardos, 2002). These research projects have helped to outline the contemporary practices associated with clinical supervision in the public rehabilitation system.

The private rehabilitation settings are growing in terms of service delivery and the number of professionals practicing in these myriad settings. Beyond the work of King (2009) that looked at clinical supervision in the long-term disability setting, little work has been done to clarify the contemporary practices of clinical supervisions in the private-not-for-profit and private-for-profit settings of vocational rehabilitation. This study was undertaken to begin the process of identifying the contemporary practices associated with clinical supervision in private rehabilitation. The study explored participant perceptions of clinical supervision knowledge, clinical supervision related behaviors, self-efficacy in delivering clinical supervision, and perceptions of the supervisory working alliance. Satisfaction with and perceived quality of

clinical supervision were also examined. A preliminary sample of 2,000 rehabilitation counselors employed specifically in private rehabilitation work environments was obtained for this study from the Commission on Rehabilitation Counselor Certification (CRCC), of which 432 provided some type of data.

Results of this study indicated statistically significant differences between counselors and supervisors perceptions of present levels of supervisory knowledge, supervisory behaviors, self-efficacy in delivering clinical superivsion, and supervisory working alliance. Knowledge and gender were found to be significant predictors of satisfaction with supervision, and behavior and supervisory working alliance were significant predictors of perceived quality of clinical supervision.

Rehabilitation educators and practitioners in the private-for-profit and private-not-for-profit settings can use the data generated and examined in this study to improve overall understanding of clinical supervision and delivery of clinical supervision. With the pending curriculum changes resulting from the Council on Rehabilitation Education (CORE) and the Council for Accreditation of Counseling & Related Educational Programs (CACREP) merger, rehabilitation educators can use the data to consider how to develop and implement coursework emphasizing the nature of clinical supervision and its overall importance in counselor professional development.

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CHAPTER 1

INTRODUCTION

Since its inception as a profession, rehabilitation counseling has continued to grow and evolve to match the needs of individual with disabilities. This process of professionalization has included the development of a professional code of ethics, the delineating and validation of standards of practice, the formation of professional associations, the establishment of accreditation standards for pre-service training programs, and led to a nationally recognized certification process (King, 2009; Wright, 1980). Rehabilitation counselors today are practicing in an increasing number of areas and state vocational rehabilitation (VR) programs are no longer the largest employer of certified rehabilitation counselors (Saunders, Barros-Bailey, Chapman, & Nunez, 2009). Additionally, changes in legislation, work settings and employment practices germane to persons with disabilities necessitate that rehabilitation counselors continually expand their knowledge areas, skills, and professional competencies to proficiently serve diverse consumer populations and navigate evolving work settings (Leahy, Chan, & Saunders, 2003). A critical component of ensuring skill and professional development in counselors, while simultaneously ensuring client safety, is clinical supervision (Glosoff & Matrone, 2010). With continued high demand within traditional settings and a growing need for rehabilitation counselors in emergent practice settings (Chan & Ruedel, 2005), the demand for rehabilitation counselors is at an all time high. Clinical supervision is necessary in order to ensure adherence to ethical standards, foster continued professional development of practitioners, and ensure client safety. For this to happen, the profession must understand the practice of and proficiency with which clinical supervision is provided in the myriad practice settings.

Clinical supervision has been defined as, "… an intervention provided by a more senior member of a profession to a more junior colleague or colleagues of who typically (but not always) are members of the same profession. This relationship is evaluative and hierarchical, extends over times, 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 gatekeeper for the particular profession the supervisee seeks to enter" (Bernard & Goodyear, 2014, p. 9). This definition has been recognized as applicable to the rehabilitation field (Maki & Delworth, 1995; Schultz, 2008; Thielsen & Leahy, 2001). From this definition, the goals and outcomes of clinical supervision (promotion of quality assurance and ethical practice) are readily apparent and when provided appropriately, clinical supervision will help foster professional development and clinical competence leading to counselors possessing a higher sense of self-efficacy (Lorenz, 2009; Magnuson, Norem & Wilcoxon, 2002) and professional identity. While the supervisory practices of the state VR setting have been examined (English, Oberle, & Byrne,1979; Herbert, 2004c; Herbert & Trusty, 2006; McCarthy, 2013; Schultz, Ososkie, Fried, Nelson, & Bardos, 2002), the supervisory practices in the non-profit and private/for profit rehabilitation practice settings have received little attention. As non-profit and private/for profit practices settings continue to expand, knowledge of clinical supervision practices in these settings is critical.

Background of the Study

As a profession, the advent of VR is unique when compared to other helping professions; the profession's formulation in the United States is tied to the legislative process. Beginning with a recognized need to serve wounded veterans, the 1918 Soliders Rehabilitation Act provided veterans wounded in combat the opportunity to receive training and skill development

for "a realistic occupation that had to be feasible" (Wright, 1980, p. 6). While this act targeted veterans, there was no comparable legislation mandating VR services to civilians. Previous legislation had suggested the nation was setting a new course in terms of vocational education and rehabilitation (Wright, 1980), but it was not until the 1920 Civilian Rehabilitation Act (Smith-Fess Act) that services to civilians were guaranteed. The rights of civilians in the VR process were later expanded by the 1943 Vocation Rehabilitation Act Amendments (Barden-LaFollete Act) which increased funding and expanded both the types of disabilities eligible for and services provided within the rehabilitation process (Wright, 1980). Both the civilian and veterans rehabilitation services continued to grow and develop and as the value of counseling and guidance received greater recognition, particularly within the veterans' programs, subsequent legislation (1954 Vocational Rehabilitation Act Amendments: Hill-Burton Act) recognized the need for specialized training relative to disability and appropriated training funds to establish graduate training programs (Leahy & Szymanski, 1995; Wright, 1980). As rehabilitation counseling continued to develop as a field, accreditation of the curriculum within training programs and certification of training program graduates helped to further the professionalization process.

Accreditation

The Commission on Rehabilitation Education (CORE) was incorporated in 1972 and utilized previous research completed at the University of Wisconsin – Madison to build a foundation for the knowledge standards recognized as foundational to the rehabilitation profession (Leahy & Szymanski, 1995). These standards have been substantiated through various role and function studies identifying the seminal knowledge components necessary for effective practice in rehabilitation (Leahy, Chan, & Saunders, 2003; Leahy, Chan, Sung, & Kim,

2013; Leahy, Muenzen, Saunders, & Strauser, 2009; Leahy, Shapson, & Wright, 1987; Leahy, Szymanski, & Linkowski, 1993; Muthard & Salamone, 1969). CORE presently accredits 97 graduate training programs in the United States and Puerto Rico (CORE, 2014). Historically, these universities have been free to implement the instructional guidelines outlined by CORE in their respective programs as they saw fit and were subject to periodic review of their instruction to ensure compliance with the established standards. With the recent CORE/Council for Accreditation of Counseling & Related Educational Programs (CACREP) merger agreement, CACREP will be the accreditation body of the future (CACREP, 2015).

Certification

The Commission for the Certification of Rehabilitation Counselors is the oldest certifying body in the counseling field and was established contemporaneously with CORE in 1974 (Leahy & Holt, 1993; Saunders et al., 2009; Wright, 1980). When rehabilitation counselors obtain certification, it gives persons with disabilities, specialists, and the general public a standard with which to compare service providers (Leahy & Holt, 1993). Certification is also a ratification of the skills and knowledge obtained through pre-service training methods (typically a graduate program), as well as practicum and internship hours and generally suggests the certified individual is ready for entry into the field. Similar to CORE and its accreditation process, CRCC has empirically examined its credentialing process to ensure its test specifications and certification standards match the role and function of the rehabilitation counseling field (Leahy, Chan & Saunders, 2003; Leahy et al., 2013; Leahy et al., 2009; Leahy, Shapson, & Wright, 1987; Leahy, Szymanski, & Linkowski, 1993; Muthard & Salomone, 1969; Rubin et al., 1984).

Qualified Professional

As recognized by the rehabilitation counseling professional associations, graduation from a master's program in counseling (or closely related field), certification as a Certified Rehabilitation Counselor (CRC), appropriate state licensing, and adherence to the CRCC Code of Professional Ethics are the integral parts of being recognized as a qualified professional (Leahy, 2013). Studies have shown properly trained rehabilitation counselors to be more effective in fostering the service delivery outcomes to persons with disabilities (Cook & Bolton, 1992; Szymanski, 1991; Szymanski & Danek, 1992; Szymanski & Parker, 1989). Additionally, when speaking of clinician expertise, Wampold suggested the expertise of the clinician in conjunction with the working relationship between therapist and consumer is what truly makes a difference rather than specific services (University of Wisconsin, 2015), thereby reinforcing the idea of and need for a highly qualified practitioner.

Supervision

As demonstrated through the history of VR and the development of the accreditation and certification process, rehabilitation counselors are a specialized group providing unique services, and similar to other professional fields, "it can be assumed that the nature of the work is too difficult or complex for anyone but the specifically trained members of the profession to engage in" (Write, 1980, p. 21). With this in mind, mechanisms have been developed in order to control both those gaining entrance into the profession and the criteria for admittance into that profession. Pre-service training in a graduate counseling program and certification through CRCC are two such mechanisms. An additional mechanism is supervision within the practitioner's chosen practice setting. As previously defined, supervision is evaluative in nature, protects consumers and the supervisee through a gatekeeping process, and helps to ensure the

knowledge obtained in the pre-service setting is applied appropriately in the practice setting (Bernard & Goodyear, 2014).

Practice Setting & Clinical Supervision

Thielsen and Leahy (2001) identified the essential knowledge and skills required for effective field based clinical supervision of rehabilitation counselors. These six supervisory knowledge and skill domains of ethical and legal issues, theories and models, intervention techniques and methods, evaluation and assessment, rehabilitation counseling knowledge, and supervisory relationship were found to be essential in all rehabilitation practice settings. While this commonality should be expected given the core rehabilitation philosophy inherent in all rehabilitation practice settings, it is also reasonable to assume some variation in the delivery of clinical supervision services as a result of differing goals, priorities, and consumer characteristics. The need for identifying the most effective supervisory techniques and practices in a variety of field based settings remains (Thielsen & Leahy, 2001).

State rehabilitation system. With the 1920 Civilian Rehabilitation (Smith-Fess) Act, the state rehabilitation system was established. Subsequent legislation (e.g., 1935 Social Security Act, 1943 Vocational Rehabilitation Act [Barden-Lafollete Act], 1954 Rehabilitation Act Amendments [Hill-Burton Act], 1973 Rehabilitation Act, 1990 Americans with Disabilities Act (ADA), served to strengthen and expand the service provided by the state rehabilitation system (Sales, 2012; Wright, 1980). Studies have demonstrated clinical supervision in the state VR system to be poorly understood, administered on an as needed basis (often less than 30 minutes per month), reactionary, and primarily administrative in nature (Herbert, 2004c, Herbert & Trusty, 2006; Schultz et al., 2002). Historically, the state VR system was the largest employer

of rehabilitation counselors; recent trends suggest emerging practice areas and a shift in the overall practice settings of rehabilitation counselors (Saunders et al., 2009).

Private-for-profit rehabilitation. A viable and growing part of rehabilitation counseling since the 1970s, private-for-profit rehabilitation includes those counselors "providing disability insurance rehabilitation, including workers' compensation, federal employees' compensation, longshore and harbor worker's rehabilitation, and long term disability" (Brodwin, 2008, p. 503). With increasing employment opportunities outside of the state VR system, private-for-profit now represents the largest and fastest growing employment field for CRCs (Saunders et al., 2009). Some work has explored clinical supervision in this field (King, 2009), but this piece examined one specific setting within private-for-profit settings (Long Term Disability). While it could be argued that the state VR system is also only one specific practice setting, it is a relatively homogeneous group from state to state due to legislative and administrative oversight, whereas private-for-profit encompasses the closely aligned yet distinctively differing practice settings of worker's compensation, forensic rehabilitation, life care planning, long term disability, disability management, and substance abuse rehabilitation (Brodwin, 2008). When taken collectively, private-for-profit rehabilitation is expanding and has overtaken the state VR system in terms of the number of CRCs working in the respective practice settings (Saunders et al., 2009). However, given the nuanced instruction and skill sets necessary for the many differing opportunities within private-for-profit settings, private-for-profit rehabilitation remains an area where little understanding of clinical supervision practices exits (J. Herbert, personal correspondence, March, 11, 2015).

Private-not-for-profit rehabilitation. Another long-standing employment option for CRCs, and a closely aligned partner in the rehabilitation process is the non-profit rehabilitation

practice setting (Wright, 1980). This practice setting includes rehabilitation facilities (e.g., workshops, independent living centers, etc.). Funded through a variety of federal, state, and private resources, non-profit rehabilitation settings provide a variety of services, including facility-based employment services for persons seeking to develop work skills, community based job placement assistance, and long term supported employment options (Fabian & MacDonal-Wilson, 2012). Again, little is known about the clinical supervision practices in these settings (J. Herbert, personal correspondence, March, 11, 2015).

Statement of the Problem

The private-for-profit and non-profit practice settings continue to hire increasing numbers of CRCs (Saunders et al., 2009). Clinical supervision is one of the professional safeguards ensuring counselor growth and development while simultaneously ensuring client well being. Additionally, it is widely accepted that rehabilitation counselors have professional characteristics, knowledge areas, and competencies such that a more seasoned professional remains the ideal candidate to both model the expected behaviors and skills as well as evaluate and support new counselors as they enter the practice setting of their choice (Bernard & Goodyear, 2014). Of note is the fact private-for-profit settings are often built around a business model and direct supervisors of rehabilitation counselors may not be rehabilitation counselors; they may instead be rehabilitation nurses, occupational or physical therapists, or some other member of the rehabilitation team (King, 2009). This potentially introduces competing interests (e.g., the needs of the agency versus the needs of the client; medical model approach versus a bio-psychosocial model) to the rehabilitation counselor and ethical dilemmas may arise from these competing interests. Where limited research exists into the clinical supervision practices in these settings, and where these practices settings are typically not built around the counseling

practice, but rather around a business model with a rehabilitation counselor integrated into a rehabilitation team (King, 2009), it is important to understand how rehabilitation counselors in the private-for-profit and non-profit settings are obtaining supervision and from whom they are obtaining clinical supervision as they seek to enhance and develop their own skills, provide high quality rehabilitation services to their clientele and ensure an ethics based service delivery.

Purpose of the Study

Previous research has helped to outline the knowledge and skills associated with clinical supervision in rehabilitation counseling (Thielsen & Leahy, 2001), as well as the delivery of clinical supervision in the state VR system (Austin, 2012; Herbert, 2004c, Herbert & Trusty, 2006; McCarthy, 2013; Schultz et al., 2002). With research indicating similarities in the major knowledge domains required for rehabilitation counseling, yet differences in the frequency with which certain knowledge areas are used in differing practice settings (Leahy et al., 2008), it is important to understand how practice settings are ensuring rehabilitation professionals learn the necessary skills specific to the setting. To date, outside of the dissertation by King (2009) on the long-term disability practice setting, little is known about the clinical supervisory practices within the non-profit and private-for-profit VR practice settings. Where clinical supervision has an important function in the day to day work setting for rehabilitation counselors, this study helped to identify the baseline of clinical supervision practices within the private-for-profit and non-profit practice settings, compared beliefs of supervisees and supervisors on clinical supervision, and sought to identify those factors leading to higher satisfaction rates and perceptions of the overall quality associated with the provision of clinical supervision in the private-for-profit and non-profit settings.

Significance of the Study

With the recent trend in the movement of CRCs from the state VR Settings to other practice settings, particularly the private-for-profit sectors, understanding the practices associated with, and beliefs and attitudes towards clinical supervision in the private-for-profit and non-profit settings helped to identify potential strengths in the delivery of clinical supervision. These best practices of clinical supervision may also be transferable to other practice settings in VR and serve to better inform the field on the overall implementation of clinical supervision across a variety of rehabilitation practice settings. Findings indicated a lack of understanding of clinical supervision and statistically significant differences between counselor perception and supervisor perceptions of clinical supervision knowledge levels, behaviors, self-efficacy, and working alliance. Results also indicate some concern over the perceived need or importance of clinical supervision; these results were similar to findings from research into the State VR settings (Herbert, 2004c, Herbert & Trusty, 2006; Schultz et al., 2002). Findings from the present study indicated a need to revisit the way clinical supervision is discussed and taught in the pre-service training of professionals (Herbert & Bieschke, 2000).

Research Questions

The following research questions were of interest to this study:

1. What are the contemporary practices associated with clinical supervision in non-profit and private-for-profit vocational rehabilitation settings?
2. Is there a difference in clinical supervision practice between non-profit and private-for-profit VR practice settings (e.g., e.g., minutes per week/month receiving clinical supervision, satisfaction levels associated with clinical supervision, perceived quality of clinical supervision, use of a supervisory contract)?

3. Is there any difference between supervisee and supervisor perceptions of clinical supervision provided across private practice settings in terms of supervisory knowledge, supervisory behavior, supervisor self-efficacy, and supervisory working alliance?
4. Is there an association between perceptions of counselor satisfaction and quality of supervision as related to perceptions of supervisory knowledge, behavior, self-efficacy, supervisory working alliance, ethnicity, and gender?

Descriptive statistics, independent samples t-tests, Pearson χ^2, and analysis of variance (ANOVA) were used to analyze the contemporary practices (e.g., frequency of clinical supervision sessions, length of clinical supervision sessions) of clinical supervision in the private-for-profit and private-not-for profit settings and used as baseline measures with which to compare private-for-profit supervisory practices against those in private-not-for profit settings. As question three entailed a comparative analysis, independent samples t-tests and multivariate analysis of variance (MANOVA) compared differences between responses from supervisees and supervisors employed in private-not-for-profit and private-for-profit practice settings. Question four required multiple regression analysis and clarified the amount of variance in clinical supervision satisfaction and quality explained by the independent variables.

Assumptions

This study made a number of assumptions regarding clinical supervision and rehabilitation counselors' knowledge of clinical supervision:

1) Perhaps the biggest assumption was that clinical supervision is occurring in non-profit and private-for-profit rehabilitation practice settings.

2) It was assumed rehabilitation counselors possessed the knowledge and expertise to honestly and accurately respond to a survey instrument questioning them on clinical supervision practices as professional accreditation and certification requirements dictate training in and knowledge of clinical supervision practices (CORE, 2012, C.5.11 & Section D; CRCC, 2014),
3) It was assumed rehabilitation counselors accurately and honestly described the role, function, and practices of clinical supervision in their practice setting.
4) Where all CRCs are recognized by CRCC as competent to provide certification, it was assumed CRCs identifying as supervisors were qualified to provide clinical supervision.

Definitions of Terms

As the possibility for confusion exists regarding frequently utilized terminology within this study, definitions of key words and concepts as utilized in the present study are provided to add clarity and ensure understanding of the underlying principles and framework of clinical supervision, particularly in relation to clinical supervision across the three common rehabilitation practice settings of state/federal, non-profit and private-for-profit VR.

Administrative supervision. Type of supervision provided to counselors as a way to address counselor effectiveness and efficiency (Herbert, & Trusty, 2006); focuses on the documentation aspects of vocational rehabilitation and often espouses a review of compliance with agency policies and procedures as well as overall contribution to agency outcomes (Herbert, 2012).

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

- 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 (Bernard & Goodyear, 2014, p. 9).

Private-not-for-profit rehabilitation sector. Comprising non-governmental associations and charitable organizations providing services to individuals with disabilities (e.g., Goodwill, Jewish Vocational Services, and Catholic Charities), often these agencies subcontract with state/federal VR agencies to assist with job development and placement. Many of these agencies also provide facility-based employment training and services (Fabian & MacDonald-Wilson, 2012).

Private-for-profit rehabilitation sector. Area of vocational rehabilitation where rehabilitation counseling and related services are provided on a fee for service basis. Working in collaboration with public agencies, private-nonprofit organizations, practitioners in this field provide services in the area of worker's compensation, long-term disability, forensic rehabilitation or expert witness testimony, life care planning, disability management, legal and policy consulting, and substance abuse (Brodwin, 2008).

Public rehabilitation sector. Often called the state/federal VR system, the public VR system was established via the Vocational Rehabilitation Act of 1920 and renewed and re-emphasized in subsequent legislation. This sector operates in each of the 50 states, the District of Columbia, and several territories of the United States. This sector is open to all citizens requiring assistance with disability related employment needs, independent living, and emphasizes service delivery to those identified as most significantly disabled. Oversight is provided by the Rehabilitation Services Administration (RSA) at the federal level and funds are

dispersed to state agencies based on a "match" requirement. While not available to civilians, for the purposes of this study, the federal Veterans' Administration Vocational Rehabilitation program will also be included in this definition as its funding source is also obtained through tax dollars.

Qualified professional. As recognized by the various rehabilitation counseling professional associations, those individuals with 1) a graduate degree in rehabilitation counseling or closely aligned field, 2) possesses the CRC designation and state licensure (e.g. Licensed Professional Counselor, LPC) in those states requiring this level of credential, and 3) active membership and involvement in at least one professional association associated with rehabilitation counseling are considered to be qualified providers of VR services (Leahy, 2012).

Rehabilitation counselor. A counselor possessing the specialized knowledge, skills, and attitudes needed to collaborate in a professional relationship with person with disabilities to achieve their personal, social, and psychological, and vocational goals (RCC, 2005). The specialized knowledge and skills used by rehabilitation counselors may include, but are not limited to: (a) assessment and appraisal; (b) diagnosis and treatment planning; (c) career (vocational) counseling; (d) individual and group counseling; (e) case management, referral, and service coordination, (f) program evaluation and research; (g) interventions to remove environmental, employment, and attitudinal barriers; (h) consultation services among multiple parties and regulatory systems; (i) job analysis, job development, and placement services, including assistance with employment and job accommodations; and (j) the provision of consultation about and access to rehabilitation technology (CRCC Scope of Practice, 2012).

Supervisory working alliance. The relationship between supervisor and supervisee(s) where agreement on the goals and tasks associated with the supervision process are mutually

established, an affective bond is developed between counselor and supervisor, and the supervisor provides appropriate feedback to the supervisee (Efstation, Patton, & Kardash, 1990; Herbert, 2012).

CHAPTER 2

REVIEW OF THE LITERATURE

While growing interest in and overall levels of research associated with the practice of clinical supervision in state vocational rehabilitation (VR) settings has continued to grow (Austin, 2012; Herbert, 2004, Herbert & Trusty, 2006, Schultz et al., 2002), little attention has been given to clinical supervision practices in the non-profit and private/for profit practice settings. Although King (2009) explored clinical supervision in the long-term disability practice setting, very little has been done in terms of continued research in this area of rehabilitation counselor practice. As King (2009) noted, the limited research specific to clinical supervision in the non-profit and private/for-profit practice settings presents a unique challenge when conducting a comprehensive review of the literature. As such, an overall view of the practice of rehabilitation counselor supervision was considered as it relates to the professional development process of both new and established rehabilitation counselors. In order to give the literature review an organized flow, the literature review was divided into the following major sections: the professionalization and specialization of rehabilitation counseling, supervision, qualified providers of clinical supervision, and private practice rehabilitation settings.

The Professionalization and Specialization of Rehabilitation Counseling

As defined by the American Association of State Counselor Licensure Boards (AASCB) and the American Counseling Association (ACA), "Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (Stebnicki, 2012, p. 242). Rehabilitation counseling is a sub set of this much larger field of psychotherapy and rehabilitation counselors specialize in the areas of disability, accommodation of disability, and employment aspects of disability. Counseling

specialties are not unusual, and specialization typically occurs in order to ensure a high quality of services provided to the recipient (Remley, 2012). Evidence of this dedication to high quality service provision is found within the Scope of Practice for rehabilitation counselors (CRCC, 2015a):

> Rehabilitation counseling is a systematic process which assists persons with physical, mental, developmental, cognitive, and emotional disabilities to achieve their personal, career, and independent living goals in the most integrated setting possible through the application of the counseling process. The counseling process involves communication, goal setting, and beneficial growth or change through self-advocacy, psychological, vocational, social, and behavioral interventions. The specific techniques and modalities utilized within this rehabilitation counseling process may include, but are not limited to:
>
> - Assessment and appraisal
> - Diagnosis and treatment planning
> - Career (vocational) counseling
> - Individual and group counseling treatment interventions focused on facilitating adjustments to the medical an psychosocial impact of disability
> - Case management, referral, and service coordination
> - Program evaluation and research
> - Interventions to remove environmental, employment, and attitudinal barriers
> - Consultation services among multiple parties and regulatory systems
> - Job analysis, job development, and placement services, including assistance with employment and job accommodations
> - The provision of consultation about and access to rehabilitation technology.

Thus, the very core of the practice of rehabilitation counseling is centered in the counseling profession (Maki & Tarvydas, 2012). Inherent within the scope of practice for rehabilitation counselors is an expectation of competency. In order for rehabilitation counselors to learn the skills necessary to adequately and ethically function as outlined by the scope of practice, specialized pre-professional training and continued skill development upon entering professional practice is necessary. This process is known as professional development.

Professional Development

To help professionals learn the knowledge, skills, and abilities necessary to practice in the field of counseling and by extension protect the people they serve from inadvertent harm, rigorous graduate training beyond the bachelor's level is seen as the standard. Graduate level training for rehabilitation counseling initially began in the 1940s, and after the passage of the 1954 Vocational Rehabilitation Amendments and the accompanying grants to support universities and colleges with the pre-professional training of rehabilitation counselors, the number of programs continued to grow (Leahy & Tansey, 2008; Wright 1980).

With this growth came the need for standardized curriculum across the many institutions engaged in training future rehabilitation counselors. The related fields of social work and psychology had previously developed program accreditation standards, and rehabilitation counseling followed their model, which led to the incorporation of the Council on Rehabilitation Education (CORE) in 1972 (Linkowski & Szymanski, 1993). CORE argued accreditation would allow employers and the public alike to have access to better-trained professionals. This standardization came to fruition in 1975 with the recognition of CORE's accreditation responsibility by the Council of Postsecondary Accreditation (COPA). CORE is the oldest counseling accreditation body, and CORE's primary purpose is to review and accredit master level training programs (Leahy & Tansey, 2008; Linkowski & Szymanski, 1993).

In order to ensure the validity of knowledge areas incorporated in the master's level training, on-going studies have continually analyzed and empirically validated the core knowledge and skills required for the delivery of rehabilitation counseling (Leahy, Chan, & Saunders, 2003; Leahy et al., 2009). Thus, CORE standards continue to provide specific guidelines, as well as program expectations, for the pre-professional training of rehabilitation

counselors (Leahy & Tansey, 2008) that are empirically sound. Additionally, the uniqueness and distinction of rehabilitation counseling from closely aligned fields, who have articulated their own scope of practice, has been demonstrated (Leahy, 2012).

Supervision and accreditation standards. Section III of the 2009 Council for the Accreditation of Counseling & Related Educational Programs' (CACREP) standards (a revision of the standards is presently underway and due out in 2016) sets forth ideals for the professional practice where the "application of theory and the development of counseling skills" are fostered through the application of supervision (p. 14). Responsibilities of both site supervisors and students serving as peer supervisors are outlined. Additionally, frequency rates (minimum of weekly) and specific amounts of time (minimum of 1 and ½ hours) dedicated to supervision are prescribed during the internship for master's level training.

The Council on Rehabilitation Education's (CORE) 2012 standards outlines the curriculum expectations for individuals wanting to enter the field during their pre-professional training. Specifically, a practitioner graduating from a CORE accredited program is expected to be able to "explain the purpose, roles, and need for counselor supervision in order to enhance the professional development, clinical accountability, and gatekeeping functions for the welfare of individuals with a disability" (CORE, 2012, C.5.11.a). Guidelines for supervision within the practicum and internship mirror those of CACREP (weekly individual and group supervision, D.1.3 & D.2.3; minimum averages of one hour of individual supervision and one and one half hours of group supervision, D.1.3 & D.3) as well as requiring those providing supervision to hold the certified rehabilitation counselor (CRC) designation. Guidelines outlining expectations for distance based supervision (D.1.4 & D.3.1.), evaluation procedures (D.1.6, D.1.7, D.2.4, & D.3.3), and clarification of the preparatory role of the internship as training for practice within a

profession (D.2.6) are also included. These accreditation standards and their expressed ideals further demonstrate the continued consistency of the supervisory principles previously outlined by Leddick and Bernard (1980).

Presently, rehabilitation counselors graduating from CORE accredited programs are expected to have completed 100 hours of supervised practicum and 600 hours of supervised internship (CORE, 2012). Additionally, as rehabilitation counseling is a unique specialty of the much larger counseling field, counselors in training are expected to be able to "explain the purpose, roles, and need for counselor supervision in order to enhance the professional development, clinical accountability, and gate keeping function for the welfare of individuals with a disability" (CORE, 2012, C.5.11.a). While this is the stated expectation, a review of Master Degree programs and their curricula found that curriculum often did not have a stand-alone supervision course; programs instead were more likely to infuse training on supervision in the required practicum and internship (Herbert, 2004a). Further, the type, scope, and depth of training on supervision varied from institution to institution (Herbert, 2004a). Programs also varied in the type of supervision they implemented in the practicum and internship stages, with some focusing on individual supervision, some focusing on group supervision, and others using a combination of the two supervisory practices (Herbert, 2004a). Thus, while there is a uniform standard of clinical supervision to which all CORE accredited programs are expected to adhere, the implementation of the standard varies greatly and the message delivered to counselors in training regarding the importance of supervision and knowledge of supervisory practices is largely "idiosyncratic" (Herbert, 2004, p. 25).

Supervision, Certification, & Professional Codes of Ethics

Growing out of concerns for the quality of practice by the National Rehabilitation Counseling Association (NRCA) and the American Rehabilitation Counseling Association (ARCA) and the need for practitioners to demonstrate competence in the field of rehabilitation counseling, the Commission for Rehabilitation Counselor Certification (CRCC) was established in 1974 (Leahy & Holt, 1993; Saunders et al., 2009; Wright, 1980). CRCC is one of the oldest and most established of all the counseling certification bodies (Saunders et al., 2009) and administers the credentialing exam for those wishing to obtain certification. This credentialing exam and its test specifications have relied on multiple role and function studies (Leahy, Chan & Saunders, 2003; Leahy et al., 2013; Leahy et al., 2009; Leahy, Shapson, & Wright, 1987; Leahy, Szymanski, & Linkowski, 1993; Muthard & Salomone, 1969; Rubin et al., 1984) for empirical grounding and to guide the development of test specifications.

In order to be eligible to take the certification, an interested applicant is required to submit materials to CRCC outlining their pre-professional training as evidenced by a master's degree in counseling or closely related field, and completion of a professionally supervised internship and practicum (CRCC, 2014; Leahy & Holt, 1993; Saunders, et al., 2009). The certified rehabilitation counselor (CRC) designation bestowed by the CRCC to rehabilitation counselors provides professional recognition of the successful completion of the minimum standards for competency and practice "as reflected by education, experience, peer and supervisor evaluation, and a standard national examination" (Wright, 1980, p. 31). The successful acquisition of the CRC, coupled with the completion of graduate degree training, personifies a qualified provider of rehabilitation counseling services (Leahy, 2012); the CRC

also gives persons with disabilities, other professionals, and the general public a benchmark with which to compare service providers against (Leahy & Holt, 1993).

In an effort to ensure the continuous ethical provision of services to individuals with disabilities, a code of professional ethics was developed by CRCC. All CRCs are expected to adhere to this code upon certification regardless of their practice setting (CRCC, 2009; Leahy & Holt, 1993). Initially, the CRCC borrowed wording from the NRCA code of ethics (Wright, 1980), and subsequently published and continued to revise (most recently in 2009, CRCC) their own professional code of ethics for certified rehabilitation counselors.

While "peer and supervisor evaluation" (Wright, 1980) were part of the founding values of the CRC designation, only recently has the CRCC Code of Professional Ethics included a section outlining specific expectations of supervisors. Prior to the 2002 version of the CRCC code of ethics, little guidance to rehabilitation counseling supervisors was available (Blackwell, Strohmer, Belcas, & Burton, 2002). For those interested in and actively seeking guidelines on supervision, the general counseling field did have some resources from which rehabilitation counselor supervisors could borrow. The Association for Counselor Education and Supervision (ACES) is a division of the American Counseling Association (ACA) and published ethical guidelines specific to supervision in 1993, entitled *Ethical Guidelines for Counseling Supervision,* but the majority of ACES membership at that time was limited to educators, and those rehabilitation supervisors in practice settings outside of academia may not have had ready access to this (Glosoff & Matrone, 2010).

The initial inclusion of supervisor expectations in the 2002 CRCC code of ethics, were expanded in the 2009 revision of this code. Section H, entitled Teaching Supervision, and Training, addresses specific expectations of those responsible for the education and supervision

of persons desiring to enter the field of rehabilitation counseling or maintain their certification (CRCC, 2009). At the heart of this section of the code of ethics is a responsibility of supervisors to ensure "both the professional growth of their supervisees and the welfare of the clients being served" (Glosoff & Matrone, 2010, p. 249). Espousing the second consistency of supervision identified by Leddick & Bernard (1980), specifically supervision as a learning situation, supervision has a goal of facilitating knowledge and skill development to ensure the professional growth of the supervisee (Glosoff & Matrone, 2010).

Another element that emphasized the recognition of supervision as an essential component of professional development by the CRCC is the past designation of Certified Rehabilitation Counselor – Clinical Supervisor (CRC-CS). This certification required 60 months of professional experience and a graduate level course in clinical supervision, or 30 clock hours from professional workshops on supervision; the supervisor was also expected to demonstrate proficiency in the following ten areas: "supervision process, roles and functions of clinical supervisors, models of clinical supervision, supervisory relationship issues, diversity issues in clinical supervision, group supervision, legal and ethical concerns, and evaluation of supervisee competence and the supervision process" (Herbert & Bieschke, 2000, p. 188). Thus, CRCC recognized both experience and formal training were necessary in the provision of supervision (Herbert & Bieschke, 2000). This certification was later dropped by CRCC due to lack of interest, but is reflective of certification processes in other specialty counseling fields (e.g. addictions, marriage and family therapy, and mental health counseling) for those wishing to be recognized as supervisors (Herbert, 2012)

Post graduation. While graduate training programs do their best to prepare prospective graduates for employment in their chosen field, professional development beyond the college

classroom is imperative both to the new and tenured professional. New professionals need to develop their ability to apply theory in practice settings. Additionally, with those professionals having many years of experience, it is highly plausible there are emerging knowledge and skill areas pertinent to the present day practice of rehabilitation counseling currently available, yet nonexistent at the time of their graduate studies and consequently not covered in their graduate program (Chan, Leahy, Saunders, Tarvydas, Ferrin, & Lee, 2003). This leaves professional development and growth after graduation under the direction of the rehabilitation counselor's supervisor.

Supervision

Supervision of new and existing practitioners within a profession is not unique to counseling. The supervision and socialization of medical practitioners, lawyers, and other professionals is geared to help the neophyte learn the skills necessary to function within their profession (Bernard & Goodyear, 2014), while also ensuring continued professional development and learning for those presently in the field. Supervision within the closely related fields of social work, psychology, and counseling denotes oversight of one professional by another individual of the same profession (Leddick & Bernard, 1980). Beginning with Freud requiring future psychoanalysts to undergo psychoanalysis, supervision as it has come to be operationalized, really developed between 1925 -1930 (Leddick & Bernard, 1980).

Supervision continued to grow and develop as a practice; just as theoretical approaches and differences grew and developed from Freud's initial thoughts on psychoanalysis. Ekstein and Wallerstein (1959) reported definitive supervisory stages. Rogers (1957) outlined steps in his Facilitative Model for practitioners to see and practice for themselves those attributes used by their supervisors; thus supervisors modeled counseling skills, and then assisted in the facilitation

and development of those skills in the student. Others too proposed their own take on supervision and various models of supervision began to appear in the 1970s as counselors looked for a way to refine the supervisory process. Differences in role emphasis reflected the many theoretical orientations of those proposing the models; despite the differences, some consistencies held:

1. Supervision [was] mandated by all theoretical orientations.
2. It [was] seen as a learning situation.
3. A "good" relationship between supervisor and trainee [was] valued, but a specific focus on differences between supervisors and trainees (e.g., learning style, therapy style, personalities) [was] lacking.
4. Roles for the supervisor [had] been stressed rather than specific techniques or competencies.
5. Where either a teacher or therapist role [was] cited, that stance [was] often presented as exclusive of other roles.
6. Systematic evaluation during supervision [was] minimal.
7. The field of supervision [grew] as an adjunct to the proliferation of therapy models.

(Leddick & Bernard, 1980, p. 193).

Defining Supervision

There are two widely recognized and complimentary aspects of supervision with the field of rehabilitation counseling: administrative supervision and clinical supervision (Herbert, 2012). As previously mentioned, supervision in counseling continues to be mandated as evidenced by accreditation standards of the two main counseling accreditation bodies, CORE and CACREP. While administrative supervision and clinical supervision are designed to facilitate improvement in counseling performance (Herbert, 2015b) and have complimentary roles, such as planning, organizing, evaluating, leading, and staffing (Crimando, 2004), the application of these roles, and clinical supervision in particular, within the supervisor-counselor supervisory process is individualized and varies greatly (Schultz et al., 2002).

Administrative supervision. Administrative supervision focuses primarily on the organization; it is a monitoring system of the counselor and their contributions to agency outcomes and compliance with agency policies (Herbert, 2012). The main focus of administrative supervision is to increase the overall efficiency of an organization in the areas of timeliness of service provision and existence of sufficient documentation in order to ensure recipients of services are provided appropriate services and outcomes are achieved (Herbert; 2016a; Herbert & Caldwell, 2015). Historically, examples of administrative supervision include reviewing eligibilities, evaluating individual rehabilitation plans, and monitoring case-expenditures accrued by the counselor in the provision of services to clientele (Herbert & Trusty, 2006). Recently, the operationalization of administrative supervision ahs been expanded ton include establishing written agreements outlining the nature of supervision (purpose and goals), the methods (individual, group, or triadic) of clinical supervision to be used, and the types of evaluation procedures that will be used to assess competence, duties, and responsibilities of each person involved in the supervisory relationship (Herbert, 2016b). In order to analyze rehabilitation counselors and their satisfaction with supervisory practices within a state VR agency, Herbert & Trusty (2006) used a six point Likert type scale to assess respondent satisfaction rates. They found rehabilitation counselors to be "slightly" to "moderately" satisfied with administrative supervision (p. 73).

Given its focus on agency outcomes and policy compliance, administrative supervision is an essential part of the day-to-day operations of the rehabilitation organization as a whole and serves as a way to assess the counselor's function within the organization. Thus, administrative supervisors are typically referring to laws, regulations, and management policies when considering their actions and the potential implications (Campbell, 2006). VR counselors in

state agencies may also feel the support they receive from their supervisor in regards to administrative supervision to be sufficient. This complacency with administrative supervision may serve to mask dissatisfaction with the provision of clinical supervision.

Clinical supervision. In order to describe specialized education processes, Shulman (2005a) coined the term signature pedagogy, denoting a form of action based learning with the intent to prepare others for practice. Within counseling, clinical supervision has been identified as the signature pedagogy, denoting a specialized instruction process for counselor skill development, particularly new practitioners (Barnett, Cornish, Goodyear, & Lichtenburg, 2007; Goodyear, Bunch, & Claiborn, 2005). Just as rehabilitation counseling is a specialty of counseling, clinical supervision within rehabilitation counseling is also distinctive and unique (Bezyak, Ososkie, Trice, & Yeager, 2010; Herbert, Ward, & Hemlick, 1995). Many definitions have been proposed for clinical supervision. Maki & Delworth (1995) used an existing definition of clinical supervision and applied it to rehabilitation counseling; they proposed, "clinical supervision in rehabilitation counseling is a distinct intervention, the use of which requires the trained supervisor to have specific knowledge and skills in multiple domains, including but not limited to education, consultation, and counseling" (p. 264). Building on previous definitions and concepts, Herbert (2011), as cited by Herbert and Caldwell (2014), defined clinical supervision as, "a developmental and supportive relationship that requires the supervisor working in various capacities as consultant, counselor, and teacher where the intent is to improve counselor skills and case management decisions so that successful rehabilitation outcomes occur. Using individual, triadic, and/or group supervision approaches through direct and indirect observation methods, the supervisor works to promote counselor awareness,

knowledge and skills so that effective counseling services are provided consistent with ethical and professional standards" (pg. 445).

Bernard and Goodyear (2014) suggest clinical supervision is:

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

Similarities hold across these three definitions and from these definitions, Bernard and Goodyear's (2014) assertion of supervision as a unique intervention in its own right and with substantial overlap into other interventions appears justified.

Clinical supervision focuses on the professional development of the counselor, both within the counselor-client relationship and within the professional supervisory relationship between supervisor and counselor (Herbert, 2016a; Herbert & Caldwell, 2015). Specific examples of clinical supervision practices might include the supervisor observing counselor and employer interactions, counselor and client interactions, reviewing ethical dilemmas, and increasing the counselor's awareness of potential biases that may affect the counselor-client relationship (Herbert, 2016a). Where clinical supervision has specific duties for evaluation and gatekeeping, the presence of a power differential within the supervisory relationship exists and a natural hierarchy is in place (Herbert & Caldwell, 2015). While it could be argued a power difference exists between the counselor and client as the counselor can withhold or provide services, this power difference is unique and separate as a clinical supervision could dismiss a counselor from employment or suggest to academic faculty a student in a counseling program is

not appropriate for the counseling field based on a perceived lack of competency (Herbert & Caldwell, 2015).

English et al. (1979) conducted one of the first field based studies of clinical supervision in the state rehabilitation agency setting and established some baseline supervisory behaviors important to professionals (e.g. personal honesty, leadership, efficiency, concern for others, concern for state regulations, flexibility, and decisiveness). In conducting this national survey of rehabilitation counselors, English et al. (1979) laid a solid foundation on the importance of clinical supervision practices, the need for training, perceptions of supervisory influence, and the poor perception of the counselor evaluation procedures used at the time. In looking at specific clinical supervision interventions, Schultz, et al. (2002) evaluated responses from 111 rehabilitation counselors working in state VR agencies. Results indicated clinical supervision was provided on an irregular basis and not consistently applied by supervisors. A majority of the respondents met with their supervisor for thirty minutes or less per week (52.3%) and only 30% of respondents indicated they used a supervisory contract with their supervisor. Thus, it would appear the majority of clinical supervision within rehabilitation counseling is completed with limited goals or direction, as evidenced by the lack of a supervision contract. Supervisory contracts have been recommended as one way to address concerns regarding recruitment and retention of rehabilitation counselors (Schultz, 2007). These contracts provide information to supervisees regarding the supervision they will receive by outlining the supervisor's credentials, approach to supervision and overall counseling and supervisory experience, while clearly delineation the, "…purpose, goals, and objectives of supervision" (Glossoff & Matrone, 2010, p. 251). Further, the authors found that many respondents identified staff meetings as clinical supervision, indicating a lack of understanding of the purpose and extent of clinical supervision.

Herbert and Trusty (2006) also looked at counselor and supervisors in the state VR system. With a sample of 145 practitioners, the authors found individual supervision to be the primary supervisory method and clinical supervision occurred on average less than 20 minutes per month. Almost half of the new counselors (48%) and supervisors (45%) reported receiving or providing clinical supervision once per month, while 65% of the experience counselors receive clinical supervision no more than once per month. For those supervisors who reported providing clinical supervision, the number of supervisors who said they documented supervisory sessions was poor (80%) and supervisors were noted to only devote minimal time to the provision of clinical supervision. These findings confirmed and expanded the previous work of Schultz et al. (2002).

From these two articles, it would appear clinical supervision within state VR agencies is often provided on an as needed basis, occurs for short periods of time at irregular intervals, does not outline clear goals or purposes, and is not well documented. This type of clinical supervision is reactionary (Schultz et al., 2002). Supervisors in Herbert & Trusty (2006) suggested they used group supervision, but none of the counselors stated they received this type of clinical supervision. This corroborates the Schultz et al. (2002) suggestion that supervisors in the state VR setting seem to believe staff meetings focusing on administration tasks, adherence to agency policy, and performance evaluation constitutes the provision of clinical supervision. Furthermore, clinical supervision does not appear to be well-understood within state VR settings and this may be in part due to the term "clinical" when referring to clinical supervision (Herbert, 2004c). Further, findings indicate support for a requisite knowledge base and skill set in order to effectively apply clinical supervision in practice settings.

Qualified Providers of Clinical Supervision in Practice Settings

Given the special emphasis within the ethical codes of certification bodies (ACA and CRCC), and given the key role supervisors play in the professional development of supervisees in the practice setting, it is not surprising to see supervision requirements in pre-professional training, as well as ethical guidelines and expectations of those supervisors. Another important aspect of "qualified provider" is the trust given to the counseling profession by the larger social community in the development of practitioners. Given the high degree of preparation and the general assumption the lay person would not have the knowledge to either practice or oversee new providers in the counseling profession, there is an "implicit contract [where] self-regulation is permitted in return for the assurance that this profession will place the welfare of society and of their clients above their own interest" (Bernard & Goodyear, 2014, p. 5). The professional accreditation and certification bodies for rehabilitation counselors serve to monitor the initial self-regulation process. Self-regulation consists of gatekeeping (e.g., controlling who is admitted into practice), preparing ethical codes of conducts (e.g., setting standards of acceptable professional behavior), and disciplining professionals acting or practicing in an unethical or incompetent manner (Bernard & Goodyear, 2014). While certification bodies have some lingering self-regulation powers, once a practitioner graduates from their pre-professional training, the supervisor becomes the principle enforcer of the self-regulation process. But, what constitutes a qualified provider of supervision? Citing a doctoral dissertation (Lorenz, 2009), Hebert (2012) stated, "…the combined effect of the supervisory working alliance, supervisory style, and supervisory behavior were predictive of counselor self-efficacy for graduate students" (p. 432). Thus, supervisors should understand the elements of the supervisory working alliance, the knowledge and skills required of Rehabilitation Counseling supervisors, the styles and

behaviors associated with appropriate clinical supervision, and the elements necessary for minimally adequate supervisor, along with the potential results related to harmful or ineffective supervision.

Supervisory Working Alliance

The supervisory working alliance model posited by Bordin (1983) is similar to the working alliance between counselor and client and is a collaborative process wherein the supervisor and supervisee agree upon the goals of supervision, the individual tasks of the supervisor and supervisee within supervision, and the establishment of a working bond between supervisor and supervisee (Bordin, 1983; Rarick & Ladany, 2013). Certain styles, behaviors, and processes serve to strengthen the supervisory working alliance and critical feedback is offered to the supervisee with the intent to improve counselor development and performance (Bernard & Goodyear, 2014; Herbert, 2004c; Herbert, 2012).

The working alliance theory in the counselor/client relationship suggests a strong therapeutic relationship is necessary for change to occur (Bordin, 1983) and the SWA theory extends this to the supervisor/supervisee relationship where a strong SWA is necessary for a counselor to develop those skills necessary for effective interaction with clients (Ladany, Ellis, & Friedlander, 1999; McCarthy, 2013). A key task, which must occur early on in the clinical supervision process, is the development of a strong working alliance; this relationship requires ongoing maintenance and will serve as the basis from which future dilemmas in supervision can be managed (Bezyak et al., 2010; Nelson, Gray, Friedlander, Ladany, & Walker, 2001). If there is limited contact between the supervisor and counselor, as evidenced by meetings of thirty minutes or less per week or meetings occurring on an as needed basis (Schultz, et al., 2002; Herbert & Trusty, 2006), then the overall strength of the supervisory working alliance will

decrease and a corresponding weakening of the clinical supervision process will occur (Schultz et al., 2002). Indeed limited contact or provision of supervision may send a message that supervision does not require a great deal of commitment (Herbert, 2004b). When supervisors demonstrate a lack of commitment to the SWA, they may inadvertently and negatively influence counselor-client relationships as counselors may then lack commitment to the counselor/client working alliance (Austin, 2012). Overemphasis on administrative supervision by a supervisor may adversely impact service delivery as counselors may begin to see the counselor-client relationship as an administrative relationship (Bezyak et al., 2010).

The SWA is the relationship upon which professional development and transformational learning are based (Ladany et al., 1999; Schultz, 2008). One of the goals of supervision is the increased knowledge and skills of a counselor, which in turn intuitively leads to increased counselor self-efficacy when appropriate learning opportunities are provided as counselors will have the opportunity to implement those skills learned in the pre-service training and refined through clinical supervision (Costa, 1994). However, for the supervisee to receive and internalize recommendations made by their supervisor, an appropriate relationship must first exist. The lack of an appropriate relationship may promote turn over intentions in counselors and adversely impact client outcomes.

Relationship to burn out/turn over: The loss of rehabilitation counselors to closely aligned fields has been cited as a growing concern (Chan, 2003; Schultz, & Millington, 2007; Tansey, Bishop, & Smart, 2004). In examining the relationship between Person and Organizational (P-O) fit, Pitt (2009) surveyed rehabilitation counselors working for a state VR system. Findings indicated supervision as an area respondents were "least satisfied", and a statistically significance relationship between turnover intent and supervision satisfaction

existed. Clinical supervision has been shown to reduce professional burn out (Yagil, 2006), increase jobs satisfaction (Sterner, 2009), and enthusiasm for the job (Fischetti & Crespi, 1999). Where supervision is designed to improve professional development and ultimately foster consumer success, rehabilitation agencies should find ways to attend to the needs of their counselors through the provision of supervision, and by extension, this may help to improve the service delivery to consumers (Capella & Andrew, 2004; Pitt, 2009). Additionally, the turn over intent of rehabilitation counselors may decrease, which reduces organizational strain.

In discussing findings from a four-state multiple case studies on organizational and cultural factors promoting creative best practices in public rehabilitation settings, Sherman et al. (2014) discussed staff training and development. Findings indicated these high functioning organizations placed an emphasis on the development of an appropriate working alliance between counselor and client and fostered professional development opportunities of staff through training and clinical supervision. A shared focus on client self-actualization and work outcomes, rather than a purely administrative focus on employment outcomes, helped to foster skill development and counselor performance by sharing knowledge and expertise (Sherman et al., 2014). Clinical supervision provides opportunities for transformational learning and skill development (Schultz, 2008) and in so doing can help stabilize organizational structures by decreasing turn over intent (Pitt, 2009).

Relationship to client outcomes. The strength of the working alliance between counselor and client has been found to be the best indicator of client outcomes, even more so than theoretical orientation or service provision (Martin, Garske, & Davis, 2000). Where rehabilitation counselors will often imitate the working alliance they have with their supervisor in their work with clients (Austin, 2012), a poorly modeled SWA can inadvertently and

adversely impact the counselor/client relationship. McCarthy (2013) explored the relationship between the SWA and client outcomes within State VR practice settings.

In surveying rehabilitation counselors from five state rehabilitation agencies, McCarthy (2013) found the SWA between newer counselors (e.g., those with less than two years of experience) was a significant predictor of successful case closures. Of note is the report by Saunders, Barros-Bailey, Chapman, and Nunez (2009) describing the demographics of the contemporary CRC. Their findings indicated 30% of the present CRCs having less than five years of experience, and when considering McCarthy's findings and the impact clinical supervision has on newer professionals, clinical supervision is needed and does indeed have a place in the present work force. While McCarthy's findings on clinical supervision and outcomes did not hold true for counselors with more than two years of experience, this emphasizes the importance of applying appropriate clinical supervision in the early stages of professional and career development when clinical decision-making and overall thought complexity or case conceptualization is still developing (Skovholt & Ronnestad, 1992) and then molding the supervision to fit the need of the counselor over time.

Knowledge and Skills

Thielsen & Leahy (2001) identified supervisory knowledge and skills as perceived by field based CRCs. This was completed as part of the initial process of identifying the necessary supervisory knowledge and skills for effective field-based supervision in rehabilitation counseling. In the first part of this study, Thielsen & Leahy (2001) used a Delphi method and surveyed subject matter experts (SMEs) in the provision of supervision. The responses of the SMEs helped to identify ninety-five items for use in the construction of the Rehabilitation Counselor Supervision Inventory.

A total of 1,500 questionnaires were mailed to CRCs currently in practice and 793 (53.4% response rate) were returned. Results from this national outreach collaborated with the results of the Delphi panel, indicating agreement on the supervisory knowledge and skills necessary for the provision of supervision in rehabilitation counseling. Further, six content domains emerged allowing for a grouping of the rated items: "Domain 1: Ethical and Legal Issues, Domain 2: Theories and Models, Domain 3: Intervention Techniques and Methods, Domain 4: Evaluation and Assessment, Domain 5: Rehabilitation Counseling Knowledge, and Domain 6: Supervisory Relationship" (Thielsen & Leahy, 2001, p. 201). Overall results from this study indicate a perception by field based CRCs that there is indeed a set of supervisory knowledge and skills perceived to be important and critical to the supervision of rehabilitation counselors. Although these supervisory knowledge and skills were found to be similar to the knowledge and skills necessary for rehabilitation counseling practice, the supervisory knowledge and skills are also uniquely different (Thielsen & Leahy, 2001). Thus, promotion of a field based counselor to a supervisory position based on the premise of a good counselor automatically being a good supervisory would be erroneous. Although results indicate there are knowledge and skills for the practice of rehabilitation counseling that can only be modeled by a senior member of the same profession, results also indicate there are specific knowledge and skills necessary for supervision (Thielsen & Leahy, 2001), further substantiating previous assertions by Maki and Delworth (1995) that rehabilitation counseling supervision is a distinct intervention requiring specialized training in supervisory knowledge and skill domains.

Styles and Behaviors

Even though Thielsen and Leahy (2001) outline the skills and knowledge necessary to function as a rehabilitation counseling supervisor, familiarity with the requisite knowledge base

and skill set for rehabilitation counseling supervision is not sufficient. Certain styles and behaviors of supervision have been found to be important to the supervisory process, particularly the development of the supervisory working alliance (SWA). However, researchers have operationalized style differently. Style has been defined as approaches of supervision that are collegial, process oriented, or a combination of the two (Friedlander & Ward, 1984); other definitions feel style is referring to theoretical orientation (e.g., psychodynamic, person centered, or behavioral; Herbert, Ward, & Hemlick, 1995) or even indicative of teaching, counseling, or consulting roles within supervision (Bernard & Goodyear, 2014). Supervisors need to be accessible, available, capable, flexible, and use humor when appropriate (Herbert, 2004c). Thus, it would seem the provision of supervision is a combination of the correct knowledge and skills applied in conjunction with appropriate styles of social interaction and behavioral tendencies.

Ethical behavior. Adding to the heretofore-mentioned styles of supervision, Schultz (2011) examined the impact of supervisor ethical behavior on the supervisory process. As evidenced by the CRCC Code of Ethics (Section H, 2010), supervisors have clearly defined expectations regarding their professional behavior with those they supervise and also the customers receiving services. Schultz explored the link between perceived supervisory ethical behavior and the perceived strength of the supervisory working alliance. Supervisees from a state VR agency were asked to rate their supervisor's ethical behavior using the Supervisor Principle Ethics Scale and rate the supervisory working alliance using the Supervisory Working Alliance Inventory –Trainee Form. Results were then statistically analyzed to determine the impact of the supervisor's perceived adherence to ethical principles and the overall strength of the supervisory working alliance form the supervisee's perspective. Findings suggest an

increased potential for a productive and mutually beneficial supervisory relationship when adherence to ethical principles is present within the supervisory process (Schultz, 2011).

Within this study, Schultz (2011) also referred to the inherent power difference within the supervisory relationship. Other authors have also identified the importance of recognizing and not abusing the power difference between supervisor and supervisee (Bernard & Goodyear, 2014; CRCC, Section H.3.e, 2010; Glosoff & Matrone, 2010). Referent power and expert power have been found to be related to the quality of the SWA (Schultz et al., 2002); referent power is based on the identification of one individual with another, and expert power refers to a perception of an individual have a specific knowledge or expertness as it relates to a given task (French & Raven, 1959; as cited in Schultz et al., 2002). Thus, as supervisors seek to demonstrate effective ethical behaviors, the correct use and application of power within the SWA is necessary.

Self-efficacy and Supervision

The role and function of the rehabilitation supervision, but clinical supervisor in particular, is complex and multifaceted (Phillips, Schultz, & Thielsen, 2012). With little clinical supervision provided beyond practicum and internship in the majority of rehabilitation agencies (English et al., 1979; Herbert & Trusty, 2006; McCarthy, 2013; Schultz 2008; Schultz et al., 2002), it is reasonable to assume clinical supervisors in rehabilitation counseling practice settings are not as intentional in their promotion of counselor development as they might be (Phillips et al., 2012), particularly when clinical supervision is provided inconsistently, as needed, or passively with little thought to purpose or intentionality (Herbert & Trusty, 2006; McCarthy, 2013; Schultz et al., 2002). It has been posited that a lack of self-efficacy in regards to the

provision of clinical supervision may be one component of this passive and inconsistent approach to clinical supervision (Phillips et al., 2012).

Defined as the relationship between an individual's perceived ability and actual ability (Bandura, 1977; Bandura, 1982), self-efficacy is both domain and task specific. As such, a supervisor providing clinical supervision may feel a high sense of self-efficacy related to the counselor role (domain specific) based on familiarity developed over years of previous experience (Phillips et al., 2012). However, in regards to clinical supervision, with little to no formal training on clinical supervision being commonplace (Herbert & Trusty, 2006), levels of self-efficacy related to the provision of clinical supervision (task specific) may be low. Part of the supervisor's ability to provide a quality clinical supervision will be dependent on the outcome expectancy, or belief that a certain behavior will lead to certain outcomes (Bandura, 1977; Phillips et al., 2012). In outlining four supervisor types based on high/low self-efficacy and high/low outcome expectancies, Phillips et al. (2012) suggested the following:

- High Self Efficacy and Low Outcome Expectancy: view themselves as capable of providing quality clinical supervision in a particular relationship or environment, but do not perceive positive outcomes as being likely to follow from providing such supervision.
- Low Self-Efficacy and Low Outcome Expectancy: view themselves as incapable of providing quality clinical supervision, and that the outcomes of supervision will be negative.
- Low Self-Efficacy and High Outcome Expectancy: perceive themselves as incapable of performing clinical supervision tasks but sense positive outcomes would result from doing so.

- High Self-Efficacy and High Outcome Expectancy: see themselves as capable of performing clinical supervision, and the outcomes associated with such interventions as positive.

If practicing supervisors have limited knowledge of clinical supervision and associated benefits, this may impede expected outcomes and lower personal perceptions of ability related to clinical supervision. Such a focus may account for some of the strong focus on administrative supervision in rehabilitation agencies, as supervisors feel more comfortable in performing administrative supervision and counselors report higher levels of satisfaction associated with this type of supervision (Herbert & Trusty, 2006). This sense of familiarity and comfort may be the result of modeling, another component of self-efficacy (Bandura, 1977; Del Valle, 2015). In performing tasks related to supervision, supervisors are likely to replicate those supervisors tasks previously modeled to them by their supervisors (Austin, 2012). While no formal studies have examined supervisor self-efficacy and outcome expectancy in rehabilitation counseling settings, "it is reasonable to deduce that supervisors practicing without formal training would be less likely to experience high supervisor SE" (Phillips et al., 2012, p. 20). The lack of formal training on clinical supervision and a lack of vicarious learning experiences acquired in a work setting, (e.g., modeling, imitation, and observational learning) are potential reasons for low self-efficacy in clinical supervisors.

Minimally Adequate Clinical Supervision

In seeking to understand what is necessary and requisite for supervision to occur at a minimally accepted level, Ellis et al. (2014) conducted a two part study, with the purpose of the first study being the empirically validation of a framework differentiating inadequate clinical supervision from harmful clinical supervision; this was necessary as a previous study conducted

by Ellis (2001) had identified twelve different terms used to describe undesirable scenarios in the clinical supervision process such as negative experiences (Ramos-Sanchez et al, 2002), bad supervision (Jacobsen & Tanggard, 2009), and ineffective supervision (Ladany, Mori, & Mehr, 2013). Study two investigated the occurrence rate of ineffective and harmful supervision from a sample of 363 supervisees.

Previously, Ellis (2001) had defined bad supervision as ineffectual supervision, which did not harm or otherwise traumatize the supervisee. Ellis et al. (2014) suggested this definition required revision in order to accommodate the relative degrees of variance within harmful and bad supervision. In order to produce a baseline of minimally accepted standards, Ellis et al. (2014) utilized codes of ethics, accreditation standards, licensure standards, and the standards established by various counseling and related fields specific to supervision. Noticeably absent were the CORE accreditation standards and CRC certification standards and accompanying code of professional ethics representative of the rehabilitation counseling field (Herbert, 2014). From this list they operationalized that minimally adequate supervision occurred when the supervisor:

- Has the proper credentials as defined by the supervisor's discipline or profession;
- Has the appropriate knowledge of and skills for clinical supervision and an awareness of his or her limitations;
- Obtains a consent for supervision or uses a supervision contract;
- Provides a minimum of 1 hour of face to face individual supervision per week;
- Observes, reviews, or monitors supervisee's therapy/counseling sessions (or parts thereof);
- Provides evaluative feedback to the supervisee that is fair, respectful, honest, ongoing, and formal;
- Promotes and is invested in the supervisee's welfare, professional growth and development;
- Is attentive to multicultural and diversity issues in supervision and in therapy/counseling;
- Maintains supervisee confidentiality (as appropriate); and
- Is aware of and attentive to the power differential (and boundaries) between the supervisee and the supervisor and its effects on the supervisory relationship (p. 439).

The development of this list developed the foundation on which to define inadequate supervision and to the operationalizing of two separate constructs: inadequate clinical supervision and harmful clinical supervision (Ellis et al., 2014).

Inadequate clinical supervision. Ellis et al. (2014) defined inadequate clinical supervision as "the supervisor's failure to provide the minimal level of supervisory care as established by his or her discipline or profession, by law, or by failure to meet the minimally adequate supervision criteria" (p. 439). A supervisee need not identify inadequate clinical supervision in their supervisor; it is plausible a supervisee would be unaware of inadequate clinical supervision occurring. Inadequate clinical supervision occurs when a supervisor is unable, unwilling, or otherwise fails to meet the minimal criteria of clinical supervision; added to this is the inability of the supervisor to enhance the professional functioning of the practitioner, the lack of professional service monitoring, and failure to serve as a gatekeeper for the profession (Bernard & Goodyear, 2014; Ellis et al, 2014). Inadequate clinical supervision can be harmful to the supervisory working alliance, and as the professional skill development of counselors is impeded, then by extension, the counselors' clients may be harmed as well (Ellis et al., 2014).

Harmful clinical supervision. Those actions or even inaction that results in actual harm to the counselor is known as harmful clinical supervision; the two essential components of harmful clinical supervision are identified as genuine harm to the counselor as a direct result of the supervisor's inappropriate action/inaction and the supervisor's behavior leading to harm of the counselor, regardless of the counselor's acknowledgement of the harm (Ellis et al., 2014). Examples of harmful clinical supervision include the inappropriate use of the power differential within the supervisory relationship, sexual advances or improprieties directed towards the counselor by the supervisor and exploitative multiple relationships (Ellis et al., 2014). The

majority of these harmful clinical supervision incidents would be highly unethical behavior for a supervisor, and potentially illegal as well, such as in the case of physical harm or sexual misconduct.

These two types of clinical supervision are not mutually exclusive, with harmful clinical supervision encompassed within ineffective clinical supervision as all harmful clinical supervision results in the ineffective delivery of clinical supervision (Ellis et al., 2014). While there are many potential barriers to the effective provision of clinical supervision resulting in ineffective clinical supervision, some potential examples include lack of formal training in clinical supervision, poorly monitored interactions between counselor and supervisor, and organizational culture.

The lack of formal training in clinical supervision has been identified as problematic (Herbert, 2004c; Schultz et al., 2002). Strong recommendations exist for the ethical mandate to receive training prior to the provision of supervision (Glosoff & Matrone, 2010). Additionally, a uniform approach to the provision of clinical supervision is inappropriate as each counselor is unique; consequently supervisors need to possess a variety of knowledge and skills in order to provide clinical supervision (McCarthy, 2013). But, without formal training, uninformed supervisors will rely on the same roles and models of supervision they received (Herbert & Trusty, 2006). This translates into a variety of problematic frameworks that "include 'laissez-faire (no clinical supervision), 'expert' (supervisor assumes role as the 'problem solver' to the counselor), 'one size fits all' (supervisees get the same type of supervision regardless of individual counselor need and skill level0), 'buddy' (supervisor seeks more of a friendship and social support in supervisory role), and 'doctor' (supervisor responds to counselor as if it were a client-counselor relationship in which the intent is to find out what is 'wrong with the

counselor)" (Campbell, 2006 as cited by Herbert & Caldwell, 2014, p. 446). This lack of training on supervision and poor implementation results in rehabilitation counselors in the public and private setting being left to their own devices and often implementing haphazard and problematic supervision (Herbert, 2004c; Herbert, 2016b; Herbert & Trusty, 2006; King, 2008; Schultz et al., 2002).

Organizational emphasis, particularly in the state rehabilitation setting, tends to be outcome centric, with little to no focus then being applied to counselor development (Herbert & Trusty, 2006). As culture within the organization helps to emphasize what is and is not important (Sherman et al., 2014), the knowledge acquired by individuals working for the agency will be reflective of the values emphasized by the organization as important. Thus, if agency leadership does not highly value will be minimally effective and serve to meet compliance standards of regulatory bodies (Leahy, Thielsen, Millington, Austin, & Fleming, 2009; Sherman et al., 2014). Thus addressing and repairing harmful, and subsequently ineffective clinical supervision can be viewed as a systems issue, but one in which training and emphasis on clinical supervision at the individual level. When counselor and supervisor are able to agree on the goals and tasks of supervision and establish a working relationship, supervision has the potential to impact outcomes, particularly for new counselors (McCarthy, 2013).

Private Practice Settings

While the state and federal rehabilitation systems may be the most well-known of the three major service delivery arenas, recent growth in other practice settings for CRCs has been demonstrated (Saunders et al., 2009). Much of the known information regarding clinical supervisor practices has been gathered from the state/federal rehabilitation program (Herbert, 2004c, Herbert & Trusty, 2006, McCarthy, 2013, Schultz et al., 2002). Where more than 30% of

CRCs have less than five years of experience, and many are now seeking employment outside of the state/federal VR systems (Saunders et al., 2009), it is plausible many CRCs are presently receiving some form of supervision and it would be ideal to better understand the supervision practices associated with these various practice settings.

Contextual Differences

Despite the similar mission of providing services to persons with disabilities, there are contextual differences in the scope and mission of the public, private-for-profit, and private-not-for-profit sectors. Length of time spent in service delivery, funding source, and organizational hierarchy are a few examples of contextual differences. While these differences add to the richness and diversity of service delivery methods and options available to persons with disabilities, it does create subtle differences necessitating innovative and adaptive clinical supervision practices to meet the needs of CRCs in each respective setting. Table 1 outlines some of the contextual differences of public, private-for-profit, and private-not-for-profit practice settings.

Table 1

Contextual Differences Between Vocational Rehabilitation Practice Settings

Factors	Public	Private-for-profit	Private-not-for-profit
Mission	Help individuals obtain, regain, or retain employment and increase personal independence and self-sufficiency.	Help employers and consumers decrease disability-related costs through the promotion of employment.	Help individuals obtain, regain, or retain employment and increase personal independence and self-sufficiency.
Emphasis	Provide services to people with disabilities which promote full access to employment, independence, and community inclusion.	Provide early intervention and early return to work services and minimize the functional limitations associated with disability.	Provide services to people with disabilities which promote full access to employment, independence, and community inclusion.
Consumer Eligibility	Must meet eligibility requirements by providing proof of a disability from a qualified individual (e.g., medical doctor, psychiatrist, psychologist, physical therapist) causing a barrier to employment, or provide proof the individual is a recipient of Social Security Disability Insurance/Supplemental Security Insurance (SSDI/SSI)	Not an eligibility based system. Consumers must be insured and have an active claim. Policy coverage and rehabilitation potential as set by internal policy and rehabilitation counselor judgement determine what type of, or if any VR service will be delivered.	Many of these consumers will have been referred by public VR systems or community programs (e.g., Mental Health, Independent Living). Thus while an eligibility process may not be formal, there are certain requirements to obtain services.
Successful Outcome	Full or part time employment based on the individuals' maximum potential, and competitive employment must be maintained for a minimum of 90 days.	Return to preinjury or pre-disability wage level or comparable as a direct result of VR services and therefore the individual no longer receives insurance benefits.	Employment is often the primary goal and standard for rehabilitation outcomes in Non-Profit settings, though other outcomes (e.g., increased independent living skills) are also recognized (Thomas,

Table 1 (cont'd)

			Menz, & Rosenthal, 2001).
Caseload Size	Often serve caseloads in excess of 100 individuals.	Caseload is generally less than 40.	Caseload is generally less than their Public VR counterparts.
Individuals Served	Caseload is more diverse in terms of populations (e.g., developmental, psychiatric, transition-youth) and working-age adults.	Caseload composition is less diverse depending on work setting (e.g., orthopedic disabilities, physical impairments from work injuries, psychiatric disabilities and working-age adults).	Caseload is often specialized and tends to be focused on individuals (e.g., developmental disabilities, intellectual disabilities, mental health) requiring specialized intensive rehabilitation services to maintain employment (Hagen-Foley, Rosenthal, & Thomas, 2005)
Assessment and Testing	Typically contracted to a community rehabilitation provider for work related assessment or a psychologist/psychiatrist for mental health related testing.	Vocational testing and assessment typically conducted in house.	Often provided as a contracted service to the public VR system as part of joint service delivery. Can be community based and in house.
Counseling	Counselor/consumer relationship can extend for long periods of time and counselors are active in providing vocational and adjustment counseling and long-term support when needed.	Counselor/consumer relationship is often limited in length of time necessitating directive short-term vocational and adjustment counseling only, typically focused on problem solving.	Counselor/consumer relationship can extend for long periods of time and counselors are active in providing vocational and adjustment counseling and long-term support when needed.
Job Development and Job Placement	Despite this skill being identified as necessary (Leahy et al., 2003; Leahy et al., 2009), counselors do not view this as part of their job or place a	Counselors take an active and hands-on job development and placement approach. They are often involved in occupational and	Counselors take an active and hands-on job development and placement approach. They are often involved in occupational and

Table 1 (cont'd)

	high priority on job placement (Schultz, 2008).	labor market analyses and surveys.	labor market analyses and surveys.
Funding	Primarily a combination of state and federal funding as mandated by federal legislation.	Primarily through insurance companies or policies (e.g., Worker's Compensation, Long Term Disability).	Comes through a variety of federal, state, and private sources.
Administrative Tasks	Completion of required agency forms/paperwork (e.g., eligibility determinations, Individual Plan for Employment, Case Closures). No paperwork associated with billable hours for personal pay.	In addition to required agency forms and paperwork, counselors often engage in fee for service/billable hours submissions (often to insurance companies, medical professionals, lawyers, and direct service providers), timesheets, customer marketing, and other business related activities.	In addition to required agency forms and paperwork, counselors often engage in fee for service/billable hours submissions (often to the public VR system and Medicaid/Medicare), timesheets, customer marketing, and other business related activities.
Rehabilitation Counselor Qualifications and Employment Status	Certification (e.g., CRC) not required in every state if otherwise qualified. Public rehabilitation counselors typically belong to unions; salary levels may be determined by wage scales negotiated through collective bargaining and/or civil service.	Certification (e.g., CRC, CDMS, CCM, CVE) required for most positions in private rehabilitation. Private- for-profit rehabilitation counselors are not unionized; salary levels are determined and based on open market value; may be self-employed.	Certification (e.g., CRC) not required in every state if otherwise qualified. Many of these agencies will have accredited programs through the Commission on Accreditation for Rehabilitation Facilities (CARF). Private- not-for-profit rehabilitation counselors are not unionized; salary levels are determined and based on open market value.

Table 1 (cont'd)

Adapted from "Similarities and Differences Between Vocational Rehabilitation in the Public and Private Sectors," by R. O. Weed and T.F. Field (2001) and "Rehabilitation Counselor Supervision in the Private Sector: An Examination of the Long Term Disability Setting by C. King (2009). Used with permission (C. King, personal communication, July 9, 2015)

Private-for-profit

This sector of vocational rehabilitation has experienced significant growth over the last four decades due in large part to the following factors:

- The realization by business sand industry of the high and steadily increasing costs of disability and lost time from work in the workforce.
- Legislation mandating vocational rehabilitation under state workers' compensation
- Legislation protecting and promoting the rights of person with disabilities
- The ability of private sector rehabilitation counselors to provide timely and cost-effective services
- The entry of rehabilitation professionals into the forensic arena
- The increasing role of rehabilitationists in case management practice
- The development of a cadre of rehabilitationists with entrepreneurial skills necessary for owning and managing companies (Brodwin, 2008, p. 503).

With such a strong emergence into the rehabilitation field, it is little wonder the private-for-profit sector was identified as the largest single work arena for CRCs (Saunders et al., 2009).

Rehabilitation counselors in private-for-profit venues work typically provide counseling and other services on a fee-for-service basis (Brodwin, 2008). Venues include disability insurance (e.g., worker's compensation, long term disability), forensic rehabilitation (e.g., expert witness testimony, life care planning, disability management), and more recently in the areas of substance abuse and disability legislation related consultation (Brodwin, 2008). Much of the VR counselor's focus in private-for-profit settings is the coordinated and systematic delivery of VR services designed to return the consumer to employment in the shortest possible amount of time while simultaneously mitigating the financial cost associated with the disability and rehabilitation process (Brodwin, 2008; Lynch, Leonard, & Powers, 1997)

With the exception of long-term disability (e.g., King, 2009), little research has been conducted on the supervisory practices within the private-for-profit arena (J. Herbert, personal correspondence, March 10, 2015). While practitioners in the state/federal systems would typically have a clear organization hierarchy with CRCs employed throughout the agency, employment in private-for-profit settings does not always allow for such clearly delineated supervisory hierarchies. Often the rehabilitation counselor will be providing services as part of a rehabilitation team where a non CRC (e.g., rehabilitation nurse, occupational therapist, physical therapist, medical doctor, psychologist, psychiatrist) is the direct formal supervision of the CRC (King, 2009). Where CRCC and CORE are clear on supervision eligibility requirements, particularly as it relates to new practitioners, understanding how the provision of clinical supervision is occurring is imperative to ensure appropriate professional development of rehabilitation counselors.

Private-not-for-profit

CRCs employed in the private-not-for-profit setting work in various community, national, and even religious organizations. Many of these community rehabilitation programs (CRPs) provide ongoing VR services to individuals requiring continuous and on-going supports not available in the state/federal system (e.g., supported employment, extended job coaching). CRPs are also typically closely aligned with the state/federal agencies in each state and offer variety of supports on a contractual basis (e.g., vocational evaluations, job development, job placement, job coaching, disability related support services, etc.). The role of CRPs also increased over the last few years with legislation changes impacting the ways services are provided to Medicaid/Medicare recipients, transition youth, and other specific disability populations (Fabian & MacDonald-Wilson, 2012).

CRCs employed in CRPs are likely to be service provides and also part of the management teams of the service agencies. Thus, CRCs employed in this sector would likely be directly involved in both the direct service delivery to a variety of consumers, and also engaged in supervisory practices with other CRCs working for the same agency. Some studies have been conducted on service delivery methods and consumer satisfaction with CRPs, but no work with supervisory practices has been noted (J. Herbert, personal communication, March 10, 2015).

Similarities in VR Practice Settings

Despite some of the differences evidenced in practice settings, similarities between public and private rehabilitation settings do exist and are outlined in Table 2.

Table 2
Similarities Between Vocational Rehabilitation Practice Settings

Core Rehabilitation Philosophy	A process of restoration and remediation which encourages independence, self-sufficiency, and productivity.
Definition of Rehabilitation Counselor	A counselor possessing the specialized knowledge, skills, and attitudes needed to collaborate in a professional relationship with person with disabilities to achieve their personal, social, and psychological, and vocational goals (RCC, 2005).
Education	A professional possessing a graduate degree from a CORE accredited program or closely aligned field, and either possessing certification as a CRC or eligible to sit for the CRC exam.
Core Knowledge and Skill Requirements	1) Individual Counseling, 2) Group and Family Counseling, 3) Mental Health Counseling, 4) Psychosocial and Cultural Issues in Counseling, 5) Career Counseling and Assessment, 6) Job Development and Placement Services, 7) Vocational Consultation and Services for Employers, 8) Case and Caseload Management, 9) Medical, Functional, and Environmental Aspects of Disabilities, 10) Foundations, Ethics, and Professional Issues, 11) Rehabilitation Services and Resources, and 12) Health Care and Disability Systems (Leahy et al., 2009).
Outcomes	Employment (full or part time)

Adapted from King (2009) and used with permission (C. King, personal communication, July 9, 2015)

Such similarities validate the findings of Thielsen and Leahy (2001), which demonstrated core knowledge and skills for rehabilitation counselor supervisors across practice settings. While specific nuances do exist for each practice setting, the core understanding and expertise foundational to clinical supervision is not limited to practice setting. Exploring the different delivery mechanism across practice settings will help to identify strengths in the delivery of supervisory practices and well as potential deficiencies. This knowledge can then help to better outline training programs for supervisors based on practice setting demands as well as inform counselors receiving supervision on areas where it may be necessary to seek additional consultation via a qualified supervisor as a result of organizational on contextual barriers otherwise inhibiting the provision of clinical supervision in their practice setting.

Summary

Clinical supervision is perhaps the most important aspect of professional development and pre-service training for rehabilitation counselors (Thielsen & Leahy, 2001). Clinical supervision helps to bridge the gap between theoretical aspects discussed in the classroom to the practical application of those theories and techniques in the work setting. Although close monitoring of counselor-client practices has been recommended and is part of pre-professional training (CORE, 2012), this practice does not often continue into the work setting, particularly the state VR system (King, 2009; Schultz et al., 2002). While similar knowledge, skills, and philosophy are held across VR practice settings, research regarding clinical supervision has focused primarily on the public VR setting (English et al., 1979; Herbert, 2004c; Herbert & Trusty, 2006; McCarthy, 2013; Schultz et al. 2002). This study will build off the previous work exploring clinical supervision in the public setting and the long term disability field (King, 2009) by exploring the contemporary practices surrounding clinical supervision in the burgeoning

private-for-profit and private-not-for profit fields of rehabilitation counseling. Additionally perspectives from both supervisors and supervisees will be gathered to compare the perceived differences of the effectiveness of clinical supervision, importance of supervisory styles and behaviors, and overall satisfaction levels of supervisees in receiving clinical supervision.

CHAPTER 3

METHODOLOGY

The goals of this study were to better understand the state of clinical supervision in private rehabilitation practice settings and compared supervisor and supervisee perceptions on the effectiveness of clinical supervision practices, as well as the factors related to counselor satisfaction with clinical supervision. It is believed that the study findings help inform rehabilitation researches, educators, and practitioners of the contemporary clinical supervision practices, and the potential barriers and strengths in the provision of clinical supervision within the private-for-profit and private-not-for-profit practice settings of vocational rehabilitation (VR). Given the purpose of the study, a quantitative design was selected. The Commission for Rehabilitation Counselor Certification (CRCC) assisted in screening potential study participants to ensure participants were employed in the practice settings of interest. Utilizing Internet based survey instruments, this cross-sectional study surveyed CRCs receiving and providing clinical supervision in the private-for-profit and private-not-for profit rehabilitation practice settings.

Research Questions

The following research questions were of interest to this study:

1. What are the contemporary practices associated with clinical supervision in non-profit and private-for-profit vocational rehabilitation settings?
2. Is there a difference in clinical supervision practice between non-profit and private-for-profit VR practice settings (e.g., minutes per week/month receiving clinical supervision, satisfaction levels associated with clinical supervision, perceived quality of clinical supervision, use of a supervisory contract)?

3. Is there any difference between supervisee and supervisor perceptions of clinical supervision provided across private practice settings in terms of supervisory knowledge, supervisory behavior, supervisor self-efficacy, and supervisory working alliance?
4. Is there an association between perceptions of counselor satisfaction and quality of supervision as related to perceptions of supervisory knowledge, behavior, self-efficacy, supervisory working alliance, ethnicity, and gender?

Sampling and Procedures

The target population for this study was those qualified VR professionals as identified by the possession of a current CRC designation and working in the private practice settings, both non-profit and for profit. Participants were identified through assistance from the Commission on Rehabilitation Counselor Certification (CRCC) via their national database of CRCs. CRCs were chosen for this study given their academic training (typically a graduate degree in rehabilitation counseling or closely aligned field) and certification through CRCC; two of the three components previously identified as conditions for consideration as a highly qualified professional (Leahy, 2013). There are over 17,000 CRCs (CRCCb, 2015) and a random sample representative of the larger population of CRCs was obtained from CRCC.

Sample Size

Prior to the sampling process, the determination of an appropriate sampling size was completed. As multiple regression analysis was used to examine one of the research questions, (e.g., RQ 4: "Is there an association between counselor satisfaction with supervision and clinical supervision knowledge, behavior, counselor self-efficacy, and supervisory working alliance strength?"), an *a priori* power analysis was conducted. Power and sample size were considered prior to data collection in order to address the probability of failing to reject the null hypothesis

when it is false (Type II error). In order to calculate the appropriate sample size, six predictor variables (see variable section) were identified, power ($1 - \beta$) was set at .80, and alpha level was set at .05. Power was set at .08 as it has been suggested as an appropriate level for social science research when determining sample size (Field 2013). Where a medium effect size (.15) has been found to be appropriate for social science research (Cohen, 1988; Field, 2013), a medium effect size was selected for this study. Calculations suggested an appropriate sample size as 98 responses. Given the need for appropriate representation from both supervisors and supervisees, a sample of 2,000 individuals was requested from CRCC. Of the obtained 2,000 emails, some of the potential participants were deemed inappropriate for inclusion in the study given their work setting and others voluntarily opted out of participation. While 432 individuals started the survey, some provided no information, and a total of 399 responses (response rate of 22.2%) were deemed suitable for the study and subsequent analyses.

Instrumentation/Variables

The Clinical Supervision Knowledge Scale, an instrument designed for assessing the impact of a clinical supervision-training program for state vocational rehabilitation supervisors, was selected for this project (Herbert & Schultz, 2014). This instrument is comprised of four scales: 1) The Clinical Supervision Knowledge scale is a 33 item instrument based on the work of Thielsen and Leahy (2001) and designed to measure the knowledge necessary as part of the role and function of the rehabilitation clinical supervisor, 2) The Clinical Supervision Behavior scale is a 29 item instrument designed to measure the use of appropriate supervisory behaviors, 3) The Clinical Supervision Self-Efficacy scale has 15 items and looks at perceptions of supervisors' self-efficacy in delivering supervisory practices, and 4) The Supervisory Working Alliance Inventory designed by Efstation et al. (1990) was used to measure the strength of the

working alliance between counselors and supervisors. In order to allow for supervisor/supervisee comparison, the instrument had parallel forms. The respective forms were designed to assess perceptions on the knowledge of effective clinical supervision practices, perceived effectiveness in performing clinical supervision tasks, perceptions of those practices consistent with good clinical supervision, and overall effectiveness of the supervisor-supervisee relationship from the supervisee and supervisor viewpoints.

As research question four utilized multiple regression to analyze the effect of five predictor variables (e.g., gender, ethnicity, clinical supervision knowledge, supervisory behavior, and supervisor self-efficacy) on the outcome variables (supervisory working alliance strength, supervisee satisfaction and quality of supervision), predictor variables were operationalized as follows:

1. Gender: Coded as a dichotomous variable, either male or female.
2. Race/Ethnicity: Coded as dichotomous also, either white/Caucasian or all other ethnicity.
3. Clinical Supervision Knowledge: Based off the work of Thielsen and Leahy (2001), clinical supervision knowledge for rehabilitation counselors encompasses the six domains of ethical and legal issues, theories and models of supervision, interventions techniques and methods of supervision, evaluation and assessment, rehabilitation counseling knowledge, and supervisory relationship.
4. Supervisory Behavior: Those minimally acceptable standards of supervision as suggested by research (Ellis, et al., 2014; Herbert, 2004c).
5. Supervisor Self – efficacy: Perception of ability and confidence in a supervisor to effectively perform the tasks associated with supervision.

6. Supervisory Working Alliance: The relationship upon which the goals and tasks associated with clinical supervision are discussed, considered, and ultimately realized (Bordin, 1983); it was hypothesized the SWA would have a strong predictor effect associated with perceptions of satisfaction and quality.

The establishment of a collaborative and working relationship between supervisor and supervisee leading to the realization of agreed upon goals and tasks of the supervisory process is known as the supervisory working alliance (Bordin, 1983; Rarick & Ladany, 2013). The intuitive outcome of increased knowledge of clinical supervision, the use of appropriate clinical supervision behaviors, and higher levels of self-efficacy in providing clinical supervision would be a stronger supervisory working alliance. Thus, while the supervisory working alliance was considered to be an independent variable, it was anticipated there would be high correlation between the SWA and knowledge, behavior, and self-efficacy. The dependent variable of supervisee satisfaction represented the supervisees' overall satisfaction with the level of supervision received and the supervisor's perceived ability to implement intervention techniques and methods associated with acceptable supervision. The second dependent variable was a rating of the perceived quality of supervision provided and was operationalized as the level of confidence the supervisee has in the supervisor to perform the tasks of supervision, or the level of confidence the supervisor has in their personal ability to perform the tasks of supervision.

Reliability and Validity

The instrument selected for this study had four scales (each with parallel forms for supervisor and counselor/supervisee) and reliability measures were conducted in a previous research study (Herbert & Schultz, 2014). The first scale of the instrument was the Clinical Supervision Knowledge Scale, which consists of 33 items and is designed to measure

supervision knowledge and skills based on the work of Thielsen and Leahy (2001). Herbert and Schultz (2014) found this scale to have a Cronbach alpha of .98 (n = 440) on the counselor form and Cronbach alpha of .97 (n = 217) on the supervisor form.

Reliability of the second scale, Clinical Supervision Behavioral Scale (29 items), was shown for the counselor form to have a Cronbach alpha of .97 (n = 436), with the supervisor form having a .93 Cronbach alpha (n = 216). The third scale, Clinical Supervision Self-Efficacy Scale (15 items) measures supervisor self-efficacy in completing the tasks associated with clinical supervision. The self-efficacy scales demonstrated reliability with a Cronbach alpha of .96 on the supervisor form (n=216) and .98 (n=437) for the supervisee form.

The final scale measures the strength of the supervisory working alliance. This instrument was originally designed by Efstation et al. (1990) and has been utilized in a number of studies on the supervisory working alliance (e.g., Schlosser & Gelso, 2001) and is presently included in the Supervisor's Toolbox in a widely used text on supervision practices (Bernard & Goodyear, 2014). It has been suggested that evidence for the validity of this scale can be attributed to the negative relationship between the scale and supervisee role conflict and role ambiguity (Ladany et al., 1999; Ladany & Friedlander, 1995). As for reliability, Herbert and Schultz found the Cronbach alpha for the supervisor form to be .91 (n=214) and .98 (n=432) for the supervisees. The supervisor form has 23 items and the counselor form has 19 items. Additional demographic items completed the instrument; this was a total of 117 items for supervisees and 122 items for supervisors.

According to Raykov and Marcoulides (2011), a Cronbach alpha in excess of .80 is suitable for reliability purposes. As all scales included in the instrument were found to exceed the .80 level in previous research, it was felt this instrument was a reliable measure for

supervisory knowledge, behavior, self-efficacy, and the supervisory working alliance for the present study.

Procedure

This study analyzed certain aspects of human behavior and phenomena, as such; approval for the use of human subjects in research was obtained through the Michigan State University Institutional Review Board (IRB) process. This approval was obtained prior to any attempts to acquire and collect data of any type. Following the receipt of appropriate IRB approval, the CRCC research committee was sent a research submittal letter, along with the previously prepared study proposal. These elements constituted a formal request for permission to conduct the study. CRCC reviewed the proposed study, and upon verification of the validity of the study, provided a list of e-mail address of CRCs collected through a combination of convenience and simple random sampling methods from their national database of CRCs (Remler & Van Ryzin, 2011).

Based on reviews of similar dissertation work in rehabilitation counseling utilizing CRCs in Internet based survey research methods (Del Valle, 2015; Kuo, 2013; Lewicki, 2015), a general response rate between 20% and 25% was expected. Research conducted on general Internet based surveys suggests similar results (Granello & Wheaton, 2004). While internet and email based surveys have response rates lower than the traditional mail surveys, it has been suggested that follow up reminders, clearly delineating the amount of time expected for survey completion, and a personalized link for accessing the survey help to increase response rates (Granello & Wheaton, 2004). These parameters were followed in the design and implementation of the Internet based survey. Qualtrics software was used to disseminate the instruments. While automated features within Qualtrics were able to automatically send out reminders to those

participants who have not yet responded, it was decided that the initial invitation to participate and subsequent reminders would be sent from the researchers personal email. This was done in an attempt to eliminate a sense of automated survey distribution and add a personal touch to the data collection. Another feature in Qualtrics allowed participants to close the instrument and return to it at a later time provided they accessed it through the same initial computer. It was anticipated this feature combined with the reminder emails helped to increase the response rate.

Data Analysis

Qualtrics, an Internet based survey system, was used as the dissemination platform for data collection in this cross sectional study. Results were analyzed using descriptive statistics, independent samples t-tests, Pearson χ^2, analysis of variance (ANOVA), multivariate analysis of variance (MANOVA), and stepwise multiple linear regression analysis. Data was downloaded from Qualtrics into the Mac version of the Statistical Package for Social Science (SPSS) version 24.0. Initial steps of data analysis included data cleansing procedures; this process included the importing of the data, naming variables, checking accuracy, examining missing data, and determining if collected responses were appropriate for inclusion (e.g., sufficient number of items responded to, responses appear to be valid).

For question one, "What is the current state of clinical supervision in non-profit and private-for-profit vocational rehabilitation settings?" descriptive statistics were used to explore satisfaction with receipt of clinical supervision by supervisees, years of experience providing clinical supervision on the part of supervisors, and related demographic information. This was designed to gather general information regarding the contemporary practices associated with or interpreted as clinical supervision in the private-for-profit and private-not-for profit sectors of vocational rehabilitation.

For question two, "What are the differences in clinical supervision practice between non-profit and private-for-profit VR practice settings (e.g., job title and certification of direct supervisor, minutes per week/month receiving clinical supervision), descriptive statistics (e.g., frequency of supervision meetings, length of supervision meetings) and independent samples t-tests allowed for comparison of potential differences between the provision of clinical supervision practices in private-for-profit and private-not-for practice. ANOVA was also run to compare and verify results. Some of the analyses for this question required the use of a Pearson χ^2 as the variables are categorical in nature.

For question three, independent samples t-tests were used to measure differences on perceptions of supervisory knowledge, behavior, self-efficacy, and supervisory working alliance according to role and work environment. In preparing for the regression analysis outlined in question four, multiple analysis of variance (MANOVA) was used to examine role (operationalized as counselor or supervisor and identified by the participant) and setting (operationalized as private-for-profit or private-not-for profit and identified by the participant) as independent variables with perceptions of supervisory knowledge, self-efficacy, behavior, and supervisory working alliance as the dependent variables.

For question four, stepwise multiple linear regression analysis was used to examine how much variance in supervisee satisfaction level and perceived quality of clinical supervision can be attributed to predictor variable influence (e.g., gender, ethnicity, clinical supervision knowledge, supervisory behavior, supervisor self-efficacy, and supervisory working alliance). It was anticipated that a higher level of satisfaction associated with clinical supervision and perceived quality of clinical supervision would be suggestive of a well-developed supervisory

relationship leading to greater counselor skill development and implementation of professional competencies leading to a more effective delivery of service(s) and overall practice.

Summary

A random sample of CRCs for participation in the study was selected from the CRCC membership database. A total of 2, 000 emails were obtained from CRCC, and of those participants invited to participate, 399 responses (22.2% response rate) were utilized in the data analysis process. The instrument utilized for this study was comprised of a demographic section and four scales designed to measure perceptions of clinical supervision knowledge, appropriate supervisory behaviors, self-efficacy in delivering clinical supervision, and the overall strength of the supervisory working alliance. A combination of statistical analyses was conducted to examine the contemporary practices of clinical supervision within the private-not-for-profit and private-for-profit practice settings of vocational rehabilitation.

CHAPTER 4

RESULTS

The purpose of this study is to understand current Certified Rehabilitation Counselors' (CRCs) perceptions in relation to the contemporary practices of clinical supervision in the private-for-profit and private-not-for-profit vocational rehabilitation (VR) practice settings. The goals of this study are to better understand the state of clinical supervision in private rehabilitation practice settings and compare supervisor and supervisee perceptions on the effectiveness of clinical supervision practices, as well as the factors related to counselor satisfaction with clinical supervision. The results provide a basis for understanding the contemporary practices associated with clinical supervision in private-for-profit and private-not-for-profit practice settings of VR.

This chapter will address the demographic characteristics of the participants, how missing data was handled, and results of specific data analysis for each of the four respective research questions of interest. The IBM Statistical Package for the Social Sciences (SPSS) version 24 and Microsoft Excel were used to conduct data analyses for this study.

Participants

The target population for this study was CRCs working in the private-for-profit and private-not-for-profit practice settings of vocational rehabilitation. Prior research (Herbert & Trusty, 2006; McCarthy, 2013; Schultz et al., 2002) has looked at clinical supervision practices in the state VR setting. Where CRCs are now employed in greater numbers outside of the state/federal practice setting than in years past (Saunders et al., 2009), and scant research is available exploring the clinical supervision practices associated with these practice settings (King, 2009), this study sought to specifically target CRCs employed in practice settings outside

of the traditional state and federal VR settings. As part of the participant selection process, the CRCC administrative team pulled potential participants from the CRCC database based on the caveat the participants were known to be employed in the private-for-profit and private-not-for profit practice settings.

Response Rate

Given the specific target population for this study, and the length of the instrument participants would be responding to, it was felt a larger starting sample of CRCs would be needed in order to obtain an appropriate number of responses. As a result of this, 2,000 email addresses of potential participants were requested of and later obtained from the CRCC. Of the initial 2,000 email addresses, 150 were found to be undeliverable or otherwise incorrect and another 50 participants responded to the researcher via email declining participation in the study. This left 1,800 deliverable email addresses available for participation. Based on comparable research studies (Del Valle, 2015; Kuo, 2013; Lewicki, 2015), the researcher had anticipated a response rate in the low to mid 20% range. While 446 participants started the survey (25%), fourteen provided no data of any kind (0.01%). This left 432 participants who provided at least some information. Of these, only participants responses identifying employment in private-for-profit or private-not-for-profit settings were utilized for analyses. A response rate of 22.2% (n = 399) more accurately reflects participant involvement. As is often common in data collection, decreased completion rates were noted across the four subscales and of the 399 participants, 307 (76.9% completion rate) were determined to have fully completed the survey per Qualtrics software.

Missing Data

While there are many ways to deal with missing data, decisions regarding the use of surveys with missing data were predicated primarily on whether the instrument was completed in its entirety or only partially. Only those instruments containing data on the scales were used for the multiple regression analysis specific to research question four (n = 243; with 134 counselors in private-not-for-profit and 95 counselors in private-for-profit). For those instruments providing only partial data, it was decided partial data would be used for respective scales (e.g., Clinical Supervision Knowledge Scale, Clinical Supervision Behavior Scale, Clinical Supervision Self-Efficacy Scale, Supervisory Working Alliance Inventory), provided the respective scale was completed fully. The scales were considered in light of the respective role selected by the respondent. As previously stated, 446 responses were collected, and of those, 432 participants provided demographic information (96.9%). Participants identifying as students (n = 5), unemployed (n = 17), or retired (n = 11) were also removed at this stage, as so as to focus analyses on those responses directly from private-for-profit and private-not-for-profit settings. A decreased response pattern across the four scales was present, and respective scale participation rates for counselors (n = 300) and supervisors (n = 99) in order of administration on the instrument are as follows: a) knowledge-counselor, 86.7% (n = 260) and knowledge-supervisor, 86.9% (n = 86), b) behavior-counselor, 74.5% (n=244), and behavior-supervisor, 84.8% (n = 84), c) self-efficacy-counselor, 79.3% (n = 238) and self-efficacy-supervisor, 81.8% (n = 81), and d) supervisory working alliance-counselor, 76% (n= 228) and supervisory working alliance-supervisor, 79.8% (n = 79).

Participant Demographics

Of the participants (n = 399) who provided demographic characteristics selecting either private-for-profit or private-not-for-profit as their current practice setting, 80.7% (n = 322) were female and 19.0% (n = 76) were male. One respondent preferred not to respond. In regards to race/ethnicity, the majority responded as White/Caucasian (76.4%, n = 305), 11.0% identified as Black/African Descent (n = 44), 5.8% of the participants were Latino(a)/Hispanic (n = 23), 2.5% were of Asian Descent (n = 10), 1.0% were Native American (n = 4), 0.3% selected Middle Eastern Descent (n = 1), and 0.3% identified as Native Hawaiian/Pacific Islander (n = 1). The remaining individual selected other (2.0%, n = 8) and these participants identified predominantly as bi-racial in their write in responses. In comparing the study sample demographics against the general demographics of the CRCC population, the study sample is analogous to the CRCC population. Table 3 is a comparison of the study sample against the CRCC population.

Table 3
Study Sample vs. CRCC Population - Gender & Race/Ethnicity

Gender & Race/Ethnicity	Study Sample %	CRCC Population %
Male	19.0	25.19
Female	80.7	74.7
White/Caucasian	76.4	76.3
Black/African Descent	11.0	11.1
Latino(a)/Hispanic	5.8	4.9
Asian Descent	2.5	2.4
Native American	1.0	.5
Middle Eastern Descent	0.3	Not provided
Native Hawaiian/Pacific Islander	0.3	0.1
Other/Prefer Not to Answer	3.0	0.1

Note: Study Sample n = 399

Of the 399 participants providing some form of demographic information, 97.7% (n = 390) provided their age. The *mean* age of the participants was 44.0 years, with a range of 23

years old to 75 years old. In terms of age, the study sample was fairly evenly distributed across the 10-year age group demarcations used by CRCC. The 30-39-age range had a slightly higher representation when compared to the CRCC population, and the under 30-age range had almost double the representation as the general CRCC population (15.9% Sample vs. 8.5% CRCC Population). Table 4 outlines the age range of the population in comparison to the CRCC population age range.

Table 4
Study Sample Age Range vs. CRCC Population Age Range

Age Range	Study Sample %	CRCC Population %
Under 30	15.9	8.5
30-39	25.6	19.7
40-49	21.6	22.2
50-59	19.5	23.8
60+	17.4	25.9

Note: Study Sample n = 399. 9 participants did not respond.

Years of work experience were viewed within the context of the role the participant selected (e.g. Rehabilitation Counselor Supervisor (RCS), Counselor). Participants (n =99) identifying as an RCS had a *mean* of 20.47 years (SD = 10.62 years) of service, with a range of two years to 42 years of experience; participants also had 13.92 years (SD = 9.92, range zero to 40 years) of experience as a supervisor. Participants identifying as an RCS also had a *mean* of 10.45 years (SD = 8.74 years) of experience in their present work setting with a range of one to 32 years. Thus, many of the participants identifying as an RCS had multiple years of experience not only within the field of rehabilitation counseling, but also as a provider of clinical supervision services. Study participants that identified as counselors (n = 300) had a *mean* of 13.72 years of work experience (SD = 11.798), with a range from one to 76 years of work

experience and a *mean* of 8.01 years of experience in their present setting (*SD* = 8.38). Table 5 shows counselor and RCS years of work experience.

Table 5
Study Sample Years of Work Experience

CRC Years of Work Experience	Total Years of Experience		Years of Experience in Current Work Setting
	Counselor	RCS	RCS Only
0-5	31.0% (*n* = 93)	10.1% (*n* = 10)	39.4% (*n* = 39)
6-10	20.0% (*n* = 60)	11.1% (*n* = 11)	18.2% (*n* = 18)
11-15	11.7% (*n* = 35)	10.1% (*n* =10)	11.1% (*n* = 11)
16-20	9.3% (*n* = 28)	23.2% (*n* = 23)	12.1% (*n* = 12)
21-25	7.3% (*n* =22)	6.1% (*n* = 6)	4.0% (*n* = 4)
26-30	7.7% (*n* = 23)	14.1% (*n* = 14)	5.1% (*n* = 5)
31-35	3.3% (*n* = 10)	12.1% (*n* = 12)	3% (*n* =3)
36+	5.0% (n =15)	7.1% (*n* = 7)	
Missing	4.7% (*n* = 14)	6.1% (*n* = 6)	7.07% (*n* = 7)

Note: Study Sample for counselors: *n* = 300. Study Sample for RCS: *n* = 99.

In terms of educational background, participants identifying as counselors reported their highest educational level as 92.3% master's level (*n* = 277), 6.7% as doctorate (*n* = 20), 0.7% as a bachelors or specialized training beyond a bachelors (*n* = 2). For those identifying as an RCS, 80.8% (*n* = 80) held a master's degree, 18.2% (*n* = 18) hold a doctorate, and 1% (*n* = 1) reported only having a bachelor's degree. Table 6 outlines the educational specialty of the participants' highest degree.

Table 6
Education Specialty - Highest Degree

	Counselor	RCS
Rehabilitation Counseling	80.3% (*n* =241)	76.8% (*n* = 76)
Rehabilitation Psychology	1.7% (*n* = 5)	2.0% (*n* = 2)
Psychology	1.3% (*n* = 4)	1.0% (*n* =1)
Counseling	4.3% (*n* =13)	5.1% (*n* = 5)
Counseling Psychology	1.8% (*n* =5)	2.0% (*n* =2)
Social Work	0.3% (*n* =1)	1.0% (*n* =1)
Special Education		1.0% (*n* =1)
Vocational Evaluation	1.0% (*n* = 3)	
Health Care Administration		1.0% (*n* =1)

Table 6 (cont'd)

Nursing	0.7% (*n* =2)	
Other Counseling Specialty	1.0% (*n* = 3)	
Other Rehabilitation Specialty	1.0% (*n* = 3)	2.0% (*n* =2)
Other	6.6% (*n* =20)	8.1% (*n* =8)
Total	300	99

Note: The "Other" category included responses such as sociology, counselor education, law, and education administration.

Relative to the practice setting associated with the participants, it should again be noted that CRCC assisted in selecting participants from the specific private-for-profit and private-not-for-profit practice settings. While a few emails from individuals in the state and federal VR systems were included in the sample provided by CRCC, the inclusion was rate was quite small, and some of these potential participants emailed the researcher clarifying participation eligibility and then asking to be removed from inclusion within the study due to not fitting the population of interest. Participants were asked to identify with one of the following work settings:

1) Student
2) Private-not-for-profit (e.g., Private Not-For Profit Rehabilitation (e.g., Corrections Programs, Disability Centers, College/University, Community Mental Health Centers, Community Rehabilitation Program, Independent Living Programs, K-12 Education, Non-Profit Research Institutions)
3) Private For-Profit Rehabilitation (e.g., Corporate Environment, For-Profit Research Institutions, Forensic, Medial Center or Rehabilitation Hospital, Insurance Company, Long Term Disability, Workers Compensation)
4) Retired
5) Unemployed

For those eligible participants that responded, 50.6% (n = 166) of counselors and 58.75(n = 61) of RCS reported employment in the private-not-for-profit practice setting; 40.9% (n = 134) of the participants identifying as counselors reported working in the private-for-profit practicing setting, along with 36.5% of RCS (n = 38) participants. Table 7 further clarifies the present work setting as identified by the participants.

Table 7
Present Work Setting

	Counselor	RCS
Private-Not-for-Profit	50.6% (n = 166)	58.7% (n = 61)
Private-for-Profit	40.2% (n = 134)	36.5% (n = 38)

Note: Study sample for counselor, n = 300. Study sample for RCS, n = 99.

Credentialing for rehabilitation counselors through licensing and certification processes continues to expand and provides a measure of quality assurance to the general public and specifically those seeking services (Wright, 1980). For this study, 99.5% (n = 397) of the 399 participants were CRCs and 4.5%(n = 18) were Licensed Rehabilitation Counselors. Other reported credentials included American Board of Vocational Experts (4.3%, n = 17), Certified Case Manager (7.5%, n = 30), Certified Disability Management Specialist (7.5%, n = 30), Certified Life Care Planner (2.3%, n = 9), Certified Vocational Evaluation Specialist (4%, n = 16), National Certified Counselor (4%, n = 16), Licensed Clinical Mental Health Counselor (4.8%, n = 19), Licensed Clinical Professional Counselor (2.3%, n = 9), Licensed Clinical Social Worker (0.3%, n = 1), Licensed Marriage and Family Therapist (0.3%, n = 1), Licensed Professional Counselor (13.3%, n = 53). Table 8 reports the frequency breakdown of credentialing based on counselor and RCS roles.

Table 8
Credentialing: Reported State Licensing and National Certifications

	Counselor	RCS	Total
American Board of Vocational Experts (ABVE)	3% (*n* = 12)	1.3% (*n* = 5)	4.3% (*n* =17)
Certified Case Manager (CCM)	5.5% (*n* = 22)	3.6% (*n* = 8)	7.5% (*n* = 30)
Certified Disability Management Specialist (CDMS)	4.5% (*n* = 18)	3% (*n* = 12)	7.5% (*n* = 30)
Certified Life Care Planner (CLCP)	1.8% (*n* = 7)	.5% (*n* = 2)	2.3% (*n* = 9)
Certified Rehabilitation Counselor (CRC)	75.2% (*n* = 300)	24.3% (*n* = 97)	99.7% (*n* = 397)
Certified Vocational Evaluation Specialist (CVE)	3% (*n* = 12)	1% (*n* = 4)	4% (*n* = 16)
National Certified Counselor (NCC)	1.8% (*n* = 7)	2.3% (*n* = 9)	4% (*n* = 16)
Licensed Mental Health Counselor (LMHC)	3.3% (*n* = 13)	1.5% (*n* = 6)	4.8% (*n* = 19)
Licensed Clinical Professional Counselor (LCPC)	.8% (*n* = 3)	1.5% (*n* = 6)	2.3% (*n* = 9)
Licensed Clinical Social Worker (LCSW)		.3% (*n* = 1)	.3% (*n* = 1)
Licensed Marriage and Family Therapist (LMFT)	.3% (*n* = 1)		.3% (*n* = 1)
Licensed Professional Counselor (LPC)	10.3% (*n* = 41)	3% (*n* = 12)	13.3% (*n* = 52)
Licensed Rehabilitation Counselor (LRC)	3.3% (*n* = 13)	1.3% (*n* = 5)	4.5% (*n* = 18)
Other Certifications	12.3% (*n* = 49)	3.8% (*n* = 15)	16% (*n* = 66)

Note: The "Other Certification" category included a variety of personal certifications (e.g., Registered Nurse, Licensed Psychologist, Licensed Attorney, Substance Abuse Counselor, Certified Brain Injury Specialist). Counselor and supervisor total *n* is 399.

Scales

In addition to demographic data, the instrument included four additional scales: Clinical Supervision Knowledge Scale, Clinical Supervision Behavioral Scale, Clinical Supervision Self-Efficacy Scale, and Supervisory Working Alliance Inventory. Scales consisted of counselor and supervisor forms. Participants were asked questions based on the primary role they selected (counselor vs. RCS) when completing the instrument. Again, those participants selecting student (n = 5), unemployed (n = 17), and retired (n = 11) for a respective work setting were not considered in any of the data analysis process beyond the reporting of demographics. The following section will examine each scale from both a role and setting perspective.

Clinical Supervision Knowledge Scale

This scale was designed and used by Thielsen and Leahy (2001) to measure knowledge areas consistent with rehabilitation counselor supervision and consists of 33 items. It was originally used in a national survey to establish the knowledge and skill areas associated with clinical supervision in rehabilitation counseling. Herbert and Schultz (2014) used this scale in a study with state rehabilitation agencies and corresponding counselors and supervisors. In the Herbert and Schultz study, the scale was found to have a Cronbach alpha of .98 (n = 440) on the supervisor form and Cronbach alpha of .97 (n = 217) on the supervisee form. For the purposes of this study, a test of reliability found the Cronbach's alpha for the Clinical Supervision Knowledge Scale – Counselor Form to be .98 (n = 260) and .97 (n = 86) on the Clinical Supervision Knowledge Scale – Supervisor Form. *Mean*s and standard deviations for respective roles (counselor vs RCS) and practice setting (private-not-for-profit and private-for-profit) are listed in Table 9. Responses are based on a four point Likert style scale of reporting, using the following scale: 1) No Understanding, 2) Little Understanding, 3) Moderate Understanding, and

4) Complete Understanding. Knowledge areas are listed in decreasing level of importance according to the private-not-for-profit counselors perspectives of their supervisors' knowledge area for each respective knowledge domains.

Table 9
Clinical Supervision Knowledge Scale

	Counselor				RCS			
	Private-not-for-Profit (n=150)		Private-for-Profit (n=110)		Private-not-for-Profit (n=53)		Private-for-Profit (n=33)	
	M	SD	M	SD	M	SD	M	SD
Confidentiality	3.41	0.77	3.39	0.90	3.68	0.55	3.73	0.45
Establish trust	3.35	0.76	3.45	0.85	3.77	0.76	3.85	0.36
Build rapport	3.33	0.75	3.39	0.87	3.81	0.44	3.85	0.36
Make accommodations	3.28	0.84	3.19	0.94	3.45	0.70	3.61	0.70
Implications of gender	3.24	0.77	3.21	0.88	3.40	0.63	3.64	0.55
Dual relationship issues	3.20	0.88	3.26	0.93	3.53	0.72	3.61	0.56
Implications of disability	3.19	0.85	3.24	0.88	3.51	0.61	3.73	0.52
Verbal feedback	3.19	0.86	3.16	1.00	3.64	0.56	3.79	0.42
Deal with ethical dilemmas: individual	3.19	0.88	3.31	0.90	3.57	0.57	3.58	0.56
Use humor	3.18	0.82	3.2	0.88	3.6	0.53	3.82	0.47
Negotiate power	3.17	0.78	3.24	0.90	3.47	0.67	3.55	0.56
Implications of culture/ethnicity	3.15	0.77	3.16	0.89	3.4	0.63	3.48	0.67
Deal with ethical issues: group	3.13	0.96	3.06	1.03	3.42	0.69	3.42	0.75
Use different roles	3.11	0.90	3.20	0.92	3.51	0.61	3.73	0.52
Implications of sexual orientation	3.09	0.77	3.13	0.95	3.23	0.67	3.42	0.75
Address conflict sources	3.09	0.92	3.22	0.84	3.42	0.69	3.61	0.56
Apply theory	3.09	0.90	3.20	0.90	3.47	0.61	3.67	0.54
Address sources of anxiety and stress	3.07	0.91	3.19	0.96	3.58	0.6	3.70	0.47
Clearly focused supervision sessions	3.07	0.91	3.05	0.91	3.45	0.70	3.45	0.67
Changing needs of supervisee	3.06	0.884	3.10	0.89	3.36	0.88	3.70	0.47
Establish written goals	3.03	0.98	2.96	1.06	3.30	0.75	3.27	0.8

Table 9 (cont'd)

Describe clinical vs. administrative supervision	2.98	0.96	3.12	0.92	3.40	0.72	3.67	0.60
Stages of skill development	2.97	0.92	3.12	0.94	3.34	0.73	3.67	0.54
Teacher role	2.97	0.94	3.02	1.03	3.47	0.64	3.3	0.73
Consultant role	2.97	1.00	3.08	0.98	3.49	0.64	3.67	0.69
Help counselors progress	2.93	0.95	3.09	0.93	3.26	0.76	3.55	0.67
Counselor role	2.89	0.98	3.05	0.97	3.53	0.61	3.67	0.65
Address counselor resistance	2.88	0.91	3.02	1.00	3.25	0.88	3.45	0.56
Group Supervision Techniques	2.79	0.97	2.83	1.00	3.02	0.75	3.30	0.73
Demonstrate counseling technique	2.74	1.07	2.83	1.13	3.58	0.54	3.61	0.50
Case presentation	2.73	1.08	2.89	1.10	3.49	0.80	3.52	0.76
Role – play	2.25	1.07	2.46	1.16	3.3	0.67	3.18	0.81
Use video/audio tapes	2.18	1.08	2.22	1.10	2.85	1.01	2.55	1.09

Note: Items are listed in descending order based on private-not-for-profit participant (counselor) perceptions.

Clinical Supervision Behavior Scale

The Clinical Supervision Behavior Scale is intended for measuring the degree to which perceived supervisory behaviors match up with appropriate supervisor affect in delivering supervision using the following Likert style scale: 1) Strongly Disagree, 2) Disagree, 3) Slightly Disagree, 4) Slightly Agree, 5) Agree, and 6) Strongly Agree. A test of reliability on this scale yielded a Cronbach's alpha of .91 (n = 84) for the participants identifying as supervisors, with a .97 (n = 244) on the same test for participants identifying as counselors. Table 10 outlines the *mean*s and standard deviation for each respective behavior based on the counselor vs. RCS role and work setting.

Table 10
Clinical Supervision Behavior Scale

	Counselor				RCS			
	Private-not-for-Profit (n=143)		Private-for-Profit (n=101)		Private-not-for-Profit (n=53)		Private-for-Profit (n=31)	
	M	SD	M	SD	M	SD	M	SD
Ethical delivery of supervision	5.11	1.23	5.10	1.36	5.66	0.65	5.74	0.51
Used humor appropriately	4.99	1.19	5.10	1.09	5.53	0.70	5.58	0.67
Sufficient time	4.94	1.33	4.88	1.31	5.45	0.64	5.35	0.84
Addressed questions on policy	4.91	1.33	5.06	1.37	5.47	0.75	5.65	0.55
Express different opinions	4.83	1.29	4.86	1.41	5.42	0.66	5.55	0.57
Kept appointments	4.78	1.40	4.98	1.30	5.62	0.60	5.61	0.56
Balanced talking and listening	4.77	1.39	4.81	1.35	5.34	0.73	5.45	0.68
Followed through on commitments	4.75	1.31	4.99	1.28	5.60	0.53	5.71	0.53
Shared experiences	4.73	1.41	4.79	1.51	5.45	0.77	0.565	0.66
Provided helpful feedback	4.63	1.47	4.8	1.41	5.45	0.67	5.45	0.68
Approachable: Professional growth	4.62	1.38	4.95	1.36	5.57	0.67	5.68	0.54
Timely feedback	4.59	1.54	4.74	1.35	5.26	0.88	5.68	0.48
Effectively identified and addressed ethics	4.51	1.52	4.75	1.47	5.47	0.67	5.48	0.68
Constructive feedback	4.5	1.52	4.71	1.49	5.43	0.69	5.52	0.57
Explored alternatives	4.42	1.5	4.52	1.5	5.26	0.76	5.29	0.64
Encouraged peer consultation	4.38	1.6	4.5	1.51	5.26	0.92	5.39	0.72
Pre-set times: Individual	4.34	1.67	4.29	1.73	5.3	0.93	4.42	1.63
Effectively demonstrated skill	4.31	1.63	4.37	1.63	5.28	0.82	5.23	0.81
Encouraged different approaches	4.3	1.56	4.29	1.6	5.08	1.00	5.1	0.87
Pre-set times: Group	4.24	1.8	3.73	1.94	4.81	1.58	4.42	1.71
Provided resources	4.22	1.7	4.4	1.58	5.06	1.05	5.45	0.62
Established goals	4.17	1.67	4.41	1.57	5.02	0.91	4.9	1.19

Table 10 (cont'd)

Case presentation	4.01	1.69	4.5	1.65	5.21	1.04	5.52	0.68
Processed client/counselor interaction	3.91	1.78	4.24	1.74	5.02	0.89	4.74	1.46
Feedback consistent with theory	3.79	1.78	4.05	1.78	4.72	1.34	4.65	1.6
Observed counselor/other professionals	3.68	1.67	3.64	1.92	5.06	0.91	4.84	1.27
Observed client/counselor	3.59	1.76	3.66	1.92	4.83	1.05	4.35	1.58
Irrelevant personal issues	3.45	1.89	3.61	1.86	3.66	1.78	3.71	1.88
Used role-play	3.41	1.84	3.64	1.81	4.58	1.2	4.68	1.38

Note: Items are listed in descending order based on private-not-for-profit participant (counselor) perceptions.

Clinical Supervision Self-efficacy Scale

This scale is designed to measure participant perceptions of the supervisor's self-efficacy in delivering clinical supervision. A test of reliability found a Cronbach alpha of .98 (n = 233) for the supervisee scale, and a .94 (n = 78) for the supervisor scale. Participants identifying as supervisees were asked to rate their perception of their supervisor's self-efficacy in delivering the specific clinical supervision tasks on a sliding scale ranging from zero to 100; participants identifying as supervisors used the same scale, but rated themselves and their own ability. Table 11 outlines the perceived self-efficacy levels of supervisors in delivering clinical supervision related tasks from the counselor and supervisor perspectives.

Table 11
Clinical Supervision Self-efficacy Scale

	Counselor				RCS			
	Private-not-for-Profit (n=139)		Private-for-Profit (n=99)		Private-not-for-Profit (n=51)		Private-for-Profit (n=30)	
	M	SD	M	SD	M	SD	M	SD
Help discuss client problems	76.76	26.17	75.70	26.86	92.73	9.86	90.70	13.05
Define competence and growth areas	71.34	28.28	71.59	29.30	88.88	12.47	86.97	13.59
Brainstorm strategies	70.85	28.59	72.65	30.22	91.29	11.12	90.00	14.54
Solicit/Address professional needs	68.93	30.57	72.62	28.67	88.53	12.03	86.40	18.40
Counselor structures session.	68.40	30.98	69.61	30.83	82.43	17.02	71.20	27.29
Address/facilitate concerns-worries	68.00	31.63	69.64	32.01	88.39	14.23	88.17	12.23
Identify interventions	67.96	29.13	68.69	30.06	85.39	13.97	85.29	12.53
Provide alternative interventions	67.03	28.73	67.02	32.32	87.80	10.93	84.97	17.29
Evaluate interactions	66.96	28.03	70.69	29.69	86.92	10.71	79.8	23.65
Process professional concerns	66.64	31.35	68.02	31.88	87.94	15.21	81.97	22.44
Interpret events	65.62	29.45	67.00	31.83	87.08	12.72	88.17	10.45
Explore counselor feelings	65.09	31.70	63.96	32.24	87.39	13.39	80.00	24.04
Teach/model techniques	62.51	31.67	63.05	33.26	86.24	12.46	84.43	14.70
Explore feelings: certain technique	62.24	32.08	62.99	31.68	84.33	17.29	82.27	20.63
Explain rationale for interventions	61.33	31.84	62.05	33.21	82.16	18.41	82.72	14.83

Note: Items are listed in descending order based on private-not-for-profit participant (counselor) perceptions.

Supervisory Working Alliance Inventory

The supervisory working alliance (SWA) is a measure of the strength of the bond between the rehabilitation counselor supervisor and the counselor. This is the medium by which all challenges to counselor deficiencies, encouragement, planning, and goal setting occur with the supervisory relationship. A test of reliability of these measure for this study found a Cronbach's alpha of .94 (n = 79) on the supervisor response, and .98 (n = 228) on the responses of participants identifying as counselors. Participants responded using a seven point Likert style scale with the following demarcation points: 1) Almost Never, 3) Occasionally, 5) Frequently, and 7) Almost Always. Points two, four, and six were considered midpoints between the other items and not specifically identified. The number of items on the Supervisory Working Alliance inventory –Supervisee Form (19 items) and Supervisor Form (23 items) differs, and is the reason for items having no value on table 12. Table 12 outlines the *mean* scores on the supervisory working alliance inventory according to both role and work environment.

Table 12
Clinical Supervision - Supervisory Working Alliance Inventory

	Counselor				RCS			
	Private-not-for-Profit (n=134)		Private-for-Profit (n=94)		Private-not-for-Profit (n=49)		Private-for-Profit (n=30)	
	M	SD	M	SD	M	SD	M	SD
Counselors formulate own interventions	5.85	1.44	5.90	1.50	6.00	0.87	5.87	1.22
Welcome counselor explanations	5.81	1.42	5.91	1.30	6.37	0.88	6.13	0.97
Counselors appear comfortable	5.79	1.55	6.06	1.31	6.35	0.72	6.27	0.94
Treats me like a colleague	5.72	1.80	5.77	1.60				
Tactful with comments	5.69	1.66	5.76	1.54	6.24	0.78	5.83	1.12
Encourage comfortable dialogue	5.67	1.59	5.81	1.51	6.22	0.77	6.03	1.19

Table 12 (cont'd)

Counselors talk more than supervisor	5.63	1.78	5.87	1.47	5.10	1.39	4.97	1.35
Stay in tune	5.63	1.77	5.61	1.55	6.20	0.89	6.00	1.02
Effort to understand counselors	5.61	1.64	5.94	1.40	6.65	0.56	6.40	0.93
Take time to understand client	5.44	1.72	5.52	1.64	6.35	0.83	6.27	0.98
Understand client's perspective	5.39	1.7	5.36	1.63	6.22	0.77	6.17	1.15
Offer alternative interventions	5.30	1.76	5.54	1.56	6.00	1.08	6.00	1.11
Counselor more curious than anxious	5.28	2.01	5.57	1.63	5.82	1.03	5.90	1.06
Stay on track	5.18	1.88	5.43	1.58	5.84	1.03	5.97	1.16
Work with specific treatment plan	5.13	1.91	5.33	1.73	5.65	1.09	5.90	1.21
Same understanding: treatment/behavior	5.1	1.71	5.29	1.61	5.16	0.97	4.97	1.40
Systematically consider	4.87	1.91	5.35	1.66	5.82	1.07	5.67	1.3
Specific goals	4.76	2.06	5.22	1.79	5.65	1.07	5.57	1.28
Facilitate counselors talking	4.62	2.21	4.93	1.99	5.98	0.99	5.97	1.1
Counselors reflect on supervisor comments					5.80	0.87	5.77	1.28
Counselors implement suggestions					5.61	0.89	5.27	0.98
Counselors reflect					5.76	0.97	5.47	1.20
Counselors identify with supervisor					5.69	1.05	5.37	1.25
Teach through direct suggestion					5.45	1.14	5.60	1.13

Note: Items are listed in descending order based on private-not-for-profit participant perceptions.

Research Question 1: What are the contemporary practices associated with clinical supervision in non-profit and private-for-profit vocational rehabilitation settings?

The following section will focus on the contemporary practices associated with clinical supervision in private-for-profit and private-not-for-profit practices settings of vocational

rehabilitation. Specific subsections will focus on supervisor training, frequency of clinical supervision appointments, and general satisfaction rates associated with clinical supervision practices. As this research is exploratory in nature, and limited research exists regarding clinical supervision outside of the state and federal VR settings (J. Herbert, personal correspondence, March, 11, 2015, King, 2009), descriptive statistics will predominantly be used in order to begin to clarify practices associated with clinical supervision in the private-for-profit and private-not-for-profit practice settings.

Characteristics of Clinical Supervision

As limited information exits regarding the contemporary practices associated with clinical supervision in private-not-for-profit and private-for-profit practice settings of vocational rehabilitation, this section will report on participant responses related to the training associated with the provision of clinical supervision, how often clinical supervision is occurring, who is providing clinical supervision, general satisfaction levels, and perceptions of effectiveness.

Training. Only those participants identifying as clinical supervisors were asked if they had received training on the provision of clinical supervision. A total of 93 participants responded to this question, with 55 coming from private-not-for-profit and 38 participants coming from private-for-profit. Less than half of the supervisors (49.4%, n = 49) suggested they had received training on supervision. Of these 49 participants, 58.2% (n = 32) of the participants from private-not-for-profit and 44.7% (n = 17) from private-for-profit responded they had received some type of formal training on clinical supervision. For the 49 supervisors stating they had received training, a variety of mechanisms allowed for this training to occur, with the primary training opportunities including professional workshops (59.2%, n = 29), employer in-service trainings (55.1%, n = 27), master's level coursework (18.2%, n = 18), and doctrinal level

coursework (18.2%, *n* = 18). When asked to estimate the number of training hours they have received, participants' responses ranged from six hours to 4000 hours. Twenty-nine (29.3%) of the participants reported less than 100 hours of training, 11.1% (*n* =11) participants reported receiving 100 to 150 hours of training, and 9.1% (*n* = 9) reported having 240 or more hours of training on clinical supervision.

Provision of clinical supervision. Of the participants selecting counselor as their designation, only 21.2% (*n*=65) said they were actively participating in clinical supervision at this time. Of those participants receiving clinical supervision, 63.1% (*n* = 41) came from private-not-for-profit and 36.9% (*n* = 24) came from private-for-profit. When asked to describe how clinical supervision meetings are arranged, 289 participants provided responses, with 40.1% (*n*=116) suggesting there were pre-arranged, specific times for clinical supervision, 37% (*n*=107) of participants had to initiate a meeting with their supervision, and 22.8% (n=66) received clinical supervision when their supervision initiated the meeting. Conversely, when asked to describe how supervisory meetings where scheduled, 87.9% (*n*=80) participants identifying as supervisors responded. Of these, 81.3% (*n*=65) reported using both prearranged, specific times and as needed, 15% (n=12) reported using pre-arranged specific times, 2.5% (n=2) relying solely on the counselor initiating the discussion or as needed. Table 13 depicts a breakdown of the responses according to work setting and role.

Table 13
Initiation of Clinical Supervision Meetings

	Counselors (*n* = 289)		Supervisors (*n* = 80)	
How meetings were arranged.	Private-not-for-profit	Private-for-profit	Private-not-for-profit	Private-for-profit
Pre-arranged, specific times.	24.9% (*n* = 72)	15.2% (*n* = 44)	11.3% (*n* = 9)	3.8% (*n* = 3)
Whenever initiated by counselor	18.7% (*n* = 54)	18.3% (*n* = 53)		2.5% (*n* = 2)
Whenever initiated by supervisor.	11.4% (*n* = 33)	11.4% (*n* = 33)		1.3% (*n* = 1)

Table 13 (cont'd) Both when the counselor desires, and with prearranged times	51.3% (n = 41)	30% (n = 24)

Note: Counselors were not provided the "Both when counselor desires, and pre-arranged times" option.

For participants identifying as supervisors, 91 participants responded to a question regarding the number of interns or direct supervisees/counselors they have at this time. There was a range of responses from zero to 80, with the average number of supervisees being 5.93. Some participants stated they did not supervise any counselors at this time, as their job required them to oversee job developers, special education teachers, or because they were self-employed and did not provide supervision. Of the participants stating they did provide supervision, 19.8% (n=18) said they were not actively supervising anyone at this time, 65.9% (n=60) provided supervision for one to ten supervisees, 11.1% (n=10) provided supervision to 11 to 20 supervisees, and 3.3% (n=3) provided supervision to 30 or more individuals.

Format and frequency. In describing the format participants used to provide clinical supervision, 91 responses were provided by participants identifying as clinical supervisors. Of these, 60.4% (n = 55) came from private-not-for-profit and 39.7% (n = 36) came from private-for-profit. Participants identifying individual clinical supervision as their chosen delivery method accounted for 23.6% (n = 13) of private-not-for-profit responses and 16.7% (n = 6) of private-for-profit, while two participants selected they only used group methods of clinical supervision, and both came from the private-for-profit sector. The majority of both groups (67.3% from private-not-for-profit, n = 37; 61.1% from private-for-profit, n = 22) reported using both individual and group clinical supervision methods. A total of eleven participants, five from private-not-for-profit and six from private-for-profit, reported they did not provide clinical supervision at this time. Participants identifying as supervisors (n = 80) reported meeting with

their supervises on a range of zero to 45 times per month for individual supervision (*m*= 4.46, *SD* = 5.88), with those meeting lasting anywhere from 10 to 120 minutes (*m* = 46.81; *SD* = 21.59). Data reported for group supervision suggested group supervisory sessions occurred anywhere from zero to eight times per month (*m* = 1.98; *SD*= 1.72) and lasting anywhere from 20 to 180 minutes (*m* = 56.69; *SD* = 46.48).

Participants identifying as counselors (*n* = 289) also responded to questions on the frequency and duration of meetings with their clinical supervisors. Participants reported meeting with their clinical supervisors anywhere from zero to 25 times per month (*m* = 2.48, *SD* = 3.80) for individual supervision, with an average individual supervision session lasting 29.53 minutes (*SD* = 29.19). Participants were involved with group supervision for anywhere from zero to 60 times per month (*m* = 1.43 times per month), with an average group supervision session lasting for 29.89 minutes (SD = 40.05).

Satisfaction with clinical supervision. Participants were asked to rate their satisfaction with the present quality of clinical supervision they provide on a six point Likert style scale using the following ratings: 1) Very Unsatisfied, 2) Moderately Unsatisfied, 3) Slightly Satisfied, 4) Slightly Satisfied, 5) Moderately Satisfied, and 6) Very Satisfied. The number of participants identifying as supervisors that responded to this question totaled 89. The majority of these participants (87.6%, *n*=78) felt some level of satisfaction associated with their provision of clinical supervision as they selected a response between slightly satisfied to very satisfied. Within these participants reporting some level of satisfaction, 93.6% (*n*=73) rated their satisfaction as moderately satisfied to extremely satisfied, leading to an overall *mean* response rating of 4.9 (*n* = 89, *SD* = 1.46) for satisfaction amongst the supervisors participating in this

survey. Thus, a majority of responses from the participants identifying as supervisors reported an overall satisfaction with the quality of their present delivery of clinical supervision.

The number of participants identifying as counselors that responded to the satisfaction question totaled 281. Of these participants, 20.6% (n = 58) selected a satisfaction level between very dissatisfied to slightly dissatisfied. Once again, a majority of participants (79.4%, n = 223) reported some degree of satisfaction with their present level of clinical supervision they receive, leading to a *mean* satisfaction rating of 4.70 for participants identifying as counselors. Table 14 breaks down satisfaction level according to work environment and role.

Table 14
Satisfaction with Present Level of Clinical Supervision

	Counselor		RCS	
	Private-not-for-Profit (n=156)	Private-for-Profit (n=125)	Private-not-for-Profit (n=54)	Private-for-Profit (n=35)
Very Dissatisfied	3.9% (n = 11)	2.5% (n = 7)	3.4% (n = 3)	4.5% (n = 4)
Moderately Dissatisfied	4.3% (n = 12)	1.8% (n = 5)	2.2% (n = 2)	2.2% (n = 2)
Slightly Dissatisfied	5.3% (n = 15)	2.8% (n = 8)		
Slightly Satisfied	7.8% (n = 22)	2.8% (n = 8)	4.5% (n = 4)	1.1% (n = 1)
Moderately Satisfied	16.7% (n = 47)	11.4% (n = 32)	28.1% (n = 25)	13.5% (n = 12)
Very Satisfied	17.4% (n = 49)	17.1% (n = 65)	22.5% (n = 2)0	18% (n = 16)
Mean	4.47 (SD = 1.55)	4.98 (SD = 1.45)	4.96 (SD = 1.3)	4.80 (SD = 1.69)
Combined *Mean*	4.70 (SD = 1.53)		4.9 (SD = 1.46)	

Note: Counselor n=281. Supervisor n=89

Quality of clinical supervision. Similar to the satisfaction question, participants were asked to respond to their belief regarding the overall quality level of the clinical supervision they presently receive/provide. This was rated on a six point Likert style scale with the following ratings: 1) Counterproductive, 2) Not at all Valuable, 3) Minimally Valuable, 4) Somewhat

Valuable, 5) Valuable, and 6) Very Valuable. Participants identifying as supervisors (*n*=89) all felt their present supervisory practices were valuable and attributed to the professional development of those they supervisees. This is apparent in the *mean* score of 5.3 on this scale and as their responses were all scored as somewhat valuable (9%, *n*=8), moderately valuable (51.7%, *n*=46), or very valuable (39.3%, *n*=35).

Participants identifying as counselors exhibited a bit wider range of responses as 17.1% of participants stated they felt the quality of the supervision was somewhat counterproductive (*n*=7), not at all valuable (*n*=9), or minimally valuable (*n*=32). But, again, with a *mean* score of 4.65 (*SD* = 1.22), a majority of participants (82.9%) identifying as counselors felt the quality of clinical supervision received was valuable to some degree.

As the use of a supervisory contract has been noted as one aspect of minimally acceptable standards of supervision, or quality level supervision (Ellis et al., 2014), responses on the use of a supervisory contract are included here. In response to the question on the use of supervisory contracts, 74% (*n*=208) of participants identifying as counselors indicated their supervisor did not use a supervisory contract, with 26% (*n*=73) stating their supervisor did use a supervisory contract. For those participants identifying as supervisors, 33.3% (*n*=29) indicated they did use a supervisory contract, with 67.4% (*n*=60) indicating they did not use a supervisory contract. Table 15 represents perceptions of quality level of clinical supervision and the use of a supervisory contract by role and work environment.

Table 15
Perceived Quality Level of Clinical Supervision and Use of Supervisory Contract

	Counselor		RCS	
	Private-not-for-Profit (*n*=156)	Private-for-Profit (*n*=125)	Private-not-for-Profit (*n*=54)	Private-for-Profit (*n*=35)
Counterproductive	1.8% (*n* = 5)	.7% (*n* = 2)		
Not at all valuable	2.1% (*n* = 6)	1.1% (*n* = 3)		
Minimally valuable	7.1% (*n* = 20)	4.3% (*n* = 12)		
Somewhat valuable	12.5% (*n* = 35)	7.1% (*n* = 20)	5.6% (*n* = 5)	3.4% (*n* = 3)

Table 15 (cont'd)

Valuable	19.6% (*n* = 55)	16.7% (*n* = 47)	34.8% (*n* = 31)	16.9% (*n* = 15)
Very Valuable	12.5% (*n* = 35)	14.6% (*n* = 41)	20.2% (*n* =18)	19.1% (*n* = 17)
Use of supervisory contract (Yes)	17.4% (*n* = 49)	8.5% (*n* = 24)	24.7% (*n* = 22)	7.9% (*n* =7)
Use of supervisory contract (No)	38.1% (*n* = 107)	35.9% (*n* = 101)	36% (*n* = 32)	31.4% (*n* = 28)

Note: Counselor *n*=281. Supervisor *n*=89.

Research Question 2: Is there a difference in clinical supervision practice between non-profit and private-for-profit VR practice settings (e.g., minutes per week/month receiving clinical supervision, satisfaction levels associated with clinical supervision, perceived quality of clinical supervision, use of a supervisory contract)?

There are contextual differences between private –for-profit and private-not-for-profit practice settings (e.g., mission, emphasis, consumer eligibility, successful outcomes, funding source, see Table 1.). Additionally, little research presently exists enumerating the clinical supervision practices within the various private-for-profit and private-not-for-profit practice settings of VR. Therefore, question two is intended to help identify existing similarities and/or differences in the provision of clinical supervision. Independent samples T-tests were run to analyze both role and environment (e.g., counselor vs. counselor, supervisor vs. supervisor, and counselor vs. supervisor).

Clinical Supervision: Individual and Group Formats

This section expands upon the findings from question one by examining individual and group clinical supervision practices as reported by participations according to role and environment. Perceptions of frequency (e.g., number of times per month) and length (e.g., average number of minutes per session) for both individual and group formats of clinical

supervision were analyzed. Independent samples T-tests were run to determine if differences existed between role and environment.

Clinical Supervision

Participants were asked to report the number of times per month they received or provided clinical supervision on an individual basis as well as in group settings. Additionally, participants were asked to provide an estimate of the number of minutes these sessions lasted for each respective format. Frequency and length are not the only parameters associated with minimally adequate supervision; it has been suggested that supervisors should be meeting individually with supervisees on a weekly basis for sixty minutes per session (Ellis et al., 2014). Ellis and colleagues did not recommend specific guidelines for group supervision, but concern over agency staff meetings being construed as group supervision has been suggested (Herbert & Trusty, 2006).

Counselors

An independent samples t-test was conducted to determine if differences existed between private-not-for-profit and private-for-profit counselors reporting on the monthly frequency of individual clinical supervision sessions, as well as the average number of minutes these sessions lasted. Review of the Shapiro-Wilk test for normality suggested a non-parametric distribution for both participants identifying as counselors on individual supervision frequency ($SW = .616$ $df = 279$ $p = .000$) and average length of individual supervision ($SW = .813$, $df = 27$, $p = .000$). Similar findings were found on the analysis of group supervision (frequency: $SW = .258$, $df = 279$, $p = .000$; length: $SW = .764$, $df = 279$, $p = .000$). Boxplots and histograms for the respective tests were also conducted and visually depicted a non-parametric distribution with outliers present as well. Given previous findings regarding frequency and length of individual

supervision sessions (Herbert & Trusty, 2006; Schultz et al., 2002), this was to be expected. While the distribution did not meet normality indices, the use of a two-tailed test helped to ensure the effects of Type I and Type II errors were minimal.

Calculated *means* for participants identifying as counselors and working in the private-not-for-profit (n = 159) sector reported meeting with their supervisor for a *mean* of 2.99 times per month (SD = 4.36) and private-for-profit counselors (n = 130*)* reported a *mean* of 1.86 visits per month (SD = 2.89). Individual sessions reported by private-not-for-profit (n = 158) lasted 34.81 minutes (SD = 31.05) and 23.02 minutes (SD = 25.58) for private-for-profit (n = 128). Private-not-for-profit reported a *mean* of 1.74 (SD = 4.15) group sessions per month, and private-for-profit reported 1.06 (SD = 5.38) group sessions per month. Group sessions lasted for a *mean* of 39.06 (SD = 43.14) minutes in private-not-for-profit settings, and 18.58 (SD = 32.67) minutes in private-for-profit settings.

As shown in Table 16, data collected from private-for-profit participants (n = 130) and private-not-for-profit participants (n = 159) demonstrate *mean* differences between the number of individual and group supervision sessions reported per month, and the average length of those sessions in minutes. The independent t-test indicated statistically significant differences for both the number of times per month (t = 2.642, df = 275.82, p = .012) and length of sessions individual supervision was received (t = 3.463, df = 284, p = .001), as well as the difference in the length of group supervisory sessions (t = 4.581, df = 284.71, p = .000). The null hypothesis suggesting there is no difference between private-for-profit and private-not-for-profit practice settings in terms of frequency and length of individual and group supervisory sessions was rejected. However the null hypothesis stating there is no difference between the number of times

group supervision was provided between private-for-profit and private-not-for-profit settings was retained ($t = 1.200$, $df = 286$, $p = .231$).

Table 16
Counselor Perspectives on Individual and Group Supervision: Differences in Frequency and Duration

	Levene's Test for Equality of Variances		t-test for Equality of *Means*		
	F	*p*	*t*	*df*	*p*
Individual Supervision Number of Monthly Visits	3.951	.048	2.642	275.82	.009
Individual Supervision Length of Monthly Visit	2.996	.085	3.463	284	.001
Group Supervision Number of Monthly Sessions	.549	.459	1.200	286	.231
Group Supervision Length of Session	22.93	.000	4.581	284.708	.000

Note: Private-not-for-profit, $n = 159$. Private-for-profit, $n = 130$.

Supervisors

An independent samples t-test was conducted to determine if differences existed between private-not-for-profit and private-for-profit supervisors reporting on the monthly frequency of individual and group clinical supervision sessions, as well as the average number of minutes these sessions lasted. Review of the Shapiro-Wilk test for normality suggests a non-parametric distribution for private-not-for-profit and private-for-profit in providing individual clinical supervision across reported frequency of clinical supervision sessions ($SW = .515$, $df = 80$, $p = .000$) and length of sessions ($SW = .878$, $df = 80$, $p = .000$). Results for group clinical supervision and the length associated with these sessions was also evidentiary of a non-parametric distribution (frequency: $SW = .884$, $df = 80$, $p = .000$; duration: $SW = .899$, $df = 80$, $p = .000$). Boxplots and histograms for the respective tests were also conducted and visually depicted a non-parametric distribution with outliers present as well. While the distribution did

not meet normality indices, the use of a two-tailed test helped to ensure the effects of Type I and Type II errors were minimal.

Calculated *means* for participants identifying as supervisors and working in the private-not-for-profit sector (n = 50) reported meeting with their supervisees on an individual basis for a *mean* of 4.56 times per month (SD = 6.42) and private-for-profit supervisors (n = 30) reported a *mean* of 4.30 clinical supervision sessions per month (SD = 4.97). Individual sessions reported by private-not-for-profit lasted 52.90 minutes (SD = 19.87) and 36.67 minutes (SD = 20.78) for private-for-profit. Private-not-for-profit reported a *mean* of 1.97 (SD = 1.80) group sessions per month, and private-for-profit reported 2.00 (SD = 1.60) group sessions per month. Group sessions lasted for a *mean* of 62.20 (SD = 51.08) minutes in private-not-for-profit settings, and 47.50 (SD = 36.57) minutes in private-for-profit settings.

As shown in table 17, data collected from private-not-for-profit participants (n = 50;) and private-for-profit participants (n = 30) demonstrated *mean* differences between the number of individual and group supervision sessions reported per month, and the average length of those sessions in minutes. However, the independent t-test indicated statistically significant differences at the $p < .05$ level only for the length of individual supervisory sessions (t = 3.477, df = 78, p = .001). The null hypothesis suggesting there is no difference between private-for-profit and private-not-for-profit practice settings in terms of length of individual sessions was rejected.

There was neither a difference in the frequency of individual sessions (t = .190, df = 78, p = .850), frequency of group sessions (t = -.075, df = 78, p = .940), nor the length of group supervisory sessions (t = 1.377, df = 78, p = .172). The null hypotheses stating there is no difference between the number of times individual and group supervision were provided and the

length associated with group supervision between private-for-profit and private-not-for-profit settings were retained.

Table 17
Supervisor Perspectives on Individual and Group Supervision: Differences in Frequency and Duration

	Levene's Test for Equality of Variances		t-test for Equality of *Means*		
	F	*p*	*t*	*df*	*p*
Individual Supervision: Number of Monthly Visits	.000	.990	.190	78	.850
Individual Supervision: Length of Monthly Visit	1.834	.180	3.477	78	.001
Group Supervision: Number of Monthly Sessions	.023	.879	-.075	78	.940
Group Supervision: Length of Session	3.287	.074	1.377	78	.172

Note: Private-not-for-profit, $n = 61$. Private-for-profit, $n = 38$.

Supervisors and Supervisees

Private-not-for-profit. Study participants identifying as private-not-for-profit counselors ($n = 159$) and supervisors ($n = 50$) were compared across their perceptions of individual supervision frequency and length, and group supervision frequency and length. Independent samples t-tests were utilized to conduct this analysis. Statistically significant differences were found on the reported length of supervisory sessions ($t = -4.835$, $df = 129.754$, $p = .000$) and length of group supervision sessions ($t = -3.162$, $df = 207$, $p = .002$). Null hypotheses indicating no difference between the perceived length of individual and group supervisory sessions between supervisors and counselors in the private-not-for-profit settings are rejected. Statistically significant differences were not found on the items measuring frequency of individual ($t = -1.962$, $df = 207$, $p = .051$) and group supervision sessions ($t = -.387$, $df = 207$, $p = .699$). Null hypotheses indicating no difference between the perceived monthly frequency of

individual and group supervisory sessions between supervisors and counselors in the private-not-for-profit settings are retained.

Private-for-profit. Independent samples t-tests were utilized to compare *mean* differences of study participants identifying as private -for-profit counselors (n = 130) and supervisors (n =30). Analyses compared across perceptions of individual supervision frequency and length, and group supervision frequency and length. Statistically significant differences were noted on the reported number of individual monthly supervisory sessions (t = -3.575, df = 158, p = .000), length of individual supervisory sessions (t = -2.740, df = 156, p = .007), and group supervision length (t = -4.269, df = 157, p = .000). Null hypotheses for these items are rejected as statistically significance differences in reported frequency of individual clinical supervision sessions and length of individual and group supervisory session do exist. The item measuring the frequency of group supervision sessions was not found to be statistically significant (t = -.943, df = 157, p = .347), and the null hypothesis for this item is retained.

Satisfaction

Participants identifying as counselors (n = 281) were asked to respond to the following six point Likert scale style question, "How satisfied are you with respect to the amount of supervision (individual and/or group) that you receive?" Responses were rated based as follows: 1) Very Dissatisfied, 2) Moderately Dissatisfied, 3) Slightly Dissatisfied, 4) Slightly Satisfied, 5) Moderately Satisfied, and 6) Very Satisfied. The *mean* satisfaction score was 4.70 (SD = 1.53). Participants that identified as supervisors (n = 89) were asked a comparable, yet slightly different question: "Regardless of what supervision formats that you used (e.g., individual, group, both, or none) and how often you met with your counselors, how satisfied are you with respect to the overall quality of supervision that you provided?". The six scored response options were: 1)

Very Unsatisfied, 2) Moderately Unsatisfied, 3) Slightly Unsatisfied, 4) Slightly Satisfied, 5) Moderately Satisfied, and 6) Very Satisfied. Results indicated a *mean* satisfaction score for supervisors to be 4.90 (*SD* = 1.46). The following analysis examined both environment (private-for-profit and private-not-for-profit) and role (counselor and supervisor) differences. See Table 18 for results across role and environmental setting.

Counselor to counselor. An independent samples t-test was used to compare the perspective of participants identifying as counselors by practice setting according to satisfaction with present levels of clinical supervision provided. Review of the Shapiro-Wilk test for normality suggested a non-parametric distribution for both private-not-for-profit (*SW* = .843, *df* =155, *p* = .000) and private-for-profit (*SW* = .717, *df* = 124, *p* = .000). Boxplots and histograms for the respective tests were also conducted and visually depicted a non-parametric distribution, with both distributions being skewed towards the right, indicating more positive satisfaction levels of clinical supervision. While the distribution did not meet normality indices, the use of a two-tailed test helped to ensure the effects of Type I and Type II errors were minimal.

The *mean* satisfaction score for the private-not-for-profit group (*n* = 156) was found to be 4.47 (*SD* = 1.55) and the *mean* satisfaction score for the private-for-profit group (*n* = 125) was calculated as 4.98 (*SD* = 1.45). Equal variance was not assumed for this category given a Levine's Test for Equality of Variances (*F* = 3.935, *p* = .048). In comparing reported satisfaction with clinical supervision between private-not-for-profit and private-for-profit counselors, a statistically significantly difference did exist between participants identifying as counselors employed in the private-for-profit sectors and private-not-for-profit settings at the .05 α level (*t* = -2.874, *df* = 271.98, *p* = .004). Based on these findings, the null hypothesis that there

were no differences in level of satisfaction with clinical supervision between counselors in the private-not-for-profit sector and private-for-profit sector was rejected.

Supervisor to supervisor. An independent samples t-test was used to compare participants identifying as supervisors by practice setting and their ratings of satisfaction with present levels of clinical supervision. Review of the Shapiro-Wilk test for normality suggested a non-parametric distribution for both private-not-for-profit ($SW = .691$, $df = 54$, $p = .000$) and private-for-profit ($SW = .684$, $df = 35$, $p = .000$). Boxplots and histograms for the respective tests were also conducted and visually depicted a non-parametric distribution, with both distributions being skewed towards the right, indicating more positive satisfaction levels with the current provision levels of clinical supervision. While the distribution did not meet normality indices, the use of a two-tailed test helped to ensure the effects of Type I and Type II errors were minimal.

The *mean* satisfaction score for the private-not-for-profit group ($n = 54$) was found to be 4.96 ($SD = 1.30$) and the *mean* satisfaction score for the private-for-profit group ($n = 35$) was calculated as 4.80 ($SD = 1.69$). Equal variance was assumed for this category given a Levine's Test for Equality of Variances ($F = 3.465$, $p = .066$). In comparing reported satisfaction with clinical supervision between private-not-for-profit and private-for-profit supervisors, there was no statistically significant difference with satisfaction rates ($t = .512$, $df = 87$, $p = .610$); the null hypothesis that there was no difference in level of satisfaction with the present level of clinical supervision between supervisors in private-for-profit and private-not-for-profit settings was retained.

Supervisors to counselors. Independent samples t-tests were conducted to analyze perceived differences of clinical supervision satisfaction based on work role and work

environment. Study participants identifying as private-for-profit counselors (n = 125) and supervisors (n = 35) did not demonstrate a statistically significant difference on reported satisfaction with supervision (t = .638, df = 158, p = .525). The null hypothesis stating there is no difference on perceptions of satisfaction with clinical supervision by counselor and supervisors in the private-for-profit setting is retained. Statistically significant results were found for study participants employed in the private-not-for-profit setting (t = -2.289, df = 108.53, p = .024). This indicated perceptions of satisfaction are different based on the supervisee – supervisor roles, and the null hypothesis stating there is no difference between satisfaction with clinical supervision by counselor and supervisors in the private-not-for-profit setting is rejected**.**

Quality

Participants identifying as counselors were asked to respond to the following six point Likert scale style question, "How would you rate the overall quality of supervision (individual and/or group) that you receive?" Responses were rated based as follows: 1) Counterproductive, 2) Not at all Valuable, 3) Minimally Valuable, 4) Somewhat Valuable, 5) Valuable, and 6) Very Valuable. Participants that identified as supervisors were asked a comparable, yet slightly different question: "Given the quality and amount of supervision that you provide, how valuable to you believe this effort contributed to the professional development of vocational rehabilitation counselors your supervised?" The six scored response options were: 1) Counterproductive, 2) Not at all Valuable, 3) Minimally Valuable, 4) Somewhat Valuable, 5) Valuable, and 6) Very Valuable. The following analysis examined both environment (private-for-profit and private-not-for-profit) and role (counselor and supervisor) differences. Overall quality score *means* for participants identifying as counselors was 4.65 (n = 281, SD = 1.22) and 5.30 (n = 89, SD = .63)

for participants identifying as supervisors. See Table 18 for results across role and environmental setting.

Counselor to counselor. An independent samples t-test was used to compare participants identifying as counselors by practice setting. Review of the Shapiro-Wilk test for normality suggested a non-parametric distribution for both private-not-for-profit ($SW = .882$, $df = 156$, $p = .000$) and private-for-profit ($SW = .839$, $df = 125$, $p = .000$) settings. Boxplots and histograms for the respective tests were also conducted and visually depicted a non-parametric distribution, with both distributions being skewed towards the right, indicating an overall positive perception of the quality of clinical supervision amongst participants. While the distribution did not meet normality indices, the use of a two-tailed test helped to ensure the effects of Type I and Type II errors were minimal.

The *mean* quality of clinical supervision score for the private-not-for-profit group ($n = 156$) were found to be 4.50 ($SD = 1.26$) and the *mean* quality of clinical supervision score for the private-for-profit group ($n = 125$) was calculated as 4.84 ($SD = 1.15$). Equal variance was assumed for this category given a Levine's Test for Equality of Variances ($F = 2.715$, $p = .101$). In comparing reported perceptions of the quality of clinical supervision between private-not-for-profit and private-for-profit counselors, counselors identifying as employed in the private-for-profit sectors rated the provision of clinical supervision as significantly higher in level of quality at the $p < .05$ level ($t = -2.337$, $df = 279$, $p = .020$). The null hypothesis stating there was no difference between perceived levels of clinical supervision quality between counselors in the private-not-for-profit and private-for-profit settings was rejected.

Supervisor to supervisor. An independent samples t-test was used to compare participants identifying as supervisors by practice setting and their perceived quality level of

clinical supervision provided at this time. Review of the Shapiro-Wilk test for normality suggested a non-parametric distribution for both private-not-for-profit (*SW* = .763, *df* =54, *p* = .000) and private-for-profit (*SW* = .753, *df* = 35, *p* = .000). Boxplots and histograms for the respective tests were also conducted and visually depicted a non-parametric distribution, with both distributions being skewed towards the right, indicating positive perceptions of the quality level of clinical supervision. While the distribution did not meet normality indices, the use of a two-tailed test helped to ensure the effects of Type I and Type II errors were minimal.

Table 18
Perceptions of Satisfaction and Quality

		Levene's Test for Equality of Variances		t-test for Equality of *Means*		
		F	*p*	*t*	*df*	*p*
Satisfaction	Counselor to Counselor	3.935	.048	-2.874	271.98	.004
	Supervisor to Supervisor	3.465	.066	.512	87	.610
	PFP: Cou to Sup	.754	.387	.638	158	.525
	PNFP: Cou to Sup	11.390	.000	-2.289	108.53	.024
Quality	Counselor to Counselor	2.715	.101	-2.337	279	.020
	Supervisor to Supervisor	1.271	.26	-1.169	87	.245
	PFP: Cou to Sup	5.479	.021	-2.750	158	.007
	PNFP: Cou to Sup	25.900	.000	-5.669	185.49	.000

Note: Participants identifying as supervisors, *n* = 89; participants identifying as counselors, *n* = 281.

The *mean* quality score for the private-not-for-profit group (*n* = 54) was found to be 5.24 (*SD* = .61) and the *mean* quality score for the private-for-profit group (*n* = 35) was calculated as 5.4 (*SD* = .65). Equal variance was assumed for this category given the Levine's Test for Equality of Variances (*F* = 1.271, *p* = .263). There was no statistically significant difference with perceived level of quality (*t* = -1.169, *df* = 87, *p* = .245) between private-not-for-profit and

private-for-profit supervisors (see Table 18). The null hypothesis stating there was no difference between perceive quality level associated with clinical supervision between supervisors in the private-not-for-profit and private-for-profit settings was retained.

Supervisors to counselors. Independent samples t-tests were conducted to analyze perceived differences of the overall quality of clinical supervision as presently provided based on work role and work environment. Study participants identifying as private-for-profit counselors (n = 125) and supervisors (n = 35) demonstrated a statistically significant difference on reported quality of supervision (t = -3.714, df = 99.03, p = .000; see Table 18). The null hypothesis stating there is no difference on perceptions of quality of clinical supervision between counselors and supervisors in the private-for-profit setting is rejected. Similarly, statistically significant results were found for study participants (counselors, n = 156; supervisors, n = 35) employed in the private-not-for-profit setting (t = -5.669, df = 185.49, p = .000). This indicated perceptions of quality are different based on the supervisee – supervisor roles, and the null hypothesis stating there is no difference between quality of clinical supervision as perceived by counselors and supervisors in the private-not-for-profit setting is rejected.

Supervisory Contract

Supervisory contracts have been recommended as one feature of minimally adequate supervision (Ellis et al., 2014). Supervisory contracts have also been found to be used on a limited basis in state vocational rehabilitation programs (McCarthy, 2013). Participants were simply asked to respond to a dichotomous question regarding the use of a supervisory contract, with responses being provided on a "yes" or "no" basis. For those participants identifying as counselors, 156 came from the private-not-for-profit setting, and 125 came from the private-for-

profit setting. The number of participants identifying as supervisors and working in the private-for-profit setting totaled 54, with 35 coming from the private-not-for-profit settings.

Counselor to counselor. As the responses to this question were categorical in nature, a Pearson χ^2 was used to compare participants identifying as counselors by practice setting. While neither practice setting reported a high use of supervisory contracts, 31.4% (n = 49) of private-not-for-profit participants and 19.2% (n = 24) of private-for-profit participants did report the use of a supervisory contract. Measures of symmetry were computed (*Phi* = .138, α = .020; *Cramer's V* = .138, α = .020; *Contingency Coefficient* = .137, α = .020). There is a significant relationship between the use of a supervisory contract between the two practice settings (*Pearson* χ^2= 5.380, α = .020); the null hypothesis that there was no difference in the use of a supervisory contract as reported by participants identifying as counselors in the two groups was rejected. However, given that *df* =1, this relationship has an effect size that is small (*Phi* = .138, α = .020).

Supervisor to supervisor. Again, the responses to this question were categorical in nature. As such, a Pearson χ^2 was used to compare participants identifying as supervisors by practice setting. While neither practice setting reported a high use of supervisory contracts, 40.7% (n = 22) of private-not-for-profit participants and 2% (n = 7) of private-for-profit participants did report the use of a supervisory contract. Measures of symmetry were computed (*Phi* = .216, α = .041; *Cramer's V* = .216, α = .040; *Contingency Coefficient* = .211, α = .041). There is a significant relationship between the use of a supervisory contract between the two practice settings (*Pearson* χ^2= 4.159, α = .041) and the null hypothesis that there was no difference in the use of a supervisory contract between the supervisors in the two groups was rejected. However, given that *df* =1, this relationship has a small effect size (*Phi* = .216, α = .041).

Research Question 3: Is there any difference between supervisee and supervisor perceptions of clinical supervision provided across private practice settings (e.g., private-not-for-profit vs. private-for-profit) in terms of supervisory knowledge, supervisory behavior, supervisor self-efficacy, and supervisory working alliance?

This section will focuses on perceived differences between participants identifying as counselors and participants identifying as supervisors across the four sub-scales of the research instrument. *Means* and standard deviations for the sub-scales were previously provided in tables 9, 10, 11, and 12 according to practice setting and role. This section reports differences across role, counselors and supervisors, and within work environment (e.g., private-not-for-profit counselors compared against private-not-for-profit supervisors). For all scales and comparisons, A Bonferroni correction was applied to confirm statistical significance of items by using the equation $\frac{\alpha}{33}$, or $\frac{.05}{33} = .0015$. The number of items from the Clinical Supervision Knowledge Scale was selected, as it would provide the most conservative analysis of statistical significance.

Knowledge Scale

An independent samples t-test was conducted to determine if differences existed between participants identifying as counselors and participants identifying as supervisors on perceived levels of knowledge associated with the provision of clinical supervision. Review of the Shapiro-Wilk test for normality suggests a non-parametric distribution for participants providing responses on the knowledge scale as all items demonstrated a p value < .000. Responses are based on a four point Likert style scale of reporting, using the following scale: 1) No Understanding, 2) Little Understanding, 3) Moderate Understanding, and 4) Complete Understanding. Table 19 reports the counselor *means*, supervisor *means*, and statistical scores (t scores and p level).

Table 19
Differences in Participant Perceptions on the Clinical Supervision Knowledge Scale

Item	Counselor *Mean*	Supervisor *Mean*	*t*	*p*
Confidentiality issues	3.40	3.70	-3.909	<.0001**
Establish trust	3.39	3.80	-6.230	<.0001**
Build rapport	3.35	3.83	-7.092	<.0001**
Make accommodations for counselors with disabilities	3.24	3.51	-2.564	.011*
Deal with ethical dilemmas: individual	3.24	3.57	-4.041	<.0001**
Examine implications of gender	3.23	3.49	-2.722	.007*
Dual relationship issues	3.23	3.56	-3.664	<.0001**
Examine implications of disability differences	3.21	3.59	-4.635	<.0001**
Negotiate power	3.20	3.50	-3.108	<.0001**
Use humor	3.20	3.69	-6.417	<.0001**
Examine implications of culture/ethnicity	3.15	3.43	-2.837	.005*
Address sources of conflict	3.15	3.49	-3.860	<.0001**
Use different supervisory roles	3.15	3.59	-5.308	<.0001**
Apply theory	3.13	3.55	-4.887	<.0001**
Address sources of anxiety	3.12	3.63	-6.079	<.0001**
Deal with ethical issues: group supervision	3.10	3.42	-3.246	.001**
Changing needs of the supervisee	3.08	3.49	-3.994	<.0001**
Strategies to focus supervisory sessions	3.06	3.45	-3.679	<.0001**
Describe differences between clinical and administrative supervision	3.04	3.50	-4.916	<.0001**
Stages of clinical skill development	3.03	3.47	-4.007	<.0001**
Work as a consultant	3.02	3.56	-5.730	<.0001**
Use methods to assist counselor progress	3.00	3.37	-3.339	.001**
Strategies to assist in goal development	3.00	3.29	-2.807	.006*
Work as a teacher	2.99	3.53	-5.923	<.0001**
Work as a counselor	2.96	3.58	-6.890	<.0001**
Use video/audiotapes	2.96	3.58	-4.000	<.0001**
Address counselor resistance	2.94	3.33	-3.414	.001**
Group Techniques	2.81	3.13	-3.166	.002*
Use role-play	2.80	3.50	-8.790	<.0001**
Demonstrate counseling techniques	2.78	3.59	-9.281	<.0001**
Provide verbal feedback	2.34	3.26	-6.526	<.0001**
Use case presentation	2.20	2.73	-6.537	<.0001**

Note: Participants identifying as counselors, $n = 260$; participants identifying as supervisors, $n = 86$.
*p < .05, **p<.0015.

Significant differences were reported across a majority of items (32 out of 33) on the scale at the $p < .05$ level on both the initial group comparison and also when applying the Bonferroni

correction; the one exception being the item on exploring sexual orientation (t = -1.958, df = 344, p = .051). An analysis of variance on the same items was run, and confirmed the finding of the independent samples t-test results. Only the item on exploring sexual orientation (t = 3.835, df = 345, p = .051) was not found to be statistically significant. The null hypotheses stating there are no difference between perceptions of clinical supervision knowledge associated with primary role (e.g., counselor vs. supervisor) was rejected for all items except sexual orientation.

Private-not-for-profit. Additional examination explored the differences between actual work settings and reported role. Statistically significant differences did exist between counselors and supervisors in the private-not-for-profit settings across the clinical supervision knowledge scale; however, this statistical significance was found on fewer items. Those items where a statistical significance was not found, and null hypotheses were retained, include examining implications of gender (t = -1.321, df = 201, p = .188), examining implications of sexual orientation (t = -1.176, df = 201, p = .241), techniques used in group supervision (t = -1.740, df = 118.08, p = .085), making accommodations for counselors with disabilities (t = -1.338, df = 201, p = .182), and assisting with the establishment of written goals (t = -1.867, df = 201, p = .063). An additional 14 items were found to be statistically significant at the alpha < .05 level, but not when applying the Bonferonni correction include: negotiating power within the supervisory relationship (t = -2.534, df = 201, p = .012), examine implication of culture/ethnicity (t = -2.116, df = 118.01, p = .036), examine implications of disability (t = -2.911, df = 127.17, p = .004), addressing sources of conflict (t = -2.334, df = 201, p = .021), describing the similarities and differences between administrative and clinical supervision (t = -2.887, df = 201, p = .004), stages of clinical skill development (t = -2.678, df = 201, p = .008), changing needs of supervisees over the course of supervision (t = -2.233, df = 201, p = .027), methods to assist

counselors who are not adequately progressing (t = -2.294, df = 201, p = .023), address counselor resistance (t = -2.533, df = 201, p = .012), apply theoretical knowledge to real world situations (t = -2.90, df = 201, p = .004), confidentiality issues in supervision (t = -2.715, df = 128.42, p = .008), dual relationship issues in supervision (t = -2.451, df = 201, p = .015), deal with ethical issues specific to group settings (t = -2.344, df = 126.12, p = .021), and strategies to clearly focus sessions (t = -2.812, df = 201, p = .005).

Private-for-profit. Similar to private-not-for-profit, the majority of items as rated by participants from the private-for-profit remained statistically significant. Those items that were not statistically significant include examining implications of culture/ethnicity (t = -1.909, df = 141, p = .058), examining implications of sexual orientation (t = -1.648, df = 141, p = .102), using videotapes and/or audiotapes (t = -1.498, df = 141, p = .136), dealing with ethical issues specific to group supervision (t = -1.859, df = 141, p = .065), and establishing written goals related to supervision (t = -1.550, df = 141, p = .123). An additional eleven items did not meet statistical significance at the alpha < .05 level when applying the Bonferonni correction: ethical dilemmas specific to individual supervision (t = -2.056, df = 85.13, p = .043), negotiating power within the supervisory relationship (t = -2.373, df = 84.75, p = .020), address sources of conflict (t = -2.493, df = 141, p = .014), techniques used for group supervision (t = -2.529, df = 141, p = .013), use methods to assist counselor who are not adequately progress (t = -2.601, df = 141, p = .010), address counselor resistance (t = -3.181, df = 96.26, p = .002), make accommodations for counselors with disabilities (t = -2.338, df = 141, p = .021), deal with ethical dilemmas specific to individual supervision (t = -2.056, df = 85.13, p = .043), confidentiality issues in supervision (t = -2.889, df = 108.26, p = .005), dual relationship issues (t = -2.615, df = 89.28, p = .010), and

strategies to focus supervision sessions (t = -2.348, df = 141, p = .020). The null hypotheses for these items were retained.

Behavior Scale

An independent samples t-test was conducted to determine if differences existed between participants identifying as counselors and participants identifying as supervisors on perceived behaviors associated with the provision of clinical supervision. Review of the Shapiro-Wilk test for normality suggests a non-parametric distribution for participants providing responses on the clinical supervision behavior scale as all items demonstrated a p value < .000. Table 20 outlines the differences in perceptions of clinical supervision behavior according to role (counselor vs. supervisor). The clinical supervision behavior scale utilized the following Likert style scale: 1) Strongly Disagree, 2) Disagree, 3) Slightly Disagree, 4) Slightly Agree, 5) Agree, and 6) Strongly Agree.

Table 20

Differences in Participant Perceptions on the Clinical Supervision Behavior Scale

Item	Counselor *Mean*	Supervisor *Mean*	*t*	*p*
Ethical and professional	5.11	5.69	-5.560	<.0001**
Appropriate use of humor	5.04	5.55	-4.875	<.0001**
Addressed questions on agency policy	4.97	5.54	-4.948	<.0001**
Made sufficient time to meet	4.91	5.42	-4.367	<.0001**
Kept all scheduled appointments	4.86	5.62	-7.052	<.0001**
Followed through on commitments	4.85	5.64	-7.837	<.0001**
Provided different ideas and opinions	4.84	5.46	-5.685	<.0001**
Balance between talking and listening	4.79	5.38	-5.069	<.0001**
Shared a relevant professional experience	4.75	5.52	-6.270	<.0001**
Discussed professional growth	4.75	5.61	-7.658	<.0001**
Constructive feedback on skills	4.7	5.45	-6.390	<.0001**
Provided timely feedback that counselor benefitted from	4.65	5.42	-6.050	<.0001**
Effectively identified and addressed ethical concerns	4.61	5.48	-7.186	<.0001**
Constructive feedback on counselor strengths	4.59	5.46	-7.352	<.0001**
Helped explore alternatives	4.46	5.27	-6.545	<.0001**
Suggested the counselor seek consultation	4.43	5.31	-6.480	<.0001**
Effectively demonstrated skills	4.34	5.26	-6.780	<.0001**
Pre-arranged times to meet: Individual	4.32	4.98	-3.701	<.0001**
Encouraged counselor to try different approaches	4.30	5.08	-5.469	<.0001**
Provided resource information to help counselor improve	4.30	5.20	-6.201	<.0001**
Developed specific supervision goals	4.27	4.98	-4.655	<.0001**
Effectively used case presentation	4.22	5.32	-7.444	<.0001**
Processed client-counselor sessions	4.05	4.92	-5.200	<.0001**
Pre-arranged times to meet: Group	4.03	4.67	-2.956	.004*
Provided feedback consistent with counselor's theoretical orientation	3.90	4.69	-4.102	<.0001**
Field based feedback on my professional interactions	3.66	4.98	-8.126	<.0001**
Field based feedback on my counseling skills	3.62	4.65	-5.657	<.0001**
Discussed supervisor's personal issues*	3.52	3.68	-0.673	.502
Used role play	3.50	4.62	-6.177	<.0001**

Note: Participants identifying as counselors, $n = 244$; participants identifying as supervisors, $n = 84$.
*$p < .05$; **$p < .0015$.

All items met statistical significance at the $p < .05$ level on initial analysis, except for the item on the discussion of the supervisor's personal issues ($t = -.673$, $df = 326$, $p = .502$). When applying the Bonferroni correction, the item pre-arranged times to meet for group supervision ($t = -2.956$, $df = 163.72$, $p = .004$) did not meet statistical significance. ANOVA results were similar to the independent samples t-test, with only the item on discussion of supervisor's personal issues not being statistically significant ($F = .452$, $df = 327$, $p = .502$); all other items were statistically significant at the $p < .05$ level and when the Bonferroni correction was applied. The null hypotheses that there is no difference between counselor and supervisor perception of implemented clinical supervision behaviors was rejected for the majority of items (27 out of 29 items) listed above. The two exceptions being the discussion of the supervisor's personal issues and pre-arranged times for group supervision, in these cases the null hypotheses were retained.

Private-not-for-profit. Additional examination explored the differences between actual work settings and reported role. Statistically significant differences did exist between counselors and supervisors in the private-not-for-profit settings across the clinical supervision behavior scale, and similar to the combined analysis in Table 20, only the discussion of the supervisors' personal issues remained non-significant ($t = 0.687$ $df = 194$, $p = .493$) on the general comparison. When applying the Bonferroni correction, the item not meeting statistical significance was the scheduling of regular pre-arranged times for group supervision ($t = -2.145$, $df = 104.84$, $p = .034$). Null hypotheses for these items were retained.

Private-for-profit. Analogous to private-not-for-profit, the majority of items (22 out of 29 items) as rated by participants from the private-for-profit remained statistically significant. Those items that were not statistically significant include making sufficient time available to meet with counselor ($t = -1.890$, $df = 130$, $p = .061$), scheduling pre-arranged meeting times for

individual supervision (t = -.377, df = 130, p = .707), scheduling pre-arranged meeting times for group supervision (t = -1.771, df = 130, p = .079), processing client-counselor session from observations made in the field or office (t = -1.605, df = 58.48, p = .114), providing feedback consistent with the counselor's theoretical orientation (t = -1.667, df = 130, p = .098), discussion of the supervisor's personal issues (t = -0.251, df = 130, p = .802), and developing specific supervision goals (t = -1.624, df = 130, p = .107). When applying the Bonferroni correction, additional items that did not demonstrate statistical significance included: went out with me in the field to watch a counseling session (t = -2.021, df = 59.44, p = .048) and demonstrated an appropriate sense of humor (t = -2.323, df = 130, p = .022). Null hypotheses for these items were retained.

Self-efficacy Scale

An independent sample t-test was conducted to determine if differences existed between participants identifying as counselors and participants identifying as supervisors on perceived levels of self-efficacy in the delivery of clinical supervision. Review of the Shapiro-Wilk test for normality suggests a non-parametric distribution for participants providing responses on the clinical supervision self-efficacy scale as all items show statistical significance at the p = .000 level. Shapiro-Wilk testing based on role (counselor vs. supervisor) and environment (private-for-profit vs. private-not-for-profit) is similar to the comparison of role only, as all items show statistical significance at the p = .000 level. Table 21 outlines the differences in perceptions of clinical supervision self-efficacy according to role (counselor vs. supervisor). Participants' responses were obtained using a sliding scale ranging from zero to 100.

Table 21
Differences in Participant Perceptions on the Clinical Supervision Self-Efficacy Scale

Item	Counselor *Mean*	Supervisor *Mean*	*t*	*p*
Help counselor discuss client problems	76.32	91.98	-7.417	<.0001**
Brainstorming counseling strategies	71.6	90.81	-8.198	<.0001**
Help define competency level	71.4	88.17	-7.143	<.0001**
Solicit and address counselor professional needs	70.46	87.74	-6.844	<.0001**
Allows counselor to structure supervision sessions	68.89	78.27	-2.974	.003*
Address and facilitate counselor worries	68.68	88.31	-7.720	<.0001**
Evaluate counselor interactions	68.51	84.28	-5.960	<.0001**
Identify appropriate interventions	68.26	85.35	-6.997	<.0001**
Process professional concerns with counselor	67.21	85.73	-6.421	<.0001**
Provide alternative interventions	67.03	86.75	-7.958	<.0001**
Interpret significant events	66.19	87.49	-8.927	<.0001**
Explores counselor's feelings	64.62	84.65	-6.916	<.0001**
Teach, demonstrate, or model interventions	62.73	85.59	-8.819	<.0001**
Explore the counselor feelings on a specific technique	62.55	83.57	-7.215	<.0001**
Explain rationale behind specific strategies	61.63	82.37	-7.275	<.0001**

Note: Participants identifying as counselors, $n = 238$; participants identifying as supervisors, $n = 81$.
*$p < .05$; **p < .0015.

ANOVA results paralleled independent samples t-test results, with differences between supervisees and supervisor perceptions on all self-efficacy items found to be statistically significant. Based on the results of the independent samples t-test, the null hypotheses that there is no difference between counselor and supervisor perceptions of supervisor self-efficacy is rejected for all items listed above. When applying the Bonferroni correction, one item did not meet statistical significance: allowing the counselor to structure the supervisory sessions ($t = -2.974$, $df = 194.38$, $p = .003$).

Private-not-for-profit. Further examination explored the differences between actual work settings and reported role on the clinical supervision self-efficacy scale. Statistically

significant differences did exist between counselors and supervisors in the private-not-for-profit settings across the clinical supervision self-efficacy scale, and similar to the combined analysis in table 21, all items were found to have statistically significant differences at the $p < .05$ level. Application of the Bonferonni correction to the private-not-for-profit comparison of counselors and supervisors perceptions also found every item to be statistically significant. As all reported differences on self-efficacy by supervisors and supervisees in the private-not-for-profit setting were found to be statistically significant, the null hypotheses that there is no difference between supervisee and supervisor perceptions of supervisor self-efficacy is rejected for this setting.

Private-for-profit. Parallel to private-not-for-profit, the majority of items as rated by participants from the private-for-profit remained statistically significant. However, a few items were not statistically significant and the null hypotheses for these items are retained. The items include: evaluating counselor interactions with clients ($t = -1.736$, $df = 59.32$, $p = .088$) and allowed the counselor to structure the supervision session ($t = -.254$, $df = 127$, $p = .800$). When applying the Bonferroni correction, three additional items failed to meet criteria for statistical significance and included: solicit and address counselor professional needs ($t = -3.114$, $df = 75.29$, $p = .003$), explore counselor feelings during a counseling or supervision session ($t = -2.940$, $df = 63.65$, $p = .005$), and process professional concerns the counselor may be defensive about ($t = -2.682$, $df = 67.83$, $p = .009$). The null hypotheses for these five items are retained, while the other ten null hypotheses on the other items in the scale stating there is no difference between private-for-profit counselor and supervisor perceptions of self-efficacy were rejected.

Supervisory Working Alliance Inventory

An independent sample t-test was conducted to determine if differences existed between participants identifying as counselors and participants identifying as supervisors on the perceived

strength of the supervisory working alliance. However, not all items on the supervisee scale (19 items) have parallel questions on the supervisor scale (23 items). Thus, the analysis for this section only looks at 18 of the questions Review of the Shapiro-Wilk test for normality suggests a non-parametric distribution for participants providing responses on the supervisory working alliance inventory, as all items show statistical significance at the $p = .000$ level. Shapiro-Wilk testing based on environment (private-for-profit vs. private-not-for-profit) is similar to the comparison of role only, as all items for both groups again demonstrated statistical significance at the $p = .000$ level. Table 22 outlines the differences in perceptions of the supervisory working alliance according to role (counselor vs. supervisor). Equal variance can only be assumed for the item measuring whether the supervisor helps the counselor talk freely in their sessions. The items are rated on a seven point Likert style scale with the following demarcation points: 1) Almost Never, 3) Occasionally, 5) Frequently, and 7) Almost Always. Points 2, 4, and six were considered midpoints between the other items and not specifically identified.

Table 22
Differences in Participant Perceptions on the Supervisory Working Alliance Inventory

Item	Counselor *Mean*	Supervisor *Mean*	*t*	*p*
Comfortable working with supervisor	5.90	6.32	-3.113	.002*
Supervisor encourages counselor to formulate own interventions	5.87	5.95	-0.513	.609
Supervisor welcomes counselor explanations	5.86	6.28	-3.080	.002*
Supervisor makes an effort to understand the counselor	5.75	6.56	-6.181	<.0001**
Supervisor encourages counselor to talk	5.73	6.15	-2.855	.005*
Supervisor helps counselor talk freely	5.73	5.05	3.282	.001**
Supervisor is tactful	5.72	6.09	-2.466	.014*
Supervisor stays in tune with counselor	5.62	6.13	-3.316	.001**
Supervisor encourages counselor to take time to understand	5.47	6.32	-5.634	<.0001**
Counselor is more curious than anxious	5.40	5.85	-2.608	.010*

Table 22 (cont'd)

Supervisor offers alternatives when offering correction	5.40	6.00	-3.639	<.0001**
Supervisor has high priority on understanding the client	5.38	6.20	-5.433	<.0001**
Supervisor helps counselor stay on track	5.28	5.89	-3.602	<.0001**
Supervisor helps counselor work within a specific plan	5.21	5.75	-3.039	.003*
Similar understanding of treatment and behavior	5.18	5.09	0.537	.592
Careful and systematic supervisory style	5.07	5.76	-3.887	<.0001**
Counselor and supervisor work on specific goals	4.95	5.62	-3.650	<.0001**
Counselor feels free to mention troublesome feelings	4.75	5.97	-6.759	<.0001**

Note: Participants identifying as counselors, $n = 228$; participants identifying as supervisors, $n = 79$.
*$p < .05$; **p < .0015.

Two items on the supervisory working alliance inventory did not meet statistical significance: supervisor encouraging supervisee to formulate their own interventions with clients ($t = -.513$, $df = 196.03$, $p = .609$) and supervisee understanding client treatment and behavior in a manner similar to their supervisor ($t = .537$, $df = 198.30$, $p = .592$).

ANOVA results found three items that were not statistically significant, with the similar items of supervisor encouraging supervisee to formulate their own intervention ($F = .186$, $df = 306$, $p = .666$), and understanding client treatment and behavior in similar fashions ($F = .202$, $df = 306$, $p = .65$) failing to meet statistical significance. The additional item of my supervisors is tactful ($F = 3.730$, $df = 306$, $p = .054$) was close to statistical significance, and the apparent difference may be the fact that equal variances were not assumed on the independent samples t-test. ANOVA assumes variance is steady (Field, 2013), and as equal variance cannot be assumed given the results of the independent samples t-test, it was felt the independent samples t-test was the more appropriate method to apply. When applying the Bonferroni correction, the items failing to meet criteria for statistical significance included: feeling comfortable working

with supervisor (t = -3.113, df = 235.27, p = .002), supervisor welcoming supervisee explanations of counselor behavior (t = -3.080, df = 202.55, p = .002), supervisor encourages counselor to talk about clients in a comfortable way (t = -2.855, df = 224.59, p = .005), supervisor is tactful (t = -2.466, df = 234.50, p = .014), counselor being more curious than anxious (t = -2.608, df = 245.67, p = .010), and my supervisor helps me work within a specific treatment plan (t = -3.039, df = 220.40, p = .003). The remaining eleven items were found to be statistically significant both at the $p < .05$ level and when the Bonferroni correction was applied. The null hypotheses for these eleven items are rejected. The null hypotheses stating there is no difference between counselor and supervisor perceptions for those items failing to meet statistical significance at the $p < .05$ level or when the Bonferroni correction was applied were retained. Of note here is the item stating, "My supervisor helps me talk freely in our sessions". This item has a positive t value, indicating counselors rated this at a higher level when compared to supervisors. Across all four scales, this is the first such occurrence.

Private-not-for-profit. Further examination explored the differences between actual work settings and reported role on the supervisory working alliance inventory. A few items were not statistically significant and the null hypotheses for these items are retained. The items include: supervisor encouraged counselor to formulate their own interventions (t = -.851, df = 141.62, p = .396) and understanding client behavior and treatment techniques in similar fashion (t = -.291, df = 150.37, p = .772). The remaining sixteen items were found to be statistically significant at the $p < .05$ level. When applying the Bonferoni correction, an additional eight items failed to meet statistically significant criteria and these items include: supervisor welcomes counselor explanations of client behavior (t = -3.154, df = 136.98, p = .002), supervisor encourages counselor to talk about clients in a comfortable manner (t = -3.136, df =

167.52, $p = .002$), supervisor is tactful ($t = -3.036$, $df = 170.39$, $p = .003$), supervisor helps counselor talk freely in sessions ($t = 2.120$, $df = 109.10$, $p = .036$), supervisor stays in tune with counselor ($t = -2.906$, $df = 163.60$, $p = .004$), counselor is more curious than anxious ($t = -2.334$, $df = 161.38$, $p = .021$), supervisor helps counselor work within a specific treatment plan ($t = -2.322$, $df = 148.27$, $p = .022$), and supervisor helps counselor stay on track in meetings ($t = -3.001$, $df = 154.30$, $p = .003$). The null hypotheses suggesting there is no difference between counselor and supervisor perceptions on these items of the supervisory working alliance inventory are rejected. The remaining eight null hypotheses for those items meeting statistical significance both at the $p < .05$ level and when the Bonferroni correction was applied are rejected.

Private-for-profit. Unlike private-not-for-profit and the other preceding analyses, the majority of items as rated by participants from the private-for-profit were not statistically significant. When analyzing counselors and supervisors in the private-for-profit setting and their perceptions of the supervisory working alliance, the null hypotheses for 13 of the 18 items are retained. The items include: comfortable working with supervisor ($t = -.784$, $df = 122$, $p = .434$), supervisor welcoming supervisee explanations about client behavior ($t = -.846$, $df = 122$, $p = .399$), supervisor making the effort to understand the supervisee ($t = -1.699$, $df = 122$, $p = .092$), supervisor encouraging the supervisee to talk ($t = -.744$, $df = 122$, $p = .458$), supervisor being tactful ($t = -.257$, $df = 122$, $p = .798$), supervisor encouraging supervisees to formulate their own interventions ($t = .125$, $df = 122$, $p = .901$), supervisor staying in tune during supervision ($t = -1.608$, $df = 74.88$, $p = .112$), supervisor understanding behavior and treatment similar to supervisee ($t = .978$, $df = 122$, $p = .330$), supervisee being more curious than anxious ($t = -1.014$, $df = 122$, $p = .312$), supervisor's style is to carefully and systematically review material ($t = -.953$, $df = 122$, $p = .342$), supervisor offering alternatives when making corrections ($t = -1.491$, df

= 122, p = .139), supervisor helping supervisee stay on task during supervision (t = -1.735, df = 122, p = .085), and collaborative work on specific goals in supervision (t = -1.155, df = 68.12, p = .252).

Of the six items found to have statistical significance at the $p < .05$ level, when applying the Bonferroni correction an additional five items were eliminated: my supervisor helps me to talk freely in sessions (t = 2.997, df = 122, p = .003), supervisor places a high priority on understanding the client (t = -2.996, df = 69.52, p = .004), supervisor encourages supervisee to understand the client (t = -3.023, df = 83.48, p = .003), and supervisor helps supervisee work within a specific treatment plan (t = -2.004, df = 69.75, p = .049). The null hypotheses for these 17 items are retained. The only item to meet statistical significance at both the $p < .05$ level and with the application of the Bonferroni correction was: supervisee feels free to mention anything troubling them (t = -3.628, df = 90.64, p = .000). The null hypothesis for this item in the private-for-profit setting when comparing counselors to supervisor is rejected. Similar to the preceding private-not-for-profit section, there was a positive t score on supervisor helps me to talk freely in sessions, indicating counselors rated this as higher than supervisors.

Multiple Analysis of Variance

As question four is looking at two dependent variables with six independent variables, a MANOVA was conducted to examine the difference between the different participant roles (supervisee vs. supervisor) and practice settings (private-not-for-profit vs. private-for-profit) to see if significant differences existed on participant perspectives of clinical supervision knowledge, behavior, self-efficacy, and supervisory working alliance. The null hypothesis for this question is:

H_0: No difference exits between participant role and work setting on perceptions of knowledge, behavior, self-efficacy, and supervisory working alliance.

Descriptive statistics. For the knowledge variable, participants identifying as private-not-for profit rehabilitation counselors reported a *mean* score of 100.06 (n = 134, SD = 23.66) and participants identifying as private-not-for-profit rehabilitation counselor supervisors were found to have a *mean* score of 114.55 (n = 49, SD = 16.16). Private-for-profit counselors reported a *mean* score of 101.94 (n = 94, SD = 24.55) and supervisors in this setting reported a score for 118.6 (n = 30, SD = 13.15).

For the behavior variable, participants identifying as private-not-for profit rehabilitation counselors reported a *mean* score of 127.35 (n = 134, SD = 33.85) and participants identifying as private-not-for-profit rehabilitation counselor supervisors were found to have a *mean* score of 151.86 (n = 49, SD = 15.21). Private-for-profit counselors reported a mean score of 130.22 (n = 94, SD = 34.25) and supervisors in this setting reported a score for 151.03 (n = 30, SD = 14.49).

On the self-efficacy variable, participants identifying as private-not-for profit rehabilitation counselors reported a *mean* score of 1000.90 (n = 134, SD = 398.79) and participants identifying as private-not-for-profit rehabilitation counselor supervisors were found to have a *mean* score of 1310.71 (n = 49, SD = 156.48). Private-for-profit counselors reported a *mean* score of 1020.94 (n = 94, SD = 409.84) and supervisors in this setting reported a score for 1248.97 (n = 30, SD = 223.83).

For the supervisory working alliance inventory, participants identifying as private-not-for profit rehabilitation counselors reported a *mean* score of 96.77 (n = 134, SD = 27.21) and participants identifying as private-not-for-profit rehabilitation counselor supervisors were found to have a *mean* score of 107.63 (n = 49, SD = 10.36). Private-for-profit counselors reported a

mean score of 100.40 (n = 94, SD = 23.83) and supervisors in this setting reported a score for 105.87 (n = 30, SD = 6.27).

Validity of the model. Multivariate tests of the MANOVA examining the impact of role and work setting on the four dependent variables found the role (supervisee vs. supervisor, F = 10.62, p = .000) to have a significant impact on the four outcome variables. When examining the relationship between subjects and the potential effects, the overall model fit was found to be significant across all outcome variables (knowledge: F = 9.66, p = .000; behavior: F = 11.44, p = .000; self-efficacy: F = 11.87, p = .000; supervisory working alliance: F = 3.23 p = .023). Role in particular had a significant impact across the four outcome variables (knowledge: F = 27.65, p = .000; behavior: F = 31.10, p = .000; self-efficacy: F = 30.97, p = .000; supervisory working alliance: F = 6.87, p = .009).

Parameter estimates suggested the individual's role did impact the knowledge scale; participants identifying as counselors reported statistically significant lower *mean* scores on knowledge (β = -16.664, SE = 4.635, p = .000), behavior (β = -20.810, SE = 6.359, p = .001), and self-efficacy (β = -228.030, SE = 75.616, p = .003). The supervisory working alliance (β = -5.462, SE = 4.872, p = .263) did not demonstrate statistically significant *mean* differences between participants identifying as supervisors and supervisees. This suggests supervisory working alliance, when considered as part of the collective model, does not have a significant relationship to the difference in perceptions between the counselor and supervisor. The remaining three outcome variables did demonstrate statistical significance in their relationship to the role predictor variable.

Research Question 4: Is there an association between perceptions of counselor satisfaction and quality of supervision as related to perceptions of supervisory knowledge, behavior, self-efficacy, ethnicity, and gender?

Correlation and stepwise linear multiple regression analyses were conducted to examine the relationship between gender, ethnicity, years of experience, supervisory working alliance, supervisory knowledge, supervisory behaviors, and perceptions of supervisor self-efficacy on counselor reports of satisfaction and quality of supervisions. Gender and ethnicity variables were transformed into dummy variables based on male/female, and Caucasian/all other ethnicity groupings. *Mean* composite scores for clinical supervision knowledge scale (100.81, $n = 260$), clinical supervision behavior scale (128.33, $n = 244$), clinical supervision self-efficacy scale (1012.04, $n=238$), and the supervisory working alliance inventory (98.27, $n = 228$) were used to calculate the correlation and regression. In the attempt to ascertain how much variance can be accounted for with the aforementioned independent variables on the outcome variables of satisfaction and quality of supervision, the following hypotheses were tested:

1. *H_0 = Gender, ethnicity, knowledge, behavior, self-efficacy, and supervisory working alliance will not account for a significant amount of variance on supervisee satisfaction with clinical supervision.*
2. *H_0 = Gender, ethnicity, knowledge, behavior, self-efficacy, and supervisory working alliance will not account for a significant amount of variance on supervisee perceptions of the quality of clinical supervision.*

As outlined in Table 23 below, the four independent variables of knowledge, behavior, self-efficacy and supervisory working alliance demonstrated a significant and positive correlation. As these four components are highly correlated, the use of a two-tailed test helped to reduce the

potential of type II error. When examining race and ethnicity, no statistically significant correlations were found. Prior to the running of the regression models, a *post hoc* power analysis was conducted in order to verify the appropriateness of the present sample size to the proposed model with six predictor variables (see variable section), power was set at .80, and alpha level was set at .05. Where a medium effect size (.15) has been found to be appropriate for social science research (Cohen, 1988; Field, 2013), a medium effect size was selected for this study. Calculations suggest an appropriate sample size as 98 responses. Where there were 228 fully completed counselor instruments, it was felt the data was appropriate for the proposed model. Separate models were also run to consider the potential interaction effects between the supervisory working alliance and supervisory knowledge, behavior, and self-efficacy. These models showed a significant impact on the part of knowledge ($t = 2.13$, $p = .03$) and behavior ($t = 2.38$, $p = .02$) when considered independent of the supervisory working alliance. Neither self-efficacy nor supervisory working alliance accounted for any significant portions of the variance in these models. This led to the decision to keep these items separate in the model that was ultimately used.

Table 23

Correlations Between Knowledge Scale, Behavior Scale, Self-efficacy Scale, and SWA Inventory

		Know	Beh	SE	SWA	Gender	Ethnicity
Knowledge	Pearson Correlation	1	.858**	.782**	.671**	.093	.120
	Sig. (2-tailed)		.000	.000	.000	.136	.053
	n	260	244	238	228	259	260
Behavior	Pearson Correlation	.858**	1	.818**	.749**	.082	.041
	Sig. (2-tailed)	.000		.000	.000	.203	.524
	n	244	244	238	228	243	244
Self Efficacy	Pearson Correlation	.782**	.818**	1	.709**	-.002	.018
	Sig. (2-tailed)	.000	.000		.000	.976	.787
	n	238	238	238	228	237	238
SWA	Pearson Correlation	.671**	.749**	.709**	1	.077	.064
	Sig. (2-tailed)	.000	.000	.000		.247	.333
	n	228	228	228	228	227	228
Gender	Pearson Correlation	.093	.082	-.002	.077	1	-.007
	Sig. (2-tailed)	.136	.203	.976	.247		.899
	n	259	243	237	227	299	299
Ethnicity	Pearson Correlation	.120	.041	.028	.064	-.007	1
	Sig. (2-tailed)	.053	.524	.787	.334	.899	
	n	260	244	238	228	299	300

**. Correlation is significant at the 0.05 level (2-tailed).

Counselor Satisfaction

As part of the stepwise multiple linear regression process, three regression models were run. The first model specifically examined race and gender, the second model added the supervisory working alliance, and the third model included all six predictor variables. Supervisory working alliance was separated from knowledge, behavior, and self-efficacy. It was felt the SWA represents knowledge, behavior, and self-efficacy, as evidence by their high measures of correlation. However, the inclusion of these three measures separately in the third model would help to tease out more of the specific causes of variance. As outlined in Table 24, the stepwise multiple linear regression model utilizing all six predictor variables produced a significant change in the R^2 score for each successive measure, with model three accounting for 28.3% of the variance in predicting counselor satisfaction. Effect size (Cohen's $f^2 = .395$) was considered, and is reflective of a large effect size.

Table 24
Satisfaction Regression

Model	*R*	R^2	Adjusted R^2	R^2 Change	*F* change	Sig. in *F* Change	ANOVA *F*	ANOVA *p*
1	.165[a]	.027	.019	.027	3.148	.045	3.148	.045[a]
2	.427[b]	.182	.171	.155	42.172	.000	16.542	.000[b]
3	.550[c]	.302	.283	.120	12.652	.000	15.893	.000[c]

a. Predictors (Constant): race and gender
b. Predictors: (Constant): race, gender, and SWA
c. Predictors: (Constant): race, gender, SWA, knowledge, behavior, and self-efficacy.

Table 25 is a coefficient table of the model and reflects a break down of the models according to their respective predictor variables' significance, and collinearity statistics.

Table 25
Stepwise Multiple Linear Regression Results, Specific Predictor Variables

Model		Unstandardized β	Standardized β	*t*	*p*	Collinearity Statistics Tolerance	Collinearity Statistics VIF
1	(Constant)	4.720		41.230	.000		
	Gender	.565	.156	2.360	.019	1.000	1.000
	Race	-.194	.-.058	-.876	.382	1.000	1.000
2	(Constant)	2.628		7.758	.000		
	Gender	.455	.125	2.063	.040	.994	1.006
	Race	-.297	-.089	-1.458	.146	.994	1.006
	SWA	.022	.396	6.494	.000	.988	1.012
3	(Constant)	1.873		4.744	.000		
	Gender	.440	.121	2.122	.035	.972	1.029
	Race	-.321	-.096	-1.680	.094	.978	1.023
	SWA	.000	-.002	-.028	.978	.413	2.422
	Knowledge	.007	.126	1.048	.296	.220	4.548
	Behavior	.015	.345	2.579	.011	.177	5.651
	Self-Efficacy	.000	.082	.774	.440	.283	3.529

Dependent variable: Participants identifying as counselors (n = 227), satisfaction level with clinical supervision.

Per the collinearity statistics as reported in table 25 above, the stepwise multiple linear regression demonstrated high tolerance and variance inflation factor (VIF) scores. However, as the largest VI is not greater than 10 (Field, 2013) and the collinearity was somewhat expected, it was felt

these models do describe the relationship between counselor satisfaction with clinical supervision and the predictor variables. Gender was found to be significant across all three models, and while SWA was found to be a significant predictor in the 2nd model, it was replaced in the third model by behavior. Using the third model, the null hypothesis stating: *Gender, ethnicity, knowledge, behavior, self-efficacy, and supervisory working alliance will not account for a significant amount of variance on supervisee satisfaction with clinical supervision* has been rejected. Caution over the impact of behavior does need to be considered as its tolerance score is .18 and scores below .2 indicate potential problems (Field, 2013). As the overall model accounts for about 28% of the variance, the model was broken down further to consider specific work environments separately, rather than the collapsed participant-counselor category described above.

Private-not-for-profit: Following the same stepwise multiple linear regression approach outlined above, the model was found to predict a higher percentage of the variance for private-not-for-profit when private-for-profit participants were excluded. Table 26 outlines the model summary when applied to private-not-for-profit.

Table 26
Satisfaction Regression: Private-not-for-profit

Model	*R*	R^2	Adjusted R^2	R^2 Change	*F* change	Sig. in *F* Change	ANOVA *F*	ANOVA *p*
1	.166[a]	.027	.013	.027	1.837	.163	1.837	.163[a]
2	.581[b]	.337	.322	.310	60.235	.000	21.861	.000[b]
3	.672[c]	.451	.425	.114	8.747	.000	17.273	.000[c]

a. Predictors (Constant): race and gender
b. Predictors: (Constant): race, gender, and SWA
c. Predictors: (Constant): race, gender, SWA, knowledge, behavior, and self-efficacy.

However, as outlined in Table 27, despite the overall better predictive ability of model three (43% of the variance) and large effect size (Cohen's $f^2 = .739$) for private-not-for-profit, there

are some concerns with collinearity. Similar to previous findings, there is a high degree of collinearity between supervisory working alliance, knowledge, behavior, and self-efficacy. In the second model SWA was once again statistically significant, and SWA was then replaced in the third model by behavior. Unlike the previous model where private-for-profit and private-not-for-profit participants were combined, gender was not found to be significant in this model considering only participants from private-not-for-profit.

Table 27
Stepwise Multiple Linear Regression Results: Private-not-for-profit

Model		Unstandardized β	Standardized β	t	p	Collinearity Statistics	
						Tolerance	VIF
1	(Constant)	4.499		28.869	.000		
	Gender	.685	.163	1.888	.061	1.000	1.000
	Race	-.100	-.030	-.343	.732	1.000	1.000
2	(Constant)	1.585		3.991	.000		
	Gender	.348	.083	1.146	.254	.980	1.021
	Race	-.137	-.041	-.567	.572	1.000	1.000
	SWA	.031	.562	7.761	.000	.979	1.021
3	(Constant)	.864		1.887	.061		
	Gender	.388	.093	1.363	.175	.943	1.060
	Race	-.210	-.062	-.927	.356	.964	1.038
	SWA	.004	.067	.553	.582	.295	3.388
	Knowledge	.001	.020	.142	.887	.227	4.408
	Behavior	.023	.518	3.159	.002	.162	6.172
	Self-Efficacy	.000	.077	.624	.533	.285	3.512

Dependent variable: Participants identifying as private-not-for-profit counselors (n = 133), satisfaction level with clinical supervision.

Private-for-profit: Similar to the private-not-for-profit and combined population, when applied to private-for-profit, the third model did predict a percentage (12%) of the variance; effect size was considered small (Cohen's f^2 = .139). However, the overall predictability was considered lower for private-for-profit given the model summary outlined in Table 28.

Table 28
Satisfaction Regression: Private-for-profit

Model	*R*	R^2	Adjusted R^2	R^2 Change	*F* change	Sig. in *F* Change	ANOVA *F*	ANOVA *p*
1	.128[a]	.016	-.005	.016	.757	.472	.757	.472[a]
2	.150[b]	.023	-.010	.006	.570	.452	.692	.559[b]
3	.422[c]	.178	.122	.156	5.505	.002	3.150	.008[c]

a. Predictors (Constant), Race and ethnicity
b. Predictors: (Constant), race, ethnicity, and SWA
c. Predictors: (Constant), race, gender, SWA, knowledge, behavior, and self-efficacy.

Table 29 is the coefficient table and reflects concerns with collinearity despite the overall predictive ability of the model for private-for-profit,. Similar to previous findings, there is a high degree of collinearity between supervisory working alliance, knowledge, behavior, and self-efficacy. Additionally and in contrast to the previous two stepwise multiple linear regression models (combined participants and private-not-for-profit), no specific items were found to be statistically significant predictors of the variance. As such, the utility of this model as applied to private-for-profit participants is negligible.

Table 29
Stepwise Multiple Linear Regression Results: Private-for-profit

Model		Unstandardized β	Standardized β	*t*	*p*	Collinearity Statistics Tolerance	Collinearity Statistics VIF
1	(Constant)	5.044		30.893	.000		
	Gender	.313	.106	1.021	.310	1.000	1.001
	Race	-.242	-.075	-.724	.471	1.000	1.001
2	(Constant)	4.622		7.931	.000		
	Gender	.320	.109	1.043	.300	.998	1.002
	Race	-.293	-.091	-.858	.393	.959	1.042
	SWA	.004	.080	.755	.452	.960	1.041
3	(Constant)	3.846		5.713	.000		
	Gender	.240	.082	.824	.412	.965	1.037
	Race	-.297	-.092	-.918	.361	.935	1.070
	SWA	-.013	-.241	-1.826	.071	.544	1.838
	Knowledge	.014	.276	1.286	.205	.201	4.965
	Behavior	.005	.141	.629	.531	.189	5.281
	Self-efficacy	.000	.119	.614	.541	.253	3.946

Dependent variable: private-for-profit counselors' ($n = 94$) satisfaction level with clinical supervision.

Counselor Perception of Quality

Following the same process as previously outlined for the satisfaction stepwise multivariate linear regression, three regression models were run. Again, the first model specifically examined race and gender, the second model added the supervisory working alliance, and the third model included all six predictor variables. Similar to the satisfaction results indicating high collinearity with a degree of separateness, the supervisory working alliance was separated from knowledge, behavior, and self-efficacy as it was felt the SWA represents knowledge, behavior, and self-efficacy. Regression models were run considering the interaction effect between the SWA and knowledge, behavior, and self-efficacy. However, VIF scores were higher on knowledge(4.548), behavior (5.651) and self-efficacy (3.529). Scores over 10 are considered problematic (Field, 2013), and as none of these items reached that threshold, it was decided to keep these variables separate. Additionally, it was felt the separate inclusion of these three measures in the third model would help to tease out more of the specific causes of variance in perception of quality. As outlined in Table 30, the stepwise multiple linear regression model used all six predictor variables and produced a significant change in the R^2 score for each successive measure, with model three accounting for 50.3% of the variance in predicting counselor perceptions on the overall quality of supervision. Effect size is considered large (Cohen's $f^2 = 1.012$).

Table 30
Quality of Supervision Regression

Model	*R*	R^2	Adjusted R^2	R^2 Change	*F* change	Sig. in *F* Change	ANOVA *F*	ANOVA *p*
1	.117[a]	.014	.005	.014	1.561	.212	1.561	2.12[a]
2	.586[b]	.343	.335	.330	111.999	.000	38.889	.000[b]
3	.719[c]	.516	.503	.173	26.232	.000	39.161	.000[c]

a. Predictors (Constant), Race and ethnicity
b. Predictors: (Constant), race, ethnicity, and SWA
c. Predictors: (Constant), race, gender, SWA, knowledge, behavior, and self-efficacy.

Table 31 is a coefficient table and reflects a break down of the models according to their respective predictor variables' significance, and collinearity.

Table 31
Stepwise Multiple Linear Regression Results, Specific Predictor Variables

Model		Unstandardized β	Standardized β	*t*	*p*	Collinearity Statistics Tolerance	Collinearity Statistics VIF
1	(Constant)	4.576		47.895	.000		
	Gender	.192	.064	.964	.336	1.000	1.000
	Race	.271	.098	1.471	.143	1.000	1.000
2	(Constant)	2.045		8.129	.000		
	Gender	.060	.020	.366	.715	.994	1.006
	Race	.146	.053	.966	.335	.994	1.006
	SWA	.026	.578	10.583	.000	.988	1.012
3	(Constant)	1.045		3.837	.000		
	Gender	.024	.008	.170	.865	.97	1.029
	Race	.085	.031	.648	.518	.98	1.023
	SWA	.007	.148	2.032	.043	.41	2.422
	Knowledge	.019	.390	3.902	.000	.22	4.548
	Behavior	.008	.218	1.954	.052	.18	5.651
	Self-Efficacy	3.845E-5	.013	.149	.882	.28	3.529

Dependent variable: Participants identifying as counselors (n = 227), overall quality level of clinical supervision.

Collinearity is a concern, and needs to be taken into consideration. As reported in Table 31 above, the stepwise multiple linear regression demonstrated high tolerance and variance inflation

factor (VIF) scores. As the largest VIF is not greater than 10 (Field, 2013) and the collinearity was somewhat expected, it was felt these models do describe the relationship between counselor satisfaction with clinical supervision and the predictor variables. Unlike the gender score on the satisfaction regression, gender was not found to be significant on any of the three models. SWA was found to be a significant predictor in the second model ($t = 10.583$, $p = .000$), and in the third model ($t = 2.03$, $p = .043$). SWA was joined by knowledge ($t = 3.902$, $p = .000$) in the third model. Behavior was found to be significant in the satisfaction model, but just missed statistical significance in the quality model ($t = 1.954$, $p = .052$). Using the third model, the null hypothesis stating: *Gender, ethnicity, knowledge, behavior, self-efficacy, and supervisory working alliance will not account for a significant amount of variance on supervisee perceptions of the quality of clinical supervision* has been rejected. While the overall model accounts for about 50% of the variance, the model was broken down further to consider specific works environments separately, rather than the collapsed participant-counselor category described above.

Private-not-for-profit: Following the same stepwise multiple linear regression approach outlined above, the model was found to predict a higher percentage of the variance (56.3%) with a strong effect size (Cohen's $f^2 = 1.288$) for private-not-for-profit when private-for-profit participants were excluded. Table 32 outlines the model summary when specifically applied to private-not-for-profit.

Table 32
Quality Regression: Private-Not-For-Profit

Model	*R*	R^2	Adjusted R^2	R^2 Change	*F* change	Sig. in *F* Change	ANOVA *F*	ANOVA *p*
1	.040[a]	.002	-.014	.002	.106	.899	.106	.899[a]
2	.670[b]	.449	.437	.448	104.898	.000	35.093	.000[b]
3	.763[c]	.583	.563	.133	13.440	.000	29.343	.000[c]

a. Predictors (Constant), Race and ethnicity
b. Predictors: (Constant), race, ethnicity, and SWA
c. Predictors: (Constant), race, gender, SWA, knowledge, behavior, and self-efficacy.

As outlined in Table 33, despite the overall better predictive ability of model three (56.3% of the variance) for private-not-for-profit, there are some concerns with collinearity. Similar to previous findings, there is a high degree of collinearity between supervisory working alliance, knowledge, behavior, and self-efficacy; VIF scores remain below 10 (Field, 2013), and it was felt the model applies well to the private-not-for-profit participants. Supervisory working alliance was statistically significant on the second model, but not the third. Similar to the combined private-for-profit/private-not-for-profit model previously mentioned, knowledge remained statistically significant on the third model. Gender was not found to be significant when separating the private-not-for-profit counselors from the private-for-profit counselors.

Table 33
Stepwise Multiple Linear Regression Results, Specific Predictor Variables: Private-Not-For-Profit

Model		Unstandardized β	Standardized β	*t*	*p*	Collinearity Statistics Tolerance	Collinearity Statistics VIF
1	(Constant)	4.568		35.156	.000		
	Gender	-.019	-.005	-.061	.951	1.000	1.000
	Race	.111	.040	.457	.648	1.000	1.000
2	(Constant)	1.684		5.655	.000		
	Gender	-.352	-.102	-1.545	.125	.980	1.021
	Race	.074	.027	.410	.682	1.000	1.000
	SWA	.030	.676	10.242	.000	.979	1.021

Table 33 (cont'd)							
3	(Constant)	.723		2.200	.030		
	Gender	-.292	-.085	-1.430	.155	.943	1.060
	Race	-.028	-.010	-.171	.865	.964	1.038
	SWA	.009	.197	1.858	.066	.295	3.388
	Knowledge	.019	.378	3.128	.002	.227	4.408
	Behavior	.008	.223	1.562	.121	.162	6.172
	Self-Efficacy	7.572E-7	.025	.229	.820	.285	3.512

Dependent variable: Participants identifying as private-not-for-profit counselors (n = 133), satisfaction level with clinical supervision.

Private-for-profit: Similar to the private-not-for-profit and combined population, when applied to private-for-profit work setting, the third model was found to predict a portion (42%) of the variance and demonstrated a large effect size (Cohen's f^2 = .727). The overall predictability was considered lower for private-for-profit when compared to the private-not-for-profit model given the model summary outlined in Table 34.

Table 34
Quality Regression: Private-For-Profit

Model	R	R^2	Adjusted R^2	R^2 Change	F change	Sig. in F Change	ANOVA F	ANOVA p
1	.250[a]	.063	.042	.063	3.039	.053	.3.039	.053[a]
2	.479[b]	.229	.203	.166	19.432	.000	8.914	.000[b]
Table 34 (cont'd)								
3	.677[c]	.459	.412	.230	12.294	.000	12.294	.000[c]

a. Predictors (Constant), Race and ethnicity
b. Predictors: (Constant), race, ethnicity, and SWA
c. Predictors: (Constant), race, gender, SWA, knowledge, behavior, and self-efficacy.

As outlined in table 35, concerns regarding collinearity remain despite the overall predictive ability of the model for private-for-profit settings. Similar to previous findings, the supervisory working alliance inventory demonstrated a statistically significant score (t = 4.408, p = .000) on the second model, but was replaced by another item, knowledge (t = 2.124 p = .037), on the third model. Again, a high degree of collinearity between supervisory working alliance, knowledge,

behavior, and self-efficacy exists, but VIF scores remained below 10 (Field, 2013), and it was felt the model was still applicable.

Table 35

Stepwise Multiple Linear Regression Results, Specific Predictor Variables: Private-For-Profit

Model		Unstandardized β	Standardized β	t	P	Collinearity Statistics	
						Tolerance	VIF
1	(Constant)	4.596		33.161	.000		
	Gender	.319	.125	1.227	.223	.999	1.001
	Race	.594	.212	2.091	.039	.999	1.001
2	(Constant)	2.692		5.981	.000		
	Gender	.353	.138	1.488	.140	.998	1.002
	Race	.363	.130	1.374	.173	.959	1.042
	SWA	.019	.416	4.408	.000	.960	1.041
3	(Constant)	1.646		3.465	.001		
	Gender	.236	.092	1.148	.254	.965	1.037
	Race	.384	.138	1.686	.095	.935	1.070
	SWA	.002	.035	.323	.748	.544	1.838
Table 35 (cont'd)							
	Knowledge	.017	.373	2.124	.037	.201	4.965
	Behavior	.010	.297	1.639	.105	.189	5.281
	Self-Efficacy	.000	-.042	-.265	.791	.253	3.946

Dependent variable: Participants identifying as private-for-profit counselors (n = 94), satisfaction level with clinical supervision.

CHAPTER 5

DISCUSSION

The intent of this study was to explore contemporary practices associated with clinical supervision in rehabilitation counseling private-for-profit and private-not-for-profit practice settings. Perceptions of clinical supervision knowledge, behavior, self-efficacy in delivering clinical supervision, and the supervisory working alliance were also explored. To accomplish this, the clinical supervision knowledge scale, clinical supervision behavior scale, clinical supervision self-efficacy scale, and supervisory working alliance inventory were selected as instruments with which to gather data. Following the analysis of results in Chapter 4, the purpose of this chapter is to summarize results, provide implications of the findings, consider the limitations of the study, and recommend future research.

Based on the results of the present study, differences do exist between counselor and supervisor perceptions regarding the contemporary practices of clinical supervision in private-not-for-profit and private-for-profit vocational rehabilitation work settings. Participants identifying as supervisors consistently rated their perceptions of appropriate clinical supervision knowledge and behavior at a higher level than counselors in this study. Participants identifying as supervisors also rated their level of self-efficacy in delivering clinical supervision practices and their perception of the supervisory working alliance at higher levels than participants identifying as counselors. No significant differences existed between supervisors across settings, but participants identifying as counselors from the private-for-profit setting rated their supervisors higher on the knowledge, behavior, self-efficacy, and supervisory working alliance scales.

Of the three hundred participants identifying as counselors, only 21.2% (n =65) were presently involved in clinical supervision at this time. The time spent providing individual and group supervision was reported differently based on role (counselor vs. supervisor) and work setting (private-for-profit vs. private-not-for-profit). Private-not-for-profit counselors received more frequent clinical supervision sessions per month, and these sessions lasted for longer periods of time. There was no difference in the frequency of monthly group supervision sessions across practice settings, but the duration of the private-not-for-profit group supervision sessions was significantly longer. Counselors and supervisors participating in the study typically reflected a positive view on the quality of supervision provided at this time suggested an overall level of satisfaction with the practice of clinical supervision as it is presently provided.

Based on the results of the stepwise linear multiple regression, participants identifying as counselors noted the impact of supervisor behavior and gender as influential on the perceived level of satisfaction with clinical supervision. Supervisory knowledge was noted as predictive of the overall perceived quality of supervision. When broken down by work environment, the regression model predicted a significant portion of variance related to quality in both private-not-for-profit and private-for-profit participants identifying as counselors, and a significant portion of the variance in the private-not-for-profit satisfaction levels. However, no items were found to be a significant contributor to the private-for-profit satisfaction rates in the model.

Contemporary Clinical Supervision Practices

Previous studies have explored clinical supervision in the state rehabilitation agency context. Schultz et al. (2002) found that supervision was provided on an as needed basis, and often for 30 minutes or less per week, with 27% of their participants reporting a regularly scheduled time to meet with their supervisor. Herbert and Trusty (2006) found similar results,

with one third of their participants indicating clinical supervision occurred at least once per month, with supervision sessions typically lasting for nor more than twenty minutes. While McCarthy (2013) found the *mean* for weekly clinical supervision meetings to be somewhat longer at sixty nine minutes per session, McCarthy also suggested 55% of the study participants did not have regularly scheduled appointments with their supervisor, indicative of "as needed supervision".

In the present study, individual supervision sessions were reported by participants identifying as supervisors (*n* = 80) to occur on a *mean* of 4.46 times per month (*SD* = 5.88) and lasted for a *mean* of 46.81 minutes (*SD* = 21.59). A majority of these participants indicated meeting for individual clinical supervision sessions between one and four times per month (n = 59). Group supervision typically lasted for a *mean* of 56.69 minutes (*SD* = 46.48) and occurred a *mean* of 1.98 times per month (SD = 1.71). Participants in the study that identified as counselors reported a *mean* of 2.48 (*SD* = 3.80) individual clinical supervision sessions per month, and these sessions lasted for a *mean* of 29.53 minutes (*SD* = 29.19). Group supervision for counselors occurred on a *mean* of 1.43 times per month (SD = 4.74), and lasted for a *mean* of 29.88 minutes (SD = 40.05).

A majority of participants identifying as counselors (56.1%) stated individual supervision sessions occurred once per month (25.6%, *n* = 74) or not at all (30.4%, n = 88). As 64.7% of the participants identifying as counselors (*n* = 185) suggested they met for less than 30 minutes per month for individual supervision, and 30.1% (*n* = 86) reported no meetings at all, these findings parallel that of previous research (Herbert & Trusty, 2006; Schultz et al., 2002).

Group supervision was also conducted on an infrequent basis, with 53.8% of participants identifying as counselors (*n* = 155) suggesting they never met for group supervision and another

21.2% (*n* = 61) stating only meeting once per month for group supervision. Of note on group supervision sessions is the reported length; according to 31.6% of the respondents (n = 91), group supervision lasted for 50 minutes or longer. When combined with the fact group supervision was reported as occurring for a *mean* of 1.43 times per month, this finding could be indicative of many agencies and rehabilitation team conducting monthly staff meeting. This aligned with previous research suggesting staff meetings or administrative meetings are often confused with group supervision (Herbert & Trusty, 2006; Schultz et al., 2002).

When considering these results in against those recommended guidelines of minimally adequate supervision (Ellis et al., 2014), which suggest 60 minutes of individual group supervision per week, there is room for improvement. Of note here is the propensity of respondents to suggest they were sole-proprietors working in the private-for-profit sector. As they were self-employed with no co-workers, they reported neither providing nor receiving clinical supervision (*n* = 20). As this was a recurring theme across many emailed responses back to the researcher, permission was obtained to include some of their concerns as qualitative reflections on clinical supervision in private-for-profit sectors. Their concerns are reflected in the following two quotes.

> *"The survey was very counselor/supervisory based and made some assumptions about CRC work. For example, as a private sector for profit CRC, I rely heavily on the forensic section of the CRC and don't work in groups, don't work with classic "clients" don't "counsel" and don't have a supervisor who emphasizes that sort of thing. We just work on other stuff."*

"*I started out doing the survey as a vocational consultant, but then it wanted to know how many hours my supervisor supervised me, etc. and that doesn't fit me. I am self employed."*

These responses are reflective of some of the recent research in ethical dilemmas specific to private VR settings, particularly those that are private-for-profit. Some of the expressed and contemporaneous ethical concerns revolve around third-party billing systems (Shaw & Lane, 2008), business practices and professional practices (Saunders, Barros-Bailey, Rudman, Dew, & Garcia, 2007), and balancing financial gain against the client's best interest (Tarvydas & Barros-Bailey, 2010). These reported ethical concerns have been addressed in Section F of the CRCC Code of Professional Ethics, but remain some of the more common ethical concerns of counselors in the private practice settings of vocational rehabilitation (Beveridge, Garica, & Siblo, 2015). Differences in both the type of and frequency in dealing with ethical dilemmas has been reported across rehabilitation private and public sectors (Beveridge et al., 2015). Where private sectors reported higher frequencies associated with ethical dilemmas, specifically those falling in the professional responsibility (Section D of the CRCC Code of Ethics) and forensic and indirect services (Section F), and where clinical supervision has been suggested as a way to teach ethical decision making skills (Herbert & Trusty, 2006) and a component of multiple ethical decision making models (Cottone & Claus, 2000), this reported ideal of not needing clinical supervision is troubling.

The differences between participants identifying as supervisors and those identifying as counselors may reflect misunderstanding on the part of counselors as to when their supervision is actually providing clinical supervision. This lack of understanding on the part of participants as to when clinical supervision is actually being provided may be in part due to the low amount of

training in clinical supervision as reported by participants identifying as supervisors. Research has suggested training on clinical supervision may have little to no impact on the promotion of clinical supervision practices (Herbert, Byun, Schultz, Tamez, & Atkinson, 2014). Moreover, of the 99 participants identifying as supervisors, 52.7% (*n* = 49) stated they had received training on clinical supervision. Of those participants that had received training, 65.9% (*n* = 29) had less than 100 hours of training, 15.9% (n = 7) had between 100 and 150 hours of training, and 18.2% (n = 8) reported over 240 hours of training on clinical supervision. This is somewhat problematic as supervisors in the present study rated their abilities in a positive manner and higher than perceptions of competence as reported by counselors, indicating the lack of training was not perceived by supervisors as a barrier or obstacle in providing high quality supervision. Nonetheless, proper training regarding the practice of clinical supervision is necessary (CRCC, 2009; Glosoff & Matone, 2010). Findings from this study suggest contemporary practice is to provide clinical supervision with limited training. If the profession "… would never dream of turning [unsupervised] untrained therapists loose on needy patients, why would [the profession] turn untrained supervisors loose on those untrained therapists who help those needy patients" (Watkins, 1997, p. 603)? Such a practice seems contradictory in nature. But training alone may not be enough to change behavior and effectiveness of supervisory practices, or lead to counselors realizing the potential benefit of clinical supervision. Research on training suggests rehabilitation supervisors often enjoy the training and feel it has increased their knowledge of clinical supervision practices, but the implementation of that knowledge is limited (Herbert et al., 2014).

While no established limit of supervision training has been established by the CRCC, historically there was a Certified Rehabilitation Counselor – Clinical Supervision (CRC – CS)

designation with required levels of training and experience. This designation was discontinued due to lack of interest, but previously required 60 months of professional experience and a graduate level course in clinical supervision, or 30 clock hours from professional workshops on supervision (Herbert & Bieschke, 2000). Thus, CRCC has historically recognized both experience and formal training as necessary in the provision of supervision (Herbert & Bieschke, 2000). This recognition continues as evidenced by the inclusion of supervision in the 2010 revision of the CRCC professional code of ethics (CRCC, 2010, section H). Despite this recognition and stated level of importance, the current study found results similar to previous research on clinical supervision in terms of the time allotted to and frequency of sessions dedicated towards the provision of clinical supervision (Herbert & Trusty, 2006; McCarthy, 2013, Schultz et al., 2002).

Supervisory contracts have been recommended as a component of minimally adequate supervision (Ellis et al., 2014) and also a component of ethical clinical supervision practices (Glosoff & Matrone, 2010). Where the supervisory working alliance is a reflection of the goals and tasks to be accomplished through clinical supervision, and indicative of the relationship that will foster the appropriate selection of goals and tasks necessary to enhance the professional development of the more junior professional (Bordin, 1983), the use of supervisory contracts might provide a mechanism to clarify goals, expectations, and functions of clinical supervision. When coupled with regularly scheduled meetings for clinical supervision, the clarity offered by a succinct clinical supervision contract may in turn help supervisees better recognize when their supervisors are providing clinical supervision designed to enhance their skill level and overall proficiency.

Based on previous findings suggesting the low utilization for supervisory contracts in rehabilitation counseling settings (Herbert & Trusty, 2006; McCarthy, 2013; Schultz et al., 2002), limited familiarity with supervisory contracts was anticipated. To avoid confusion, a simple definition of supervisory contracts was provided: not a performance evaluation sheet, a but a contract outlining the goals, tasks, and processes the two of you have mutually agreed upon. This appeared as part of the question to participants inquiring about their use of a supervisory contract in supervision. A majority of participants indicated they did not utilize such contracts, but as indicated in the following sections where confusion around goal selection and realization existed, the use of a supervisory contract may benefit supervisees and supervisors in clarifying the goals and tasks of supervision.

The present study compared perceptions of clinical supervision knowledge, behavior, self-efficacy, and supervisory working alliance as rated by counselors and supervisors from private practice settings of vocational rehabilitation. In chapter four, the Bonferroni correction was applied to the comparative analysis of these perceptions based on work setting. The application of the Bonferroni correction helped to reduce the likelihood of committing a Type I error. The Bonferroni was particular useful when looking at the participants' perspectives based on role (counselor vs. supervisor) and work environment (private-for-profit vs. private-not-for-profit). As this study is the first of its kind, this conservative approach may also have prematurely eliminated some items, and further research could help to strengthen the results of the present study.

Knowledge

As supervision is an intervention in its own right (Bernard & Goodyear, 2014), it would seem reasonable there are specific knowledge domains and skills imperative to the quality

provision of clinical supervision. Thielsen and Leahy (2001) helped to lay the empirical foundation of clinical supervision knowledge specific to rehabilitation counseling, and demonstrated that the training needs of clinical supervisors include, but also exceed the knowledge domains, roles, and functions of the rehabilitation counselor. Originally designed by Thielsen and Leahy (2001), this scale, as used in the present study, helped to clarify personal perceptions (supervisors) of their understanding or their perception of their supervisors' understanding (supervisees) of the knowledge domains related to clinical supervision in rehabilitation counseling practice in private-for-profit and private-not-for-profit settings.

When comparing participants that identified as counselors against participants identifying as supervisors, significant statistical differences did exist on all items, except for the item on examining the implications of sexual orientation and potential similarities and/or differences between the supervisor and the supervisee. When applying the Bonferroni correction, 27 of the 33 items still meet statistically significant criteria (see Table 17). While statistically significant differences did exist across all other items, it is important to note that all reported supervisors perceptions on the items excluding the use of case presentation ($m = 2.73$) had a *mean* score of higher than three (moderate understanding). A majority of items (23 of 33) were also rated by supervises at the moderate understanding or higher. Ten items as rated by supervisees were below the moderate understanding level, as all had *means* in the little understanding range. Particularly troubling is the inclusion of working as a teacher and working as a counselor in the little understanding range; these two items are indicative of two recognized roles of clinical supervisions (Bernard, 1997; Bernard & Goodyear, 2014; Herbert & Trusty, 2006). Years of experience may have had some impact here, as Herbert and Trusty (2006) reported that supervisees felt the counselor and teacher roles were applied less often than supervisors

perceived. With 67.99% of the counselors in this study (n = 223) reporting more than five years of work experience, it may be that the consultant role is the role supervisees feel best describes their supervisor based on frequency of use and therefore has a higher rating on understanding and may account for the similar responses on this item by both counselors and supervisors. This high application of the consultant role would mirror previous research (Herbert & Trusty, 2006).

When examining differences based on role (supervisee vs. supervisor) and environment (private-for-profit vs. private-not-for-profit) independent of the other practice setting, some differences when compared to the larger role analysis appeared. Private-for-profit supervisees and supervisors still manifested statistically significant differences across 28 of the 33 items. Those items found to not meet statistically significant criteria comprised the examination of culture and ethnicity (t = -1.91, df = 141, p = .06), examining implications of sexual orientation (t = -1.65, df = 141, p = .10), using videotapes and/or audiotapes (t = -1.50, df = 141, p = .14), dealing with ethical issues specific to group supervision (t = -1.86, df = 141, p = .07), and establishing written goals related to supervision (t = -1.55, df = 141, p = .12). An additional eleven items were eliminated after the application of the Bonferroni correction.

For private-not-for-profit participants, 28 of 33 items remained statistically significant. Items not demonstrating statistical significance included examining implications of gender (t = -1.32, df = 201, p = .19), examining implications of sexual orientation (t = -1.18, df = 201, p = .24), techniques used in group supervision (t = -1.74, df = 118.01, p = .09), making accommodations for counselors with disabilities (t = -1.34, df = 201, p = .18), and assisting with the establishment of written goals (t = -1.87, df = 201, p = .06). An additional 14 items failed to reach statistical significance when the Bonferroni correction was applied. When these supervisee/supervisor roles are viewed in light of the separated work environment, of note is the

lack of statistical significance on establishing written goals. When considering the lack of the utilization of supervisory contracts, it is interesting to note that supervisees and supervisors still felt goals were established. This may be a reflection of supervisees and supervisors perceiving work performance expectations as the mutually agreed upon goals of supervision; this would be indicative of an administrative function, as opposed to a more clinical focus of goals on the application of theory, case conceptualization, or increased ethical awareness.

Behavior

Specific behaviors have been shown to foster and impede the delivery of clinical supervision (English et al., 1979; Herbert, 2004c; Herbert, 2012). Positive behaviors include 1) a supervisor that a counselor feels is accessible, meaning highly approachable and can effectively engage counselors, 2) a supervisor must be available when problems arise, 3) highly capable, and 4) supervisors need to be flexible and apply humor appropriately in the work setting (Herbert, 2004c; Herbert, 2012). The inclusion of a behavior scale, and subsequent statistical analysis to compare differences between supervisees and supervisors perceptions of supervisor behavior helps to clarify the perceived behaviors of contemporary clinical supervision in private-for-profit and private-not-for-profit settings.

The discussion of supervisor personal issues in the supervisory sessions was not found to be statistically significant (t = -.67, df = 326, p = .50). Given the somewhat negative perception of this item and a lower *mean* score (supervisee m = 3.52; supervisor m = 3.68) suggesting a rating of *Slightly Disagree* on the Likert style scale, the overall low *means* and general congruence between supervisees and supervisors on this scale is felt to be a positive reflection of contemporary supervision in private rehabilitation settings. This would be reflective of clinical supervisory sessions that are focused on task related functions, not personal issues. All other

items were found to be statistically significant at the $\alpha = .05$ level and when the Bonferroni correction was applied, with supervisors rating their behaviors more positively than counselors. Of note here is the difference specific to the item on making sufficient time to meet (supervisee, $m = 4.91$; supervisor, $m = 5.42$). One of the key behaviors of clinical supervisors is being approachable and accessible (Herbert 2004c; Herbert, 2012). While both responses lean positive, with the counselors reported *mean* indicative of "Slightly Agree" and supervisors reported *mean* as "Agree", the statistically significant difference in perceived availability is the concern. Supervisors should schedule pre-set, arranged times for clinical supervision (Ellis et al., 2014), but also take care to be available when needed (Herbert, 2012).

The provision of clinical supervision in an ethical and professional manner ($t = -5.56$, $df = 297.47$, $p = .00$), and the demonstrated use of an appropriate sense of humor during supervision ($t = -4.88$, $df = 243.97$, $p = .00$) were two items with high *means* on both the part of supervisees and supervisors. It has been suggested supervisors are arbiters and modelers of ethical service delivery in rehabilitation counseling (Austin, 2012; Schultz, 2011; Tarvydas, 1995) and the ethical delivery of supervision has been emphasized in the CRCC Code of Professional Ethics (Section H). The high rank of ethical delivery and professional manner in providing clinical supervision indicates those that do engage in clinical supervision seem to take their responsibility as a modeler of ethical delivery seriously, and supervisees subsequently rate the overall actions of their supervisors as exemplifying professional and ethical delivery.

Self-Efficacy

Self-efficacy centers on the belief an individual has that they can accomplish or realize a set of tasks or goals (Bandura, 1977, 1982; Phillips et al., 2012). When successful task performance occurs, cognition is shaped to include those tasks as something mastered by the

individual. When individuals possess low self-efficacy, or rephrased in a different way, when individuals do not believe they can successful complete tasks or realize goals, one of the results is for these individuals to give up more easily in challenging situations (Gist, 1987; Phillips et al., 2012). With limited time typically devoted to clinical supervision (Herbert & Trusty, 2006; Schultz et al., 2002), and with a majority of rehabilitation counseling supervisors not being familiar with or indoctrinated in clinical supervision practices as counselors (Herbert & Caldwell, 2015; Herbert & Trusty, 2006; Schultz et al., 2002), it might be reasonable to assume low self-efficacy scores on the scale by both supervisees and supervisors alike.

Study participants that identified as supervisors rated personal levels of self-efficacy in delivering specific clinical supervision components on a scale of one to one hundred. Study participants that identified as supervisees reported their confidence in their supervisors ability to perform the functions described. Statistical differences existed across all categories with supervisors reporting higher levels of self-efficacy and confidence in delivering clinical supervision at the $\alpha = .05$ level. When applying the Bonferroni correction, one additional item fialed to meet statistical significant criteria (allowing the counselor to structure the session, $t = -2.974$, $df = 194.38$, $p = .003$). Partly attributable to the scale, the differences between supervisees and supervisors were much larger, with the lowest *mean* difference being 9.38 (allows counselor structure supervision sessions). The remaining nine *mean* differences were all larger than 15.66, and the lowest *mean* supervisor score of 78.27 on the structuring of the supervisory session was still rated higher than the highest supervisee *mean* of 76.32 on the helps counselor discuss client problems. These results indicated a higher level of incongruence between supervisee and supervisor perceptions across these items than previous scales.

Further analysis examining private-not-for-profit supervisees and supervisors and private-for-profit supervisees and supervisors found no differences between the larger supervisors/supervisee analyses in the private-not-for-profit setting. All items remained statically significant at the $\alpha = .05$ level and with the application of the Bonferroni correction. Conversely, the private-for-profit setting had two items that were not statistically significant: evaluating counselor interactions with clients ($t = -1.74$, $df = 59.32$, $p = .09$) and allowed the counselor to structure the supervision session ($t = -.25$, $df = 127$, $p = .80$) and an additional three items after the Bonferroni correction was applied. Thus in some areas, private-for-profit counselors do express confidence in their supervisors ability in a similar way to the responses reported by supervisors in private-for-profit settings. One item of interest related to previous scale results, is the item on teaching, demonstrating, or modeling interventions (supervisee, $m = 62.73$; supervisor, $m = 85.59$). The *mean* difference between these two items represented the largest *mean* difference of all the rated items. Scores on the supervisee knowledge scale indicated low perceptions of supervisor knowledge on how to utilize the role of teacher ($m = 2.99$), the role of counselor ($m = 2.96$), and demonstrate counseling techniques ($m = 2.78$). This would seem to be reflected here in the corresponding low score on self-efficacy in delivering those same clinical supervision practices.

Supervisory Working Alliance

It has been suggested that one of the key tasks needing to be accomplished early on in clinical supervision is the formation of a strong working alliance between the counselor and the supervisor (Bernard & Goodyear, 2014; Bordin, 1983). The ongoing maintenance of this bond over the course of the relationship is the primary responsibility of the supervisor (Nelson et al., 2001). Supervisors are also tasked with promoting discussion on differences of race, ethnicity,

gender, sexual orientation, religious affiliation, and any other difference between the counselor and supervisor where a power differential may exist (Herbert & Caldwell, 2015). The supervisory working alliance is the relationship that allows for difficult discussion to occur, and "is an important mechanism to effect positive change in processes and certain outcomes" of clinical supervision (Bernard & Goodyear, 2014, p. 79).

The independent samples t-test analysis of the supervisory working alliance inventory found statistically significant differences across 16 of the 18 parallel questions. The two items where statistical significance is not found, and indicative of similar thought patterns and ideas between supervisees and supervisors are 1) supervisor encouraging supervisee to formulate their own interventions with clients (t = -.51, df = 196.03, p = .61) and 2) supervisee understanding client treatment and behavior in a manner similar to their supervisor (t = .54, df = 198.30, p = .59). This can be interpreted that supervisees do feel their supervisors encourage them to formulate their own interventions for clients (indicative of a perceive level of trust), and also that supervisees understand client behavior and treatment technique similar to the way their supervisor does, indicating some level of interpersonal interaction and training.

The two items with the lowest counselor *mean* scores were 1) I work with my supervisor on specific goals in the supervisory session (m = 4.95) and 2) I feel free to mention to my supervisor any troublesome feelings I might have about him/her (m = 4.75). A score of four indicates neutrality, and these scores do lean more towards the frequent rating (score of 5) as opposed to occasionally rating (score of 3). The statistically significant differences on the goal items reflect similar findings on the development of specific goals on the behavior scale and overall low use of supervisory contracts as reported by participants in this study. If goals are unclear and not formally agreed upon, it can be difficult for the counselor know when they are

indeed working on goals the supervisor may have independently established for the supervisee. Despite the *mean* differences suggesting differences of perception on the strength of the working alliance, overall, the *mean* scores of both supervisee and supervisor lean to a more positive reflection of the supervisory working alliance.

Indicators of Satisfaction with Clinical Supervision

Initial consideration of satisfaction with clinical supervision was conducted through data analysis of descriptive statistics, and demonstrated an overall positive satisfaction with supervision (identifying as counselors, $m = 4.70$, $SD = 1.53$; identifying as supervisors, $m = 4.90$, $SD = 1.46$). These results placed the overall satisfaction rating on the slightly satisfied to moderately satisfied for both supervisees and supervisors. When comparing counselors across practice setting, significant differences ($t = -2.87$, $df = 271.98$, $p = .01$) did exist between the private-for-profit counselors ($n = 125$, $m = 4.98$, $SD = 1.45$) and the private-not-for-profit counselors ($n = 156$, $m = 4.47$, $SD = 1.55$). Private-for-profit counselors reported an overall satisfaction rate much closer to the moderately satisfied level and reflected an overall higher level of satisfaction with clinical supervision than their private-not-for-profit counterparts, who reported in the slightly satisfied range. No significant differences between supervisors in the respective work settings were found, suggesting supervisors from both private-for-profit and private-not-for-profit settings are similarly satisfied with clinical supervision delivery at this time.

When comparing satisfaction across role and setting, counselor and supervisors from the private-for-profit did not demonstrate a statistically significant difference in their perception of satisfaction with clinical supervision. Private-not-for-profit counselors and supervisors reported statistically significant differences across their perceptions of satisfaction with clinical

supervision (t = -2.29, df = 108.53, p = .02). This could be due in part to the nature of the work environment, with counselors in sole-proprietorship having sought out their work environment based on a perception they would not be working under the direct supervision of someone. While, counselors in private-not-for-profit settings would tend to be more in a team based rehabilitation settings with formal supervisors and colleagues where feedback and oversight would be expected.

Gender. It has been suggested that gender differences and potential resulting conflicts between the supervisee and supervisor can impact the end service user (e.g., client, consumer, customer; Bernard & Goodyear, 2014). Research has also demonstrated differences in clinical supervision style between males and females (Chung, Marshall, & Gordon, 2001; Kollock, Blumstein, & Schwarz, 1984; Sells, Goodyear, Lichtenberg, & Polkinghorne, 1997). Gender differences in reported satisfaction were considered, but no statistically significant differences were noted between male and female counselors (t = 1.04, df = 278, p = .30) and male and female supervisors (t = -.37, df = 87, p = .72) in terms of satisfaction when analyzed by an independent samples t-test. Gender did play a role in the predictive ability of the general regression model on satisfaction in each of the three models calculated in the stepwise multiple linear (See Table 25), with males generally reporting a higher degree of satisfaction. As such, it is felt gender does indeed impact satisfaction to some degree when associated with clinical supervision.

Race-ethnicity. Race was not found to be significant indicator of either satisfaction or statistically significant on the regression models. Despite this, attending to multicultural aspects of supervision has been suggested as important (Chang, Hays, & Shoffner, 2004; Herbert & Caldwell, 2015) and is recognized in the CRCC Code of Professional Ethics (2010, Section

H.2.b). While the demographics of the study generally reflected the CRCC population of interest, the relatively low participation rate of individual from diverse racial and ethnic backgrounds does make it difficult to draw substantiated conclusions as to the potential impact race/ethnicity may or may not have on satisfaction with clinical supervision in rehabilitation counseling private practice settings.

Supervisory working alliance. Satisfaction was impacted by the supervisory working alliance in the second model of the stepwise multiple linear regression. This alliance is a central component in the conceptualization of the relationship between the supervisee and supervisor. Many differences existed on the independent samples t-test, with only two of the 33 items not meeting statistical significance: supervisor encouraging supervisee to formulate their own interventions with clients (t = -.51, df = 196.03, p = .61) and supervisee understanding client treatment and behavior in a manner similar to their supervisor (t = .54, df = 198.30, p = .59). These are areas where the supervisor and supervisee would seem to have harmonious perceptions on service delivery and somewhat representative of a certain level of trust by supervisor in their supervisees, potentially as a result of the relatively high number of years of experience reflected by the counselors in this study (m = 13.1, SD = 11.1). When considering work environments separately, the supervisory working alliance was deemed a significant predictor of supervisee satisfaction in the third model for participants from the private-for-profit sector, and a significant predictor of satisfaction for

Supervisory behavior. Supervisory behavior replaced the supervisory working alliance in the third model. There are key attributes that have been shown to affect the supervisory working alliance: "the supervisor's (a) style, (b) use of expert and referent power, (c) use of self-disclosure, (d) attachment style and emotional intelligence, and (e) ethical behavior" (Bernard &

Goodyear, 2014, p. 74). Schultz et al (2002) delineated the use of expert and referent power in rehabilitation settings. Results indicated the more knowledge and expertise a supervisor was perceived to have, in addition to similar characteristics or behavioral dimensions deemed important by the supervisee, the stronger the supervisory working alliance. These also align well with the four qualities rehabilitation counselors preferred in their clinical supervisor: accessibility, approachability, availability, and flexibility (Herbert, 2004c; Herbert, 2012). There would seem to be a perceptible difference between knowing and doing. Thus, an individual may possess the knowledge necessary to be considered a competent provider of clinical supervision services, but there are certain requisite attributes or behaviors that are necessary in order to satisfactorily deliver clinical supervision services.

Indicators of Perceived Quality of Clinical Supervision

The quality of supervision is impacted by factors inherent in the supervisor and supervisee. Many of the supervisor behaviors mentioned previously are through to be predictors of clinical supervision quality: supervisory style: attractive and interpersonally sensitive, use of expert and referent power, supervisor self-disclosure, emotional intelligence, and ethical/unethical behavior of the supervisor (Bernard & Goodyear, 2014). While the supervisory working alliance is a reflection of these behaviors, the stepwise multiple regression models attempted to separate potential influences across those core elements of knowledge, behavior, and self-efficacy and assess the predictive impact of each of these respective supervisor attributes.

Initial analysis conducted through descriptive data analysis demonstrated an overall positive perception of quality by participants (identifying as counselors, m =4.65, SD = 1.22; identifying as supervisors, m = 5.3, SD = .63). These results placed the overall perception of

quality on the somewhat valuable to moderately valuable for supervisees, and between the moderately valuable and very valuable range for supervisors. When comparing counselors across practice settings, counselors from private-for-profit (m = 4.84, SD = 1.14) reported a statistically significant higher level on perceived quality (t = -2.34, df = 279, p = .02) than their private-not-for-profit counterparts (m = 4.50, SD = 1.26). While this difference is statistically significant, the overall effect is somewhat minimal given the fact the two scores are both reflective of a positive perception of quality.

When comparing perceptions of quality across role and environment, counselors identifying as employed in the private-for-profit sectors rated the provision of clinical supervision at a statistically significant higher level of quality (t = -2.34, df = 279, p = .02) than their private-not-for-profit counterparts. No statistical difference was noted between supervisors based on work setting. Statistically different perceptions were noted between counselor and supervisor when respective work settings were considered. Private-for-profit supervisors (t = -3.71, df = 99.03, p = .00) and private-not-for-profit supervisors (t = -5.67, df = 185.49, p = .00) both reported higher perceptions of quality when compared to their respective supervisees. These differences may reflect a belief on the part of the supervisors they are providing a better quality of clinical supervision than they actually are. Careful consideration of supervisee factors (e.g., emotional intelligence, past experiences with negative clinical supervision, high levels of stress or anxiety) impacting the quality of clinical supervision needs to be considered (Bernard & Goodyear, 2014). Significant differences between counselors and supervisors on the supervisory working alliance inventory in key areas like "the counselor is more curious than anxious" (t = -2.61, df = 2645.67, p = .01), "counselor feels free to mention troublesome feelings" (t = -6.76, df = 274.13, p = .00), and "counselor and supervisor work on specific goals" (t = 3.65, df = 233.86,

p = .00) may reflect supervisor behaviors impeding not only the quality of supervision, but by extension, the overall supervisory working alliance.

Supervisory working alliance. When examining the predictive ability of the supervisory working alliance on perceived levels of quality, the supervisory working alliance was found to be a significant predictor on the second and third models of the stepwise multiple linear regression. Of note is the lack of statistical significance demonstrated by gender and race/ethnicity on any of the models in the stepwise multiple linear regressions. This is counter to the results on satisfaction. The second model was found to account for 34% of the variance in perceived quality of supervision, and the supervisory working alliance was the only statistically significant predictor within that model (t = 10.58, p = .00). When examining the models based on role and work environment, supervisory working alliance was the only predictor variable to be found statistically significant on the third model (t = -3.23, p = .00) and this model accounted for 42% of the variance on perceived quality of supervision by counselors in private-for-profit settings.

Knowledge. The supervisory working alliance was joined by knowledge in the third general model of the stepwise multiple linear regression. This model accounted for 50% of the variance on perceived quality of supervision. When applying the regression model to the counselor perceptions of quality from the private-not-for-profit sector, the effect of the supervisory working alliance was no longer statistically significant, but knowledge held (t = 3.13, p = .00) and the model still accounted for 42% of the variance on perceived quality of supervision.

The relationship of behavior to satisfaction and knowledge to perceptions of quality is indicative of the high collinearity between the items in the model. The supervisory working

alliance is a sum of knowledge, behavior, and self-efficacy brought to the relationship by the supervisor in addition to the supervisee's perception of the supervisor to successfully engage in the clinical supervision process and foster the professional development of the supervisee. Of note here is the lack of statistically significance of self-efficacy on any of the regression models, yet strong statistical differences between counselor perceptions of supervisor self-efficacy and supervisor perceptions of personal self-efficacy in delivering clinical supervision (See Tables 11 and 21).

Limitations

While this study has a number of strengths and was given to sufficiently control the study and ensure accuracy, consideration of potential limitations attendant to the research design associated with this study is necessary. First, the researcher has been both a recipient and provider of clinical supervision in the state VR system. Certain attitudes and beliefs were developed as part of the researcher's previous employment, and despite precautions taken to ensure the questions and information are analyzed from a neutral research standpoint, it is possible some of these biases reinforced or masked certain aspects of the supervisory process, thereby confirming preconceived notions the researcher may already have had.

Second, limitations associated with the generalizability of this study should be noted. This study is cross sectional in design, and can only be used as a general reference for contemporary practices of clinical supervision in the private-not-for-profit and private-for-profit fields. These respective fields are dynamic and constantly changing. The needs of individuals seeking rehabilitation services are also constantly changing. It is anticipated some fluidity of the profession will continue to occur in the future as rehabilitation counseling adapts to individual needs, changes in legislature, changes in accreditation structuring, and fiscal environments.

Nevertheless, the core components of clinical supervision knowledge as outlined by Thielsen and Leahy (2001) will continue to remain applicable and this study outlines differences in clinical supervision practice according to role (rehabilitation counselor and supervisor) and practice settings (private-not-for-profit and private-for-profit).

Some of the potential participants expressed concern over the applicability of the study given to them as they were self-employed and neither received nor provided clinical supervision. While they were encouraged by the research to participate to the best of their ability, their decision to participate is not known. It is therefore unclear what influence their inclusion may have had on the results of the study. These individuals (n = 20) seemed to reflect very strongly held beliefs that clinical supervision was not necessary. They may have responded as either counselor or supervisor. They may have considered their practicum and internship from many years ago as they responded to questions on clinical supervision. Given the overall small number of individuals that so responded, it is felt their impact is negligible.

Another potential limitation was the use of an on-line survey to measure attitudes, beliefs, and knowledge of supervision in private VR settings. As online research conducted through the use of Internet based surveys typically have response rates lower than the traditional mail surveys (Granello & Wheaton, 2004), this potentially limits the generalizability of the study. Comparable studies surveying similar populations (i.e., CRCs) through on-line methods (Del Valle, 2015, Kuo, 2013; Lewicki, 2015) had response rates in the low to mid 20% range. It is possible that those individuals who chose not to respond to the survey share similar belief patterns or characteristics differing from those who do respond, which in turn may limit the interpretability and generalizability of the results. Additionally, potential participants willing to

share valuable insights may not have had reliable access to the Internet, thereby limiting their participation.

Since this research project uses self-report methods of data collection, it is possible participants responded in ways they felt were socially appropriate or near the middle of the provided Likert scales (Heppner, Kivlighan, & Wampold, 1999). Self-report surveys sometimes lack face validity due to individuals choosing to select a response that does not accurately reflect their actions in practice or responding in a manner they feel is most socially appropriate (Remler & Van Ryzin, 2011). The use of a single Likert style scale item to collect data on perceptions of satisfaction and quality associated with clinical supervision may not accurately reflect the essence of satisfaction and quality. The constructs of satisfaction and quality can be extremely subjective and without further exploration of these items beyond a single response to a question with pre-set scale, results may not accurately reflect these complex principles.

This study asks supervisees and supervisors to respond to questions regarding perceptions of knowledge, behavior, and self-efficacy. While it is possible, it is highly unlikely that the participants in this study were commenting about a supervisor/supervisee counterpart also participating in this study. While this is a nationally based survey with a good representation of the desired sample, the possibility remains that the trends and responses presented in this study do not accurately reflect overall tendencies. Having matched pairs of supervisors and supervisees would have strengthened the study.

The response rate of 24% and completion rate of 18.1% is another limitation that needs to be addressed. While CRCC continuing education units were offered as an incentive two follow up email reminders were sent to potential participants, the overall response rate is low. Despite the similar response rates to other computer based surveys using the CRCC database for their

sample population (Del Valle, 2015; Kuo, 2013; Lewicki, 2015), and despite the overall match of the study demographics to the general demographic of all CRCs provided by CRCC, the potential for survey responses provided by participants to not accurately reflect present perceptions and beliefs pertaining to clinical supervision in private practice settings remains.

In regards to the predictive ability of the regression model, there are two concerns of note. High multicollinearity, while expected, between the supervisory working alliance, supervisory knowledge scale, supervisory behavior scale, and supervisory self-efficacy scale may have reduced the predictability of the regression models. While variance inflation scores (VIFs) were considered and correlations between variables were carefully observed and considered, the possibility that the strong relationship between the items influences results in such a manner so as to mask the actual significance or non-significance of certain predictor variables.

Another concern revolves around the effect size of the private-for-profit satisfaction model (Cohen $f^2 = .139$). The other five models demonstrated statistically significant items accounting for a reasonable amount of the variance, with all effect scores between the range between .395 and 1.288, all falling in the large effect size. The private-for-profit satisfaction model had a Cohen f^2 score of .139. In conducting a post hoc power analysis to ensure appropriate effect size and power were maintained, this item failed to have the necessary number of participant responses (actual $n = 94$; required $n = 105$). Of the six models, this was the only model that failed to identify any significant predictors of counselor satisfaction in the private-for-profit work setting. Future studies might look to replicate the present study and bolster the participation of the private-for-profit counselors to ensure appropriate measures of power and effect size are maintained.

Implications

The rehabilitation counselors that participated in this study demonstrated differences in the way they perceive clinical supervision knowledge, behavior, self-efficacy in providing clinical supervision, and the overall strength of the supervisory working alliance. These differences were shown to impact overall satisfaction with supervision and perceptions of clinical supervision quality. Similar to previous studies (Herbert & Trusty, 2006; McCarthy, 2013; Schultz et al., 2002), this study found rehabilitation counselors to engage in clinical supervision on an infrequent basis and for limited time periods. Implications from this study impact educators, private-not-for-profit settings, and private-for-profit settings. Recommendations for future research are also presented.

Implications for Rehabilitation Counseling Educators

Clinical supervision has been suggested as the most import component in the pre-service preparation of rehabilitation counselors (Scofield & Scofield, 1978; Thielsen & Leahy, 2001). Past evaluation of clinical supervision practices through content analysis of course syllabi, student handbooks, and program information suggested the nature and extent of clinical supervision training is unique to each counseling programs' preferences and emphasis (Herbert, 2004a). Limited course availability given accreditation standards has made it difficult to implement a course specifically focusing on clinical supervision, though calls for this to occur have been suggested (Herbert & Beishke, 2000). While programs have historically followed the CORE Graduate Standards, the recent merger of CORE and the Council for Accreditation of Counseling and Related Educational Programs (CACREP) will require CORE programs to expand their educational coursework from 48 hours to 60 credit hours. While a previous call to expand to sixty credit hours was met with varied degrees of success (Leahy, 2002), this merger

will be finalized effective on June 30, 2017 and all counseling programs accredited by CACREP will be required to have 60 credit hours of instruction by July 1, 2020.

One of the barriers associated with clinical supervision training at the pre-service level is the limited professional development and cognitive and emotional readiness of practitioners to engage in discussions on the shift from the supervisee to supervisor role (Scott, Nolin, & Wilburn, 2006). While the majority of doctoral programs offer coursework in clinical supervision, many master's programs do not, leading to graduates who have received clinical supervision, but not provided any type of clinical supervision (Scott et al., 2006). Additionally, the provision of clinical supervision is infrequent, reactionary, and inconsistent from setting to setting (Herbert & Trusty, 2006; McCarthy, 2013; Schultz et al., 2002; Scott et al., 2006). This perpetuates a cycle of inadequate training on and implementation of clinical supervision. If educators and clinicians alike note the need for and overall importance of clinical supervision and education across the professional lifespan, a standard educational model may be necessary (Scott et al., 2006).

Section three of the CACREP 2016 standards require program-appropriate audio and or video recordings, combined with live supervision of students' interactions with clients. Based on the findings of this study, these are specific areas where contemporary clinical supervision practices for private rehabilitation settings could improve. Section 2.F.1.m of the CACREP 2016 standards is considered a foundational knowledge point for future counselors, and states that documentation of the role of counseling supervision in the program's curriculum is required. As previously discussed, the profession has pre-service training and clinical supervision as safeguards to avoid turning [unsupervised] untrained therapists loose on needy patients; enacting the same type of safeguards with those providing clinical supervision so as to avoid untrained

supervisors providing clinical supervision would seem a reasonable requirement (Watkins, 1997). With the expansion to sixty credits hours being a necessary part of CACREP accreditation, the time may be now to implement the supervision course proposed by Herbert and Bieschke (2000). Another viable alternative may be the provision of a three-credit hour course in clinical supervision for those already possessing a master's degree; this could be provided for continuing education units for the CRC but help to standardize training for rehabilitation counselor supervisors. Rehabilitation counselor educators must make a better effort to instill in their students the benefits from and rationale for clinical supervision as it helps with the professional development over the career of the individual.

Implications for Private-not-for-profit Practice Settings

Private-not-for-profit settings of VR practice serve over 9 million individuals with disabilities, and often bridge the gap between individual need and specific agency capacity (Fabian & MacDonald-Wilson, 2012). Community rehabilitation programs continue to grow in terms of role and service provision, and will likely continue to do so given changes in federal legislation (Fabian & MacDonald-Wilson, 2012). While these practice settings mirror the state/federal VR system to some degree in terms of a formal agency structure and organization, and often work in conjunction with state/federal VR systems, differences still exist (See Table 1). Given the reliance of many of these private-not-for-profit agencies on Medicaid and other federal funds and an increasing expectation to implement evidence-based practices, clinical supervision remains a viable method for counselor training and professional development.

Similar to state/federal VR programs, employment outcomes and other client goal based outcomes are benchmarks for success in private-not-for-profit settings (Thomas et al., 2001; See also Table 2). Within the present study, some of the larger discrepancies between counselors and

supervisors' perceptions existed in the private-not-for-profit setting. Low application rates of clinical supervision, limited time dedicated to the provision of clinical supervision, and poorly structured goals are reflective of reactionary and "as needed" clinical supervision (Herbert & Trusty, 2006; Schultz et al., 2002). Clinical supervision has been shown to impact consumer outcomes, specifically for those counselors within their first two years of employment post graduation (McCarthy, 2013). With high numbers of recent graduates entering the community rehabilitation program settings (Fabian & MacDonald-Wilson, 2012), the continuity and familiarity of extending practicum/internship based supervision principles to the work setting may help with the overall work adjustment of new practitioners.

Additionally, 27.5% of the CRCs in this study are entering the closing years of their practice and are presently preparing for retirement; the population of this study did mirror the general population of CRCs, and this potential loss of experience and knowledge will necessitate the advancement of counselors into supervisory and managerial roles. Past criteria for appointment as a supervisor was often conditional upon high performance as a counselor (Herbert, 2012), through an approach of assuming "the best counselor is the best supervisor" (Thielsen & Leahy, 2001). Where clinical supervision is an intervention in its own right (Bernard & Goodyear, 2014), length of work experience is not related to professional growth or development of supervision skills (Herbert, 2012; Worthington, 1987), and ethical standards mandate training for rehabilitation counseling supervisors (Glosoff & Matrone, 2010), training and preparation of supervisors should be more thoughtful and measured than a "next-in-line-approach" based on performance indicators.

Implications for Private-for-profit Practice Settings

Herbert and Trusty (2006) found that counselors who were the most satisfied with clinical supervision met with their supervisors infrequently, typically once per month or less. For the study participants employed in the private-for-profit settings, this type of satisfaction also seems to hold true. Limited clinical supervision occurred, and some of the participants emailed the researcher over participation concerns as they neither received nor provided clinical supervision. These participants and their email responses reflected a tone of indifference in the receipt of clinical supervision, suggestive of a lack of clarity on the purpose of clinical supervision and limited desire to engage in the clinical supervision. While private-for-profit rehabilitation counselors likely chose their profession in part based on the freedom of the work environments, the increased rates of ethical dilemmas in specific areas of practice may justify requirements for clinical supervision hours as well. Clinical supervision has been suggested as a way to target ethical-decision making (Herbert & Trusty, 2006). While counselors should not feel obligated to provide clinical supervision, inherent within the professional development process is a desire to improve and continually learn. While it can be difficult to review one's own training, worldview, beliefs, and biases (Glossoff & Matrone, 2010), failure to do so can lead to unproductive or harmful counseling interventions (Estrada, Wiggins, Frame, & Braun-Williams, 2004). Moreover, one of the important functions of clinical supervision is the protection of client welfare (Bernard & Goodyear, 2014; Glosoff & Matrone, 2010). Counselors that operate in isolation with little to no formal clinical supervision are missing a vital component of ethical service delivery and potentially jeopardizing client welfare. Presently, the CRCC Code of Professional Ethics only mandates specific training requirements for 10 of the 100 continuing education units necessary in a five-year period, with that obligatory training

focusing on ethical provision of services (CRCC, 2010). While overall complaints and formal grievances with CRCC remain low, given the high propensity for ethical dilemmas in the private-for-profit settings (Beveridge et al., 2015) and the increasing public scrutiny of rehabilitation counseling as a profession, now may be the time to require counselors, particularly those working as sole-proprietors, to document the receipt of clinical supervision for a designated number of hours per month.

Implications for Future Research

While the present study has built off of previous research on clinical supervision practices in the state/federal rehabilitation setting, and expanded clinical supervision research into the private practice settings of VR, further need still exists to better understand clinical supervision, its implementation, and overall effect in rehabilitation counseling.

Peer-to-peer consultation. Given the overall lack of clinical supervision as reported in this study, it may be necessary to present alternative forms of clinical supervision to private-not-for-profit and private-for-profit rehabilitation counselors. Herbert (2012) noted an aversion on the part of many state rehabilitation counselors to receive clinical supervision. Herbert suggested this may be in part due to the terminology being used and being unfamiliar with the purpose of clinical supervision. With the term "clinical" often associated with the medical model of disability (Herbert, 2012), a model seen as flawed by contemporary rehabilitation counseling philosophy, some counselors may equate clinical supervision to remedial supervision for those with lesser counseling skills. Counselors then reject a formal approach to supervision out of fear of being perceived as inadequate. When asked if they were presently receiving clinical supervision, some of the present study participants suggested they did not receive clinical supervision, but did have someone they would seek out in the event they needed consultation on

a specific problem or concern. Thus, findings from the present study indicate counselors do seek out guidance and direction, particularly in instances of difficult decisions. In essence, they seek out clinical supervision that meets their needs. Exploration of this peer to peer consultation may help to clarify how clinical supervision occurs in less formal ways.

Outcome based measures. Some work has been done to document the impact of clinical supervision on client outcomes (McCarthy, 2013). This has not been replicated in the private practice settings. This may be difficult to determine given some of the time-limited relationships and differences in measured outcomes for those rehabilitation counselors in forensic settings. However, particularly for those private-not-for-profit rehabilitation counselors where independent living skills, vocational evaluation, job training, job placement, and supported employment services are purchased in conjunction with state/federal VR agencies, understanding the role of the rehabilitation supervisor in the development of private-not-for-profit counselor skill proficiency may help to streamline services and develop better strategies designed to improve counselor expertise in meeting the needs of service recipients.

Supervisor and counselor expectations. Counselors and supervisors seem to have varied expectations of what clinical supervision is and what can actually be achieved through clinical supervision. A qualitative analysis of counselor perceptions leading to a field generated definition of clinical supervision may help to clarify the nomenclature between academia and practitioners. Clinical supervision is about professional development and models of supervision hold transformational learning as inherent within the supervision process (Schultz, 2008). Understanding counselor perceptions of how supervision can best be implemented and taught could help to clarify educational goals and outline best practices associated with the delivery of clinical supervision specific to rehabilitation counseling settings that can be used in conjunction

with the more general Ellis et al (2014) counseling supervision guidelines. Research could also explore supervisor understanding, perceived definition of, and ideas on how best to implement clinical supervision to bridge the gap between counselors and supervisors.

Consumer expectations. Consumers are a key element in the clinical supervision, though their participation and involvement is often considered only from a philosophical standpoint. Research clarifying consumer expectations of rehabilitation counselors in the private-not-for-profit and private-for-profit settings may help to delineate the specific roles and functions of rehabilitation counselors perceived by clients to be necessary for adequate service provision. These could be combined with the known empirical standards (Leahy et al., 2009, 2013) to better orient clinical supervisors on the types of skill development and areas of proficiency most likely to directly impact consumer expectations.

Conclusion

Clinical supervision remains an intervention in its own right (Bernard & Goodyear, 2014). It is a way to transmit learning and proficiency from the regulated and structured academic environment to the more fluid and subtly nuanced work environment. Clinical supervision has been implemented with varying degrees of success in state rehabilitation settings (Herbert & Trusty, 2006; McCarthy, 2013; Schultz et al., 2002). The present study sought to expand this previous research into the expanding and quickly growing private-not-for-profit and private-for-profit settings of rehabilitation counseling. Results indicated statistically significant differences between counselors and supervisors' perceptions of the frequency and format of clinical supervision, perceptions of supervisor clinical supervision knowledge, behavior, self-efficacy, and supervisory working alliance. While overall satisfaction rates and perceptions of quality were generally positive, statistically significant differences existed between reported

counselor perceptions and supervisor perceptions. Results also indicated limited use of supervisory contracts. Clinical supervision knowledge and participant gender were found to be a significant predictor of supervisory satisfaction. Clinical supervision behaviors and the supervisory working alliance were found to be predictive of overall perceptions of clinical supervision quality. While the study present study has helped to clarify contemporary practices of clinical supervision within the private settings of rehabilitation counseling, much remains to be done to better understand the impact of clinical supervision in the development of rehabilitation counselors and service delivery to clients.

APPENDICES

Appendix A

Clinical Supervision Knowledge Scale – Counselor Form

Instructions: Listed below are knowledge areas related to providing field-based clinical supervision of rehabilitation counselors. Please rate the level of understanding that you believe your supervisor has for each area based on the following scale: 1 – No Understanding, 2 – Little Understanding, 3 – Moderate Understanding, and 4 – Complete Understanding.

_____1. Build rapport with a counselor during supervision.
_____2. Establish trust within the supervisory relationship.
_____3. Negotiate power within the supervisory relationship.
_____4. Examine implications of culture/ethnicity similarities/differences between supervisor and counselor.
_____5. Examine implications of gender similarities/differences between supervisor and counselor.
_____6. Examine implications of sexual orientation similarities/differences between supervisor and counselor.
_____7. Examine implications of disability similarities/differences between supervisor and counselor.
_____8. Address sources of conflict that sometimes occur in the supervisory relationship.
_____9. Describe the similarities and differences between clinical and administrative supervision.
_____10. Stages of clinical skill development that counselors experience as they start as novice counselors all the way through becoming experienced and integrated counselors.
_____11. Changing needs of supervisees over the course of supervision.
_____12. Use different supervisory roles (e.g., teacher, counselor, consultant) as part of supervision.
_____13. Techniques used in group supervision.
_____14. Work as a teacher as part of supervision to enhance my counseling skills.
_____15. Work as a consultant as part of supervision to enhance my counseling skills.
_____16. Work as a counselor as part of supervision to facilitate my awareness of areas that I need to work on to improve my counseling skills.
_____17. Use video/audiotapes as part of supervision.
_____18. Use case presentation as part of supervision.
_____19. Use role-play as part of supervision.
_____20. Provide verbal feedback to improve my counseling skills.
_____21. Demonstrate counseling techniques as part of supervision.
_____22. Use Humor during supervision.
_____23. Address sources of anxiety and stress that counselors sometimes experience.
_____24. Use methods to assist counselors who are not adequately progressing professionally.
_____25. Address counselor resistance that sometimes occurs during supervision.
_____26. Make accommodations for counselors with disabilities as part of supervision.
_____27. Apply theoretical knowledge to real-world situations.

_____28. Deal with ethical dilemmas specific to individual supervision.
_____29. Confidentiality issues in supervision.
_____30. Dual relationship issues in supervision.
_____31. Deal with ethical issues specific to group supervision.
_____32. Strategies to use so that supervision session are clearly focused.
_____33. Strategies to assist the counselor in establishing written supervision goals.

Appendix B

Clinical Supervision Behavioral Scale – Counselor Form

Instructions: Please rate the level of agreement that you believe the items below characterize your interactions with your individual supervisor using the following 6 point Likert scale as follows: 1) Strongly Disagree, 2) Disagree, 3) Slightly Disagree, 4) Slightly Agree, 5) Agree, and 6) Strongly Agree.

My supervisor…

_____1. Made sufficient time available to meet with me about a client or related concern when there was no prior scheduled appointment.
_____2. Shared a relevant professional experience with me when he/she worked as a counselor that benefitted me as a counselor.
_____3. Went out with me in the field or observed me in the office to watch a client-counselor session in order to provide feedback regarding my counseling skills.
_____4. Went out with me in the field to provide feedback regarding my professional interactions with other professionals, employers and/or community members.
_____5. Scheduled regular pre-arranged times to meet for individual supervision.
_____6. Scheduled regular pre-arranged times to meet for group supervision.
_____7. Provided different ideas and opinions in a respectful manner about decisions I made about my clients.
_____8. Conducted supervision in an ethical and professional manner.
_____9. Kept all schedule supervision appointments with me.
_____10. Demonstrated an appropriate sense of humor during supervision.
_____11. Satisfactorily addressed questions pertaining to agency policy issues.
_____12. Discussed concerns and issues regarding my professional growth.
_____13. Followed through on professional commitments that were made with me.
_____14. Provided constructive feedback about my counseling skills.
_____15. Effectively demonstrated a counseling skill or technique as part of supervision.
_____16. Effectively identified and addressed an ethical concern during supervision.
_____17. Effectively used role-play as part of a supervision session.
_____18. Processed client-counselor sessions and related activities that were made from observations made in the field or in the home office.
_____19. Provided constructive feedback regarding my counseling strengths.
_____20. Effectively used case presentations to enhance my skills as a counselor.
_____21. Provided feedback consistent with my own counseling theory or orientation (e.g., CBT, Motivational Interviewing) that I use with my clients.
_____22. Discussed her/his personal issues with me that might have been irrelevant to my professional work.
_____23. Encouraged me to try different counseling approaches with my clients that might help improve rehabilitation outcomes.
_____24. Provided resource information that might help me to improve as a counselor (e.g.,

journal articles or information found on the internet).

_____25. Maintained a good balance between talking and listening to me during individual supervision.

_____26. Provided timely feedback that benefited me as a counselor.

_____27. Developed specific supervision goals with me to work on in order to improve client rehabilitation outcomes.

_____28. Helped me explore alternative before making a final decision about issues related ot my professional work.

_____29. Suggested that I seek consultation with another counselor to get another perspective about a concern that I had about one of my clients.

Appendix C

Clinical Supervision Self Efficacy Scale – Counselor Form

Directions: On a scale of **0 (not at all confident)** to **100 (highly confident)** record a number regarding the level of confidence that you have in your supervisor to perform each of the tasks stated below. For example, a number of 50 would indicate a moderately confident level.

Right now, I feel that my supervisor can effectively...

_____1. Evaluate my counseling interactions with clients as part of supervision.
_____2. Identify appropriate counseling interventions to promote positive client change.
_____3. Teach, demonstrate, or model counseling intervention techniques.
_____4. Explain the rationale behind specific counseling strategies and/or interventions.
_____5. Interpret significant events in the counseling session.
_____6. Provide alternative interventions and/or conceptualizations for me to use.
_____7. Brainstorming counseling strategies and/or interventions with me.
_____8. Help me to discuss client problems, motivation, etc.
_____9. Solicit and address my professional needs.
_____10. Allow me to structure the supervision session.
_____11. Explore my feeling during a counseling session or supervision session.
_____12. Explore my feelings concerning a specific counseling technique and/or intervention.
_____13. Address and facilitate worries I might have about the counseling session.
_____14. Help me define personal competencies and areas for growth.
_____15. Process professional concerns that I might get defensive about.

Appendix D

Supervisory Working Alliance (SWA) – Supervisee Form

Instructions: Please indicate the frequency with which each statement described below seems characteristic of your work with your supervisor. After each item, select the number corresponding to the appropriate level using the following seven-point scale: 1 - representing Almost Never to 7 - representing Almost Always.

_____1. I feel comfortable working with my supervisor.
_____2. My supervisor welcomes my explanations about the client's behavior.
_____3. My supervision makes the effort to understand me.
_____4. My supervisor encourages me to talk about my work with clients in ways that are comfortable for me.
_____5. My supervisor is tactful when commenting about my performance.
_____6. My supervisor encourages me to formulate my own interventions with the client.
_____7. My supervisor helps me talk freely in our sessions.
_____8. My supervisor stays in tune with me during supervision.
_____9. I understand client behavior and treatment technique similar to the way my supervisor does.
_____10. I feel free to mention to my supervisor any troublesome feelings I might have about him/her.
_____11. My supervisor treats me like a colleague in our supervisory sessions.
_____12. In supervision, I am more curious than anxious when discussing my difficulties with clients.
_____13. In supervision my supervisor places a high priority on our understanding the client's perspective.
_____14. My supervisor encourages me to take time to understand what the client is saying and doing.
_____15. My supervisor's style is to carefully and systematically consider the material I bring to supervision.
_____16. When correcting my errors with a client, my supervisor offers alternative ways of intervening with that client.
_____17. My supervisor helps me work within a specific treatment plan with my clients.
_____18. My supervisor helps me stay on track during our meetings.
_____19. I work with my supervisor on specific goals in the supervisory session.

Appendix E

Clinical Supervision Knowledge Scale – Supervisor Form

Instructions: Listed below are knowledge areas related to providing field-based clinical supervision of rehabilitation counselors. On the basis of your education and training, please rate the level of understanding that you have pertaining to each statement each based on the following scale: 1 – No Understanding, 2 – Little Understanding, 3- Moderate Understanding, and 4) Complete Understanding.

_____1. Build rapport with a counselor during supervision.
_____2. Establish trust within the supervisory relationship.
_____3. Negotiate power within the supervisory relationship.
_____4. Examine implications of culture/ethnicity similarities/differences between supervisor and counselor.
_____5. Examine implications of gender similarities/differences between supervisor and counselor.
_____6. Examine implications of sexual orientation similarities/differences between supervisor and counselor.
_____7. Examine implications of disability similarities/differences between supervisor and counselor.
_____8. Address sources of conflict that sometimes occur in the supervisory relationship.
_____9. Describe the similarities and differences between clinical and administrative supervision.
_____10. Stages of clinical skill development that counselors experience as they start as novice counselors all the way through becoming experienced and integrated counselors.
_____11. Changing needs of supervisees over the course of supervision.
_____12. Use different supervisory roles (e.g., teacher, counselor, consultant) as part of supervision.
_____13. Techniques used in group supervision.
_____14. Work as a teacher as part of supervision to enhance my counseling skills.
_____15. Work as a consultant as part of supervision to enhance my counseling skills.
_____16. Work as a counselor as part of supervision to facilitate my awareness of areas that I need to work on to improve my counseling skills.
_____17. Use video/audiotapes as part of supervision.
_____18. Use case presentation as part of supervision.
_____19. Use role-play as part of supervision.
_____20. Provide verbal feedback to improve my counseling skills.
_____21. Demonstrate counseling techniques as part of supervision.
_____22. Use Humor during supervision.
_____23. Address sources of anxiety and stress that counselors sometimes experience.
_____24. Use methods to assist counselors who are not adequately progressing professionally.
_____25. Address counselor resistance that sometimes occurs during supervision.
_____26. Make accommodations for counselors with disabilities as part of supervision.

_____27. Apply theoretical knowledge to real-world situations.
_____28. Deal with ethical dilemmas specific to individual supervision.
_____29. Confidentiality issues in supervision.
_____30. Dual relationship issues in supervision.
_____31. Deal with ethical issues specific to group supervision.
_____32. Strategies to use so that supervision session are clearly focused.
_____33. Strategies to assist the counselor in establishing written supervision goals.

Appendix F

Clinical Supervision Behavior Scale – Supervisor Form

Instructions: From the items listed, please rate the level of agreement that you believe best characterizes your supervision with counselors whom you supervise based on the following scale: 1 – Strongly Disagree, 2 – Disagree, 3 – Slightly Disagree, 4 – Slightly Agree, 5 – Agree, and 6 – Strongly Agree.

_____1. Even though an appointment was not scheduled, I still made sufficient time to meet with counselors to discuss client issues and related concerns.
_____2. During supervision, I shared experiences from my past professional experience so that it might benefit the counselor.
_____3. I observed client-counselor sessions in order to provide feedback to counselors regarding their counseling skills.
_____4. I observed counselor interactions with other professionals, employers, and/or community members to provide feedback to counselors regarding their professional demeanor.
_____5. I had regularly scheduled pre-set times to meet for individual counselor supervision.
_____6. I had regularly scheduled pre-set times to meet for group supervision of counselors.
_____7. I was able to express different opinions with my counselors about client decision they made while, at the same time, respected their viewpoints.
_____8. I practiced supervision in accordance to ethical principles and standards in my professional field.
_____9. I kept scheduled appointments with counselors.
_____10. I used humor appropriately during supervision.
_____11. I satisfactorily addressed questions with my counselors regarding questions pertaining to agency policies.
_____12. I was approachable when counselors wanted to talk to me about professional growth issues.
_____13. I followed through on professional commitments that were made with counselors whom I supervised.
_____14. I provided helpful feedback to counselors about their counseling skills.
_____15. I effectively demonstrated a counseling skill or technique as part of supervision.
_____16. I effectively identified and addressed ethical concerns during supervision.
_____17. I effectively identified used role-play as part of supervision.
_____18. I processed client-counselor interactions with counselors from direct observations of counseling sessions and related professional activities within the office and/or in the field.
_____19. I provided constructive feedback regarding counseling strengths of counselors I supervised.
_____20. I effectively used case presentations as part of supervision.
_____21. I provided supervisor feedback consistent with the counselor's individual counseling theory or orientation (e.g., cognitive behavioral, person-centered).

_____22. I discussed personal issues with counselors whom I supervised that might have been irrelevant to their professional work.
_____23. I encouraged counselors to try different counseling approaches with their clients that might improve rehabilitation outcomes.
_____24. I provided resources that might help counselors improve as a counselor (e.g., journal articles or information found on the internet).
_____25. I demonstrated a good balance of talking and listening during individual supervision.
_____26. I provide timely feedback that benefited counselors whom I supervised.
_____27. I established specific supervision goals with each counselor I supervised in order to improve client rehabilitation outcomes.
_____28. I explored alternatives with my counselors before making final decision about issues related to their professional work.
_____29. I encouraged counselors to seek out peer consultation from other counselors about matters related to their clients.

Appendix G

Clinical Supervision Self Efficacy Scale – Supervisor Form

Directions: On a scale of **0 (not at all confident)** to **100 (highly confident)** record a number as to how confident you are to effectively perform each of the tasks stated below. For example, a number of 50 would indicate a moderately confident level.

Right now I feel that I can effectively…

_____1. Evaluate counseling interactions with clients as part of supervision.
_____2. Identify appropriate counseling interventions to promote positive client change.
_____3. Teach, demonstrate, or model counseling intervention techniques.
_____4. Explain the rationale behind specific counseling strategies and/or interventions.
_____5. Interpret significant events in the counseling session.
_____6. Provide alternative interventions and/or conceptualizations for the counselor to use.
_____7. Encourage counselor brainstorming of strategies and/or interventions.
_____8. Encourage counselor discussion of client problems, motivation, etc.
_____9. Solicit and address the professional needs of the counselor during the session.
_____10. Allow the counselor to structure the supervision session.
_____11. Explore counselor feelings during a counseling session or supervision session.
_____12. Explore counselor feelings concerning a specific counseling technique and/or intervention.
_____13. Facilitate counselor self-exploration of confidence and/or worries in the counseling session.
_____14. Help counselor define personal competencies and areas for growth.
_____15. Provide opportunities for counselors to process their own affect or defenses.

Appendix H

Supervisory Working Alliance (SWA) – Supervisor Form

Instructions: Please indicate the frequency with which each statement described below seems generally characteristic of your clinical supervision with counselors that you supervise. After each item, select the number corresponding to the appropriate level using the following seven-point scale: 1 representing Almost Never to 7 representing Almost Always.

_____1. My counselors understand client behavior and treatment techniques similar to the way I do.
_____2. I welcome my counselors' explanation about their clients' behaviors.
_____3. In supervision, I expect my counselors to think about or reflect on my comment to him/her.
_____4. I help my counselors work within a specific treatment plan with their clients.
_____5. I encourage my counselors to talk about the work in ways that are comfortable for them.
_____6. I help my counselors stay on track during meetings.
_____7. During supervision, my counselors talk more than I do.
_____8. I am tactful when commenting about my counselor's performance.
_____9. My counselors consistently implement suggestions made in supervision.
_____10. When correcting counselor errors with a client, I offer alternative ways of intervening with that client.
_____11. During supervision, my counselors seem able to stand back and reflect on what I am saying about him/her.
_____12. I encourage my counselors to formulate their own interventions with the client.
_____13. My style is to carefully and systematically consider the material my counselors bring to supervision.
_____14. My counselors appear to be comfortable working/with me.
_____15. My counselors identify with me in the way he/she thinks and talks about their clients.
_____16. I stay in tune with my counselors during supervision.
_____17. In supervision, I place a high priority on our understanding the client's perspective.
_____18. In supervision, my counselors are more curious than anxious when discussing their difficulties with clients.
_____19. My counselors work with me on specific goals in the supervisory session.
_____20. I encourage my counselors to take time to understand what the client is saying and doing.
_____21. I facilitate my counselors talking in our sessions.
_____22. I make an effort to understand my counselors.
_____23. I teach my counselors through direct suggestion.

Appendix I

Demographic Information Form

1. Sex
    a. Male
    b. Female
    c. Prefer not to answer

2. What is your age?
    a. Write in the answer.

3. Race/Ethnicity (Check all that apply)
    a. Alaskan Native
    b. Asian Descent
    c. Middle Eastern Descent
    d. Black/African Descent
    e. Latino(a)/Hispanic
    f. Native American
    g. Native Hawaiian/Pacific Islander
    h. White/Caucasian
    i. Other
        i. (Fill in the blank) Please Specify
    j. Prefer not to answer

4. Certification and Licensure Credentials (Mark all that apply):
    a. ABVE – American Board of Vocational Experts
    b. CCM – Certified Case Manager
    c. CDMS – Certified Disability Management Specialist
    d. CLCP – Certified Life Care Planner
    e. CMHC – Certified Mental Health Counselor
    f. CRC – Certified Rehabilitation Counselor
    g. CVE – Certified Vocational Evaluation Specialist
    h. NCC – National Certified Counselor
    i. LCMHC or LMHC – Licensed Clinical Mental Health Counselor or Licensed Mental Health Counselor
    j. LCPC or LPCC – Licensed Clinical Professional Counselor or Licensed Professional Clinical Counselor
    k. LCSW or LSW – Licensed Clinical Social Worker or Licensed Social Worker

l. LMFT – Licensed Marriage and Family Therapist
m. LPC – Licensed Professional Counselor
n. LRC – Licensed Rehabilitation Counselor
o. Other:
    i. Please Specify
p. None

5. What is the highest degree you have earned?
    a. Bachelor
    b. Education Specialty Beyond Bachelor's Degree
    c. Master's
    d. Doctorate

6. Please indicate your major area of study for your highest degree (Mark only one)
    a. Rehabilitation Counseling
    b. Rehabilitation Psychology
    c. Psychology
    d. Counseling
    e. Counseling Psychology
    f. Social Work
    g. Special Education
    h. Vocational Evaluation
    i. Business Administration
    j. Health Care Administration
    k. Nursing
    l. Physical Therapy
    m. Occupational Therapy
    n. Other Counseling Specialty Not Mentioned
    o. Other Rehabilitation Specialty
    p. Other
        i. Please Specify

7. What is your present occupation?
    a. Student
    b. Private Not-For Profit Rehabilitation (e.g., Corrections Programs, Disability Centers, College/University, Community Mental Health Centers, Community Rehabilitation Program, Independent Living Programs, K-12 Education, Non-Profit Research Institutions).

c. Private For-Profit Rehabilitation (e.g., Corporate Environment, For-Profit Research Institutions, Forensic, Medial Center or Rehabilitation Hospital, Insurance Company, Long Term Disability, Workers Compensation)
d. Retired
e. Unemployed

8. What is your job title:
    a. Rehabilitation Counselor
    b. Administrator/Manager
    c. Supervisor
    d. Rehabilitation Consultant
    e. Rehabilitation Case Manager
    f. Professor/Instructor
    g. Vocational Specialist
    h. Disability Management Specialist
    i. Job Placement Specialist
    j. Nurse
    k. Occupational Therapist
    l. Physical Therapist
    m. Other
        i. Please Specify

9. As you perform your major work related obligations, which of the following best describes your position:
    a. Rehabilitation Counselor
    b. Rehabilitation Counselor Supervisor

<u>Questions to be asked of Counselors Only</u>:

1. How many years of experience in the rehabilitation counseling field do you have?
    a. Entry Box

2. How many years of experience in your current work setting do you have (e.g., perhaps you have worked for five years in the rehabilitation field all together, but only for two years in your present work setting)?
    a. Entry Box

3. Is your direct supervisor a Rehabilitation Counselor?
    a. Yes
    b. No
        i. If No, what is their profession (fill in the blank)

4. Is your direct supervisor a Certified Rehabilitation Counselor?
    a. Yes
    b. No

5. Is your direct supervisor a Licensed Professional Counselor (LPC)?

6. Are your receiving and participating in clinical supervision at this time?

7. How are most individual supervision meetings scheduled? (Choose one only.)
    a. Pre-arranged specific meeting times.
    b. Whenever I initiated the meeting
    c. Whenever my supervisor initiates the meeting

8. On average, how many times per month do you meet with your supervisor for individual supervision where you discuss concerns about your clients or related professional issues to improve your skills as a rehabilitation counselor? If none, mark "0" (zero).
    a. Entry Box

9. On average, how long did your individual supervision session(s) last? Record your number by the average number of minutes.
    a. Entry Box

10. On average, how many times per month do you meet with your supervisor for group supervision where you, other counselors, and your supervisor specifically discussed concerns about clients or related professional issues to improve your skills as a rehabilitation counselor? Please note group supervision <u>does not</u> refer to unit meetings where general agency information or related announcements might be shared. (If no group supervision occurred, mark “0”).
    a. Entry Box

11. On average, how long does the group supervision session last? Record your number by the average number of minutes.
    a. Entry Box

12. How satisfied are you with respect to the amount of supervision (individual and/or group) that you receive?
    a. Very Dissatisfied
    b. Moderately Dissatisfied
    c. Slightly Dissatisfied

d. Slightly Satisfied
e. Moderately Satisfied
f. Very Satisfied

13. How would your rate the overall quality of supervision (individual and/or group) that you receive?
    a. Counterproductive
    b. Not al all Valuable
    c. Minimally Valuable
    d. Somewhat Valuable
    e. Valuable
    f. Very Valuable

14. Does your supervisor utilize a supervisory contract (not a performance evaluation sheet, a but a contract outlining the goals, tasks, and processes the two of you have mutually agreed upon) as part of the supervision process?
    a. Yes/No

<u>Questions to be asked of Supervisors Only</u>:

1. How many years of experience in the rehabilitation-counseling field do you have?
    a. Entry Box

2. How long (years and months) have you worked as a rehabilitation counselor supervisor (beyond the time you worked as a VR counselor, and potentially inclusive of different employment settings)?
    a. Entry Box

3. How long (years and months) have you worked in your current work setting (e.g., perhaps you have been a supervisor for 10 years, but only for the past two in your present work setting)?
    a. Fill in the blank.

4. Have you received formal training in clinical supervision (e.g., training to help improve counselor skills of those VR counselors you supervise)?
    a. Yes
    b. No
        i. If Yes, where did you complete the clinical supervision training (Mark all that apply).
            1. Professional Workshops
            2. In-service training (on the job)

3. Master's academic level course work
4. Post-master's academic level course work
5. Other
    a. Please specify

ii. About how many hours of supervisory training does this equate to?

5. How many rehabilitation counselors (including internship and practicum students) do you supervise?
    a. Text Box

6. What clinical supervision format(s) do you currently use with counselors you supervise? (Check all that apply)
    a. Individual Supervision (one-on-one supervisor and counselor session to improve counselor's skills)
    b. Group Supervision (supervisor and several counselors meet simultaneously to improve counselors' skills)
    c. Both individual and group sessions.
    d. None/I do not provide either individual or group supervision.

7. How are most individual supervision sessions scheduled when you want to provide counselor supervision (choose one)?
    a. Pre-arranged specific meeting times.
    b. Whenever counselor desires (on an as needed basis)
    c. Whenever I initiated the meeting

8. On average, how many times per month do you meet with each of your counselors for individual supervision where you discussed concerns about their clients or related professional issues to improve their skills as vocational rehabilitation counselors? If none, mark "0" (zero).
    a. Entry Box

9. When you meet with each of your counselors to provide clinical supervision, how long, on average, did the individual supervision session last? Record your number by the average number of minutes.
    a. Entry Box
10. On average, how many times per month did you meet with your counselors for group supervision where you and the counselors whom you supervise specifically discussed concerns about clients or related professional issues to improve their skills as vocational rehabilitation counselors? Please note group supervision does not refer to unit meetings

where general agency information or related announcements might be shared. If no group supervision occurred, mark "0" (zero).

a. Entry Box

11. How long, on average, did the group supervision last? Record your answer by the average number of minutes.
    a. Entry Box

12. Regardless of what supervision formats that you used (e.g., individual, group, both, or none) and how often you met with your counselors, how satisfied are you with respect to the overall quality of supervision that you provided?
    a. Very Unsatisfied
    b. Moderately Unsatisfied
    c. Slightly Unsatisfied
    d. Slightly Satisfied
    e. Moderately Satisfied
    f. Very Satisfied

13. Given the quality and amount of supervision that you provide, how valuable do you believe this effort contributed to the professional development of vocational rehabilitation counselors you supervised?
    a. Counterproductive
    b. Not at all Valuable
    c. Minimally Valuable
    d. Somewhat Valuable
    e. Valuable
    f. Very Valuable

15. Do you use a supervisory contract (not a performance evaluation sheet, a but a contract outlining the goals, tasks, and processes you have mutually agreed upon with your supervisees) part of the supervision you provide?
    a. Yes/No

Appendix J

Research Participant Informed Consent

Title of the Study: PERCEPTIONS OF SUPERVISORY KNOWLEDGE, BEHAVIOR, AND SELF-EFFICAY: SUPERVISOR EFFECTIVENESS IN PERFORMING CLINICAL SUPERVISION AND DEVELOPING THE SUPERVISORY RELATIONSHIP

1. Purpose of the Research

You are being asked to participate as a research participant in an internet-based survey study of certified rehabilitation counselor (CRC) perceptions on clinical supervision in the private for-profit and private not-for-profit rehabilitation practice settings. As defined in this study, clinical supervision involves a developmental and supportive relationship between the rehabilitation counselor and the rehabilitation supervisor where the intent of the supervision is to improve counseling skills and case management decisions of the counselor so that successful outcomes occur.

This study examines supervisor and supervisee perceptions related to supervisory knowledge, behaviors, supervisor self-efficacy, and the supervisory working alliance. Satisfaction with and overall effectiveness of the clinical supervision provided are also considered. You have been selected as a participant in this study because you have been identified as a CRC. After you finish reading the introductory material, your participation in this study will take 20 to 30 minutes of your time.

2. Type of participant involvement

You are being asked to complete this internet-based survey. There are five parts and the number of questions varies according to your present role (counselor or supervisor). We are asking you to complete these measures regarding your perception of your own abilities (if you are supervisor) or the abilities of your supervision (if you are a counselor) related to knowledge of effective clinical supervision practices, perceived effectiveness in performing clinical supervision tasks, effectiveness of the supervisor-counselor relationship and practices consistent with good clinical supervision. Some demographic information is also collected.

This survey is designed so that you can exit the survey and return later to complete your responses. You will need to access the instrument from the same computer in order to have your responses saved (i.e., if you initially access it from work, but were then to access it from home, you would have to start all over); so please use the same computer when responding. In order to have continued access to the survey, we ask that you not delete the original email inviting you to participate until after you have completed the survey. Two reminder emails will follow.

3. Potential benefits

Your participation in this study may help generate data useful for better understanding CRCs attitudes toward clinical supervision in the private for-profit and private not-for-profit rehabilitation settings and its role in counselor development. Further, it is anticipated that the findings from this study have the potential to both inform and enhance the clinical training curricula of master's rehabilitation counseling programs in the areas of counseling skill

development, supervision and training.

4. Potential risks

The questions being asked should pose no risk to you and, as there is no identifying information being collected about you, your responses will remain anonymous within the aggregated data.

5. Privacy and confidentiality

The data for this project will be kept confidential. Only the involved researchers (Dr. Michael Leahy and Trenton Landon, Doctoral Candidate, MS, CRC) will have access to the data. The researchers will maintain your privacy throughout the research process by ensuring you are automatically assigned an ID number. No identifying information will be stored with the data. The only identifying information will be your email address that is linked to your survey on Qualtrics and will be used only for sending email reminders to complete this survey. All the data will be imported and stored on one researcher's computer for data analysis. The computer and data files are password protected to ensure protection of all participant data. The results of this study may be published or presented at professional meetings, but the identities of all research participants are anonymous.

Upon completion of the survey, if you choose to apply for the CRCC continuing education credit, you'll be asked to provide your name and email address. While you will have to provide this identifying information, it will in no way be linked back to your responses on the survey.

6. Your rights to participate, decline, or withdraw

Your participation in this research study is completely voluntary at all times. You have the right to decline or change your mind at any time and withdraw. There are no consequences in withdrawing or not completing the survey. You may choose not to answer certain questions or stop participation at any time.

7. Costs and compensation for participation

There are no costs to you to participate in this study. Also you will not receive any other form of compensation for participating in this study, however, you will be eligible for one (1.0) continuing education credit from the Commission for Rehabilitation Counselor Certification (CRCC) for participation in this study. You must complete the survey fully in order to be eligible for this CEU and the final page within this survey will redirect you to another simple survey which will collect identifying information necessary for awarding the CEU, but will in no way be associated with the responses of this primary survey.

8. Contact persons for the study

If you have any questions about this study, or prefer an alternative method for taking this survey (e.g., by phone or hard copy), please contact the researcher, Trenton Landon, Michigan State University, 455 Erickson Hall, East Lansing, MI 48824, phone: (517) 871 – 8758, or email: landontr@msu.edu.

If you have any questions and concerns about your role and rights as a research participant, you can also contact the responsible project investigator, Dr. Michael Leahy, Michigan State University, 455 Erickson Hall, East Lansing, MI 48824, phone: 517-432-0605, or e-mail:

leahym@msu.edu.

If you would like further information, offer input, or would like to register a complaint regarding this research study, you may also contact (anonymously if you wish) the Michigan State University Human Research Protection Program at 517-355-2180, Fax 517-432-4503, e-mail irb@msu.edu, or regular mail: 408 West Circle Drive Room 207 Olds Hall, MSU, East Lansing, MI 48824.

Appendix K

Participant Invitation Letter

Dear Certified Rehabilitation Counselor,

You have been selected from the CRCC database as a potential participant in my dissertation research project. The purpose of this study is to understand current **Certified Rehabilitation Counselors' (CRCs) perception's in relation to the contemporary practices of clinical supervision in the Private-for-Profit and Private Not-for-Profit Rehabilitation practice settings**. Specifically, I am seeking your input on your **perceptions of the knowledge and behavior associated with clinical supervision, the self-efficacy of delivering clinical supervision, and the supervisory working alliance**. Your participation in the study will provide important information regarding the professional development of rehabilitation counselors working in these emerging fields of practice.

Below is the link to the online survey. At the beginning of the survey, you will find a statement explaining your rights as a research participant. Please read it carefully and proceed if you agree to participate. Your responses will be kept completely confidential. The survey is web-based and conducted by a third party vendor (i.e., Qualtrics). As such, your name will not be attached to any results.

It is expected that you can complete this survey in 20 to 30 minutes. It is designed so you can exit the survey and return later to complete your responses. If you do this, you will need to access the instrument from the same computer in order to have your responses saved (i.e., if you initially access if from work, but were then to access it from home, you would have to start all over); so please use the same computer when responding.

You can save your answers by clicking the next button. In addition, you have the option to save your responses and log out and return to the survey where you left off. However, you will be unable to go back and change your answers once you have submitted them since no identifying information will be included with your responses. Upon successful completion of the survey, you will be eligible for 1.0 continuing education credit through the Commission for Rehabilitation Counselor Certification.

You will receive a reminder email invitation in one week and another in two weeks. If you have already completed the survey, please disregard the reminder emails. Thank you in advance for your participation in this important project. If you have any questions about the administration of the survey, please contact Trenton Landon, Office of Rehabilitation and Disability Studies at Michigan State University at 517- 433- 2952 or landontr@msu.edu .

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